Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

February 2013

RHP 16

RHP Lead Contact: *Kathy Lee, Director, Special Projects*
Coryell Memorial Healthcare System
1507 West Main Street
Gatesville, Texas 76528
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254-248-6364

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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						
Hospital	134772611	17418571000001	Non-state-owned public entity	Coryell Memorial Hospital	Kathy Lee, Director	1507 West Main, Gatesville, TX 76528, k.lee@cmhos.org 254-248-6364
IGT Entities						
Hospital	134772611	17418571000001	Non-state-owned public entity	Coryell Memorial Hospital	Kathy Lee, Director	1507 West Main Street, Gatesville, TX, 76528, k.lee@cmhos.org 254-248-6364
Hospital	121792903	17425700683004	Non-state-owned public entity	Hamilton General Hospital	Michele Cathey, CEO	400 North Brown, Hamilton, TX, 76531, mcathey@hamiltonhospital.org, 254-386-1950
Hospital	137075109	17415466196012	Non-state-owned public entity	Goodall-Witcher Healthcare Foundation	Adam Willmann, CEO	101 South Avenue T, Clifton, TX, 76634, awillmann@gwhf.org, 254-675-8322
Hospital	140714001	17417440892007	Non-state-owned public entity	Limestone Medical Center	Larry Price, CEO	701 McClintic Drive, Groesbeck, TX, 76642, lprice@lmchospital.com, 254-729-3281
CMHC	084859002	17416229585002	Non-state-owned public entity	Heart of Texas Region MHMR Center	Tom Thomas	110 S 12th St, Waco, TX 76703, Tom.thomas@hotrmhmr.org,

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						254-297-7053
CMHC	081771001	17418013326002	Non-state-owned public entity	Central Counties Services	Eldon L. Tietje, Executive Director	317 S. 22nd Street, Temple, TX 76501, Eldon.Tietje@cccmhmr.org, 254-298-7007
County	N/A	17460024924055	Non-state-owned public entity	McLennan County	Lynne Lockwood, Chief Administrator	501 Washington Avenue, Waco, TX 76701 lynne.lockwood@co.mclennan.tx.us 254-757-5049
County	N/A	17460016946026	Non-state-owned public entity	Falls County	R. Steve Sharp County Judge	125 Bridge Street, Rm 203 Marlin, TX 76661 rs.sharp@co.falls.tx.us 254-883-1426
Country	N/A	TBD	Non-state-owned public entity	Hill County	Justin Lewis, County Judge	PO Box 457 Hillsboro, TX 76645 countyjudge@co.hill.tx.us 254-582-4020
City	1387078	17460024684033	Non-state-owned public entity	City of Waco	Sherry Williams, Director, Waco-McLennan County Public Health District	225 West Waco Drive, Waco, TX 76707 sherry@ci.waco.tx.us 254-750-5459
Performing						

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)
Providers						
Hospital	134772611	17418571000001	Non-state-owned public entity	Coryell Memorial Hospital	Kathy Lee, Director	1507 West Main Street, Gatesville, TX, 76528, k.lee@cmhos.org, 254-248-6300
Hospital	121792903	17425700683004	Non-state-owned public entity	Hamilton General Hospital	Michele Cathey, CEO	400 North Brown, Hamilton, TX, 76531, mcathey@hamiltonhospital.org, 254-386-1950
Hospital	137075109	17415466196012	Non-state-owned public entity	Goodall-Witcher Healthcare Foundation	Adam Willmann, CEO	101 South Avenue T, Clifton, TX, 76634, awillmann@gwhf.org, 254-675-8322
Hospital	140714001	17417440892007	Non-state-owned public entity	Limestone Medical Center	Larry Price, CEO	701 McClintic Drive, Groesbeck, TX, 76642, lprice@lmchospital.com, 254-729-3281
CMHC	084859002	17416229585002	Non-state-owned public entity	Heart of Texas Region MHMR Center	Barbara Tate	110 S 12th St, Waco, TX 76703, barbara.tate@hotrmhmr.org 254-752-3451
CMHC	081771001	17418013326002	Non-state-owned public entity	Central Counties Services MHMR	Eldon L. Tietje, Executive Director	317 N. 3nd Street, Temple, TX 76501, Eldon.Tietje@cccmhmr.org, 254-778-7995

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	138962907	17411619442004	Private	Hillcrest Baptist Medical Center	Jim Morrison, MD, MPH, CMO/Senior Vice-President	100 Hillcrest Medical Blvd, Waco, TX, 76712, jmorrison@hillcrest.net, 254-202-9414
Hospital	111829102	17411096369012	Private	Providence Health Center	Karen Richardson, CFO	6901 Medical Parkway, Waco, TX, 76712, Karen.richardson@phn-waco.org, 254-751-4000
Hospital	121831504	17411096369030	Private	The DePaul Center	Karen Richardson, CFO	6901 Medical Parkway, Waco, TX, 76712, Karen.richardson@phn-waco.org, 254-751-4000
UC-only Hospitals (list hospitals that will only be participating in UC)						
Hospital	133252005	17424254823501	Private	Hill Regional Hospital	Steve Dorris, CFO	101 Circle Drive, Hillsboro, TX, 76645, steve_dorris@chs.net 254-580-8953
Hospital	133367602	17414712319007	Private	Falls Community	Willis Reese,	322 Coleman,

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 and Clinic	Hospital Administrator	Marlin, TX, 76661, wreese@fallshospital.com 254-803-3561
Other Stakeholders (specify type)						
State-owned university system				Texas A&M Agri-Life Extension Services	Julie Gardner, Extension Agent	303 Veterans Memorial Loop, Gatesville, TX 76528 j-gardner@tamu.edu 254-865-2414
State-owned university system				Texas A&M Agri-Life Extension Services	Susan Ballabina, PhD, Director	303 Veterans Memorial Loop, Gatesville, TX 76528 sq-ballabina@tamu.edu 254-865-2414
City				City of Waco	Malcolm Duncan, Mayor	300 Austin Avenue, Waco, TX, 76702 wacomayor@waco-texas.com 254-750-5600
City				City of Waco	Sherry Williams, Director Waco-McLennan County Public Health District	225 West Waco Drive, Waco, TX 76707 sherry@ci.waco.tx.us 254-750-5459

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City				City of Waco	Kelly Craine, Preparedness Trainer/Planner	225 West Waco Drive, Waco, TX 76707 kellyc@ci.waco.tx.us 254-750-5459
City				City of Waco	Tiffani Johnson, Health Education Supervisor	225 West Waco Drive, Waco, TX 76707 tiffanij@ci.waco.tx.us 254-750-5459
City				City of Waco	Hammad Akram, Epidemiologist	225 West Waco Drive, Waco, TX 76707 hammada@ci.waco.tx.us 254-750-5459
City				City of Waco	Jacque Walker, Community Promotions Specialist	225 West Waco Drive, Waco, TX 76707 jacquelinew@ci.waco.tx.us 254-750-5459
City				City of Waco	Larry Groth, City Manager	300 Austin Avenue, Waco, TX, 76702 larryg@ci.waco.tx.us 254-750-5600
City				City of Gatesville	Roger Mumby, City Manager	110 N. 8th Street, Gatesville, TX 76528 roger.mumby@ci.gatesville.tx.us 254-865-8951

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)
City				City of Copperas Cove	Andrea Gardner, City Manager	207 S 3rd Street, Copperas Cove, TX, 76522 citymger@copperascovetx.gov 254-547-4221
County				McLennan County	Eva Cruz Hamby, Health Services Director	204 North 7th Street, Waco, TX, 76701 eva.cruzhamby@co.mclennan.tx.us 254-757-5174
County				McLennan County	Lynne Lockwood, Chief Administrator	501 Washington Ave, Waco, TX 76703 lynne.lockwood@co.mclennan.tx.us 254-757-5049
County				Bosque County	Cole Word, County Judge	P.O. Box 647 Meridian, Tx, 76665 C_word@bosquecounty.us 254-435-2382
County				Coryell County	John Firth, County Judge	620 East Main Street, Gatesville, TX 76528 county_judge@coryellcounty.org 254-865-5911

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)
County				Hill County	Justin W. Lewis, County Judge	1 North Waco Street, Hillsboro, TX 76645 countyjudge@co.hill.tx.us 254-582-4020
County				Hamilton County	Randy Mills, County Judge	102 N. Rice Street, Ste 124, Hamilton, TX 76531 countyjudge@hamiltoncountytx.org 254-386-1290
County				Limestone County	Daniel Burkeen, County Judge	200 W State St, Ste 101 Groesbeck, Texas 76642 Daniel.burkeen@co.limestone.tx.us 254-729-3810
County				Falls County	R. Steve Sharp, County Judge	PO Box 458, Marlin, TX 76661 rs.sharp@co.falls.tx.us 254- 883-1408
County				Coryell County	Daren Moore, County Commissioner	620 East Main Street, Gatesville, TX 76528 dmcoryellcounty@gmail.com 254-865-5911
County				Coryell County	Jack Wall, County Commissioner	620 East Main Street, Gatesville, TX 76528 jw@coryellcounty.org 254-865-5911

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)
Independent School District				Gatesville ISD	Stewart Speer, Superintendent	311 South Lovers Lane, Gatesville, TX 76528 sspeer@gatesvilleisd.org 254-865-7251
EMS				East Texas Medical Center EMS	James Stefka, Director	23631501 Hogan Ln, Waco, TX 76705 jstefka@etmc.org 254-799-7718
EMS				East Texas Medical Center EMS	Ron Schwartz, VP and COO	1000 South Beckham, Tyler, TX 75701 rschwartz@etmc.org 254-799-7718
EMS				Heart of Texas Regional Advisory Committee	Christine Reeves, Executive Director	3000 Herring Avenue, Waco, TX 76708 creeves@hotrac.org 254-202-8740
Hospital				Lake Whitney Medical Center	Ruth Ann Crow	200 N. San Jacinto Street, Whitney, TX, 76692 ruthanncrow@hotmail.com 254-694-3165
Physician Group				Waco Family Health Center	Allen Patterson, CFO	1600 Providence Drive, Waco, TX 76707 apatterson@wacofhc.org 254-750-8200

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Physician Group				Waco Family Health Center	Roland Goertz, MD, MBA	1600 Providence Drive, Waco, TX 76707 rgoertz@wacofhc.org 254-750-8200
Physician Group				Coryell Medical Clinic	Dr. J.D. Sheffield (State of Texas House of Representatives (elected Nov 2012)	1507 West Main Gatesville, TX 76528 Jsheffield@cmhos.org 254-865-2166
Physician Group				Family Practice Rural Health Clinic	Dr. Randy Lee	400 North Brown, Bldg II Hamilton, Texas 76531 jlee@hamiltonhospital.org 254-386-1700

Section II. Executive Overview of RHP Plan

RHP 16 is located in Central Texas, including areas north, west, and east of Waco. All seven counties in the region have Medically Underserved Area (MUA) designations as noted by Health Resources and Services Administration (HRSA) and Health Professional Shortage Area (HPSA) designations. Five of the counties have population to primary care provider ratios which exceed the Texas ratio of 1,050:1. Coryell and Falls Counties are significantly higher with ratios of over 3,000:1 and over 8,000:1 respectively. Additionally RHP 16 is also a Mental Health Professional Shortage Area. These limitations in access extend to other specialties as well, which providers seek to address in their Delivery System Reform Incentive Payment (DSRIP) plans. In addition to the lack of access to care, there is a growing aging population in this region. Overall, the population is set to increase around twenty one percent leading up to 2030, but because of the larger segment of the population being over 65 years of age, it is increasingly important to introduce healthy living options with self-management goals. With the substantial presence of the largest military base, Fort Hood in Killeen, Texas, just south and west of RHP 16, it is very important for the adjacent Coryell Memorial Hospital in Coryell County and Central Counties MHMR in multiple counties in the area to be ready to address the needs of the active military and disabled and/or aging Veterans who may find dual eligibility if faced with ongoing post-traumatic stress disorder and/or physical disabilities. As noted in national and state Medicaid trends, 20 percent of patients, or less in Texas, account for 80 percent of the costs. These patients may have multiple comorbidities, be dual eligible and/or have other health issues which account for their increased need for medical care. RHP 16 is unique in the aspect that a region-wide project to combat this inverse relationship is being championed by the anchor, Coryell Memorial Hospital. As developed in the plan in Section V., RHP 16 will launch train the trainer initiatives, deploy community health workers to schools and communities, and form strategic partnerships across provider lines to teach Medicaid and uninsured residents how to engage in healthier lifestyles. Our youngest generation and at-risk populations need the tools to be healthy adults and to not be plagued with chronic conditions reducing quality of life and increasing the financial and medical burden on our healthcare system. Patient centered health and wellness initiatives, complemented by increased access to needed specialty care, give patients the tools necessary to better manage their chronic conditions as they age. This can also prevent more costly and acute admissions in the inpatient hospital setting.

RHP 16 has proposed DSRIP plans from six acute care hospitals and two Community Mental Health Centers (CMHC). Two hospitals are located in Waco, Texas, where approximately 37,000 people are enrolled in Medicaid. Additionally, two hospitals have indicated they will be participating in the Uncompensated Care (UC) pool only. There has been wide provider participation, and the hospital and centers have all actively participated in stakeholder meetings, brainstorming sessions, webinars, and conference calls

and now in the submission phase.

With various statistical data uncovering quantifiable limitations on patient access to appropriate care professionals and settings, RHP 16 has developed a regional approach to DSRIP projects to efficiently and effectively address local healthcare needs for Medicaid and the uninsured. In the enclosed plans, larger tertiary hospitals are leading the development of evidence-based protocols and initiatives and then training rural providers in how to deploy the evidence based projects in their facilities. This creates a regional approach to limit variations across providers. Target populations identified are specific to the areas where the hospital is located to ensure they do not overlap. This consolidated effort is transformational. Providers are committed to working together to address total population health outcomes across county lines. RHP 16 adopted the following goals for all projects.

- Increase access to the primary care and mental health care providers and clinics within our region in order to further advance the Triple Aim: Right Care, Right Place and Right Time.
- Transform health care for the total population through regional collaborations which deploy health promotion, wellness activities, chronic disease management, patient centered approaches to care, and patient satisfaction outcomes.

RHP 16 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 through a regional telemedicine project, we expect to better enable appropriate diagnoses in a more timely fashion to prescribe the best treatment plan for patients. Too often, patients with urgent needs cannot get a same day appointment, or they may not know where to seek appropriate care outside the ED. 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 be developed regionally. 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 16 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 16 seeks to 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; regional projects to promote healthy lifestyle initiatives and disease prevention, 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			
081771001.1.1 Technology Support Central Counties MHMR	1.11.2 Implement technology-assisted behavioral health services	OD-6-IT-6.1 081771001.3.2 Patient Satisfaction	$1,044,351
Pass 3 081771001.1.2, 1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization Central Counties MHMR	1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization.	OD-9 IT-9.1 081771001.3.2 Right Care, Right Setting	$3,071,254
Pass 3 081771001.1.3, 1.10 - Enhance Performance Improvement and Reporting Capacity Central Counties MHMR	1.10 - Enhance Performance Improvement and Reporting Capacity	081771001.3.3 Primary Care and Disease Management	$718,703
Pass 3b Old:134772611.1.1 New: 134772611.1.4 Coryell Memorial Hospital	1.1.2 - Expand Existing Primary Care Capacity	OD 12-IT-12.1, IT-12.2, IT-12.3; OD 1-IT-1.7 Old: 134772611.3.1 New: 134772611.3.13 Old: 134772611.3.2	$4,525,556

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**
		New: 134772611.3.14 Old: 134772611.3.3 New: 134772611.3.15 Old: 134772611.3.4 New: 134772611.3.16 Primary Care and Primary Prevention, Primary Care and Chronic Disease Mgt	
Pass 3b Old: 134772611.1.2 New: 134772611.1.5 Coryell Memorial Hospital	1.9.2 Improve Access to Specialty Care	OD-3-IT-3.1 Old: 134772611.3.5 New: 134772611.3.17 PPR	$5,221,795
Pass 2 134772611.1.3, 1.7 – Telemedicine Coryell Memorial Hospital	1.7 - Introduce, Expand, or Enhance Telemedicine/Telehealth	OD-1 IT-1.20 134772611.3.9 Primary Care and Chronic Disease Management	$4,693,316
Pass 3B Old: 137075109.1.1 New: 137075109.1.4 Goodall-Witcher Hospital Authority	1.1.2 - Expand Primary Care Capacity	OD-6-IT-6.1 Old: 137075109.3.1 New: 137075109.3.4 Patient Satisfaction	$2,401,703
Pass 3B Old: 137075109.1.2	1.7.1 Expand/ Introduce Telemedicine	OD-1-IT-1.20 Old: 137075109.3.2	$884,837

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**
New: 137075109.1.5 Telemedicine Goodall-Witcher Hospital Authority		New: 137075109.3.5 Primary Care and Chronic Disease Mgt	
Pass 2 137075109.1.3 Expand Access to Specialty Care Goodall-Witcher Hospital Authority	1.9 Expand Access to Specialty Care	OD-6-IT-6.1 137075109.3.3 Patient Satisfaction	$1,096,814
Pass 3B Old: 121792903.1.1 New: 121792903.1.3 1.1 - Primary Care Hamilton General Hospital	1.1.2 - Expand Primary Care Capacity	OD-9-IT-9.2 Old: 121792903.3.1 New: 121792903.3.13 Right Care, Right Setting	$6,397,395
Pass 3B Old: 121792903.1.2 New: 121792903.1.4 1.7 - Telemedicine Hamilton General Hospital	1.7 - Telemedicine	OD-1 IT-1.20 Old: 121792903.3.8 New: 121792903.3.14 Primary Care and Chronic Disease Management	$1,862,095
084859002.1.1 Heart of Texas Region MHMR	1.12 - Enhance service availability	OD-6-IT-6.1 084859002.3.1 Patient Satisfaction	$1,110,075
Pass 3 138962907.1.1	1.9.2 Expand Specialty Care in Limestone County	OD-3 IT-3.1 138962907.3.4 All Cause	$3,313,720

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**
Hillcrest Baptist Medical Center		Readmission Rate	
111829102.1.1 Providence Health Center	1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth	OD-6-IT-6.1 111829102.3.1 Patient Satisfaction	$8,053,837
Category 2: Program Innovation and Redesign			
Pass 3b Old: 134772611.2.1 New: 134772611.2.5 Coryell Memorial Hospital	2.1.3 Implement Medical Home in Rural Area	OD-9-IT-9.2 Old: 134772611.3.6 New:134772611.3.18 Right Care, Right Setting	$2,436,851
Pass 3b Old: 134772611.2.2 New: 134772611.2.6 Coryell Memorial Hospital	2.6.3 Regional Health Promotion/Health Literacy Program	OD-11-IT-11.3 Old: 134772611.3.7 New:134772611.3.19 New: 134772611.3.20 New: 134772611.3.21 Addressing Health Disparities	$5,221,795
Pass 3b Old: 134772611.2.3 New: 134772611.2.7 Coryell Memorial Hospital	2.7.5 Regional Disease Prevention Program - Obesity	OD-10-IT-10.1 Old: 134772611.3.8 New: 134772611.3.22 Quality of Life/ Functional Status	$5,221,795

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**
Pass 2 134772611.2.4 Coryell Memorial Hospital	2.10 - Use of Palliative Care Programs	OD-13 IT-13.1, 13.2, 13.5 134772611.3.10 134772611.3.11 134772611.3.12 Palliative Care	$3,754,651
Pass 3B Old: 121792903.2.1 New: 121792903.2.6 2.2 - Chronic Care Hamilton General Hospital	2.2.2 Chronic Care: Heart Failure	OD-3 IT-3.2 Old: 121792903.3.2 New: 121792903.3.16 PPRs OD-2 IT-2.1 Old: 121792903.3.3 New: 121792903.3.15 PPAs	$5,277,853
Pass 3B Old: 121792903.2.2 New: 121792903.2.7 2.2 - Chronic Care Hamilton General Hospital	2.2.1 Chronic Care	OD-2 IT-2.5 Old: 121792903.3.4 New: 121792903.3.17 OD-2 IT-2.9 Old: 121792903.3.5 New: 121792903.3.18 OD-2 IT-2.10 Old: 121792903.3.6 New: 121792903.3.19 PPAs	$5,917,597

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**
Pass 3B Old: 121792903.2.3 New: 121792903.2.8 2.12 - Care Transitions Hamilton General Hospital	2.12.1 Care Transitions	OD-3-IT-3.1 Old: 121792903.3.7 New: 121792903.3.20 PPR	$5,757,661
Pass 3B Old: 121792903.2.4 New: 121792903.2.9 2.10 - Palliative Care Hamilton General Hospital	2.10 Palliative Care	OD-13 IT-13.1 Old: 121792903.3.9 New: 121792903.3.21 OD-13 IT-13.2 Old: 121792903.3.10 New: 121792903.3.22 OD-13 IT-13.5 Old: 121792903.3.11 New: 121792903.3.23 Palliative Care	$1,862,097
Pass 3B Old: 121792903.2.5 New: 121792903.2.10 2.2 - Expand Chronic Care Management Models Hamilton General Hospital	2.2 - Expand Chronic Care Management Models	OD-1 IT 1.10 Old: 121792903.3.12 New: 121792903.3.24 Primary Care and Chronic Disease Management	$8,379,436
084859002.2.1 Heart of Texas Region MHMR	2.15.1 – Integrate Primary and Behavioral Health Care Services	OD-1-IT-1.9 084859002.3.2 Primary Care and Chronic Disease Mgt	$2,630,695

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**
084859002.2.2 Heart of Texas Region MHMR	2.13.1 – Intervention for targeted behavioral health population	OD -10-IT-10.2 084859002.3.3 Quality of Life	$1,586,828
084859002.2.3 Heart of Texas Region MHMR	2.4.2 – Redesign to improve patient experience.	OD -10-IT-10.1 084859002.3.4 Quality of Life	$600,440
084859002.2.4 Heart of Texas Region MHMR	2.13.1 – Community Based Interventions for Children and Individuals	OD-6-IT-6.1 084859002.3.5 Patient Satisfaction	$1,339,536
084859002.2.5 Heart of Texas Region MHMR	2.2.5 – Expand Chronic Care Mgt Model. Integrate Geriatric Services	OD-1-IT-1.9 084859002.3.6 Primary Care and Chronic Disease Mgt	$1,922,172
084859002.2.6 Heart of Texas Region MHMR	2.13.1 – COPSD Program	OD-9-IT-9.1 084859002.3.7 Right Care, Right Setting	$771,006
Pass 3 084859002.2.7 Heart of Texas Region MHMR	2.13 - Community Clinic for Outpatient Services	OD 9 IT 9.2 084859002.3.8 Right Care, Right Setting	$5,803,482
138962907.2.1 Hillcrest Baptist Medical Center	2.10 Palliative Care	OD-3-IT-3.1, IT-13.2, IT-13.5 138962907.3.1 138962907.3.2 138962907.3.3 Palliative Care	$7,425,000
140714001.2.1 Limestone Medical Center	2.2 - Expand Chronic Care Management Models	OD-6-IT-6.1 140714001.3.1 Patient	$1,775,227

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	

Community Needs Assessment

Regional Healthcare Partnership

Region 16

October 2012

Dick Sweeden

TMSI, Inc.

Austin, Texas

Demographics

RHP 16 consists of seven Central Texas Counties, with an overall population of 406,490 citizens, according to the 2010 census, which represents a growth of 6% since the 2000 census. The range is from -3.8% in Falls County to +10.0% in McLennan County. The measure of Female to Male residents in the Region is approximately 51%-49%, respectively. The Region encompasses a land area of 6,559 square miles, with a population density that ranges from 10 people per square mile in Hamilton County to 224 per square mile in McLennan County.

The median age of RHP 16 is 36.7 years, and the median Household Income is $37,836. The average per capita income is $19,606. The unemployment rate for the Region is 7.9%, with the number of uninsured children and adults at 27.5%. Those currently living below the poverty rate are over 18% of the Region, with children below the poverty rate in excess of 31%.

Unemployment rate	**7.9%**	**Range: 5.7--9.6%**
Residents below Poverty Rate	**18.3%**	**Range: 13.1--23.2%**
Children below Poverty Rate	**31.4%**	**Range: 17.0--46.5%**
Uninsured 0 – 64 years	**27.5%**	**Range: 23.0--31.0%**
Uninsured 0 – 17 years	**17.4%**	**Range: 11.5--23.3%**

Source: Health Facts Profile www.dshs.state.tx

	Median Household Income	Unemployment Rate
Coryell	**$41,228**	**8.9%**
Hamilton	**$37,650**	**5.7%**
Bosque	**$41,313**	**8.7%**
Hill	**$38,194**	**8.5%**
Limestone	**$35,494**	**6.8%**
Falls	**$32,137**	**9.6%**
McLennan	**$38,837**	**7.4%**

Source: www.city-data.com

The percentage of residents by County with a High School diploma or higher ranges from 72% in Limestone County to 87% in Coryell County. Residents with a Bachelor's degree or higher range from 10% in Falls County to ~~20~~ 22% in ~~McLennan County~~ Hamilton County.

	High School	Bachelor's
Coryell	**86.7%**	**15.0%**
Hamilton	**82.2%**	**22.5%**
Bosque	**79.8%**	**14.8%**
Hill	**76.7%**	**14.8%**
Limestone	**72.2%**	**11.1%**
Falls	**74.3%**	**10.0%**
McLennan	**79.5%**	**20.4%**

Source: www.findthefacts.org

Ethnicity and/or Race are important demographic measures for the Region to consider, as African Americans and Hispanics tend to have a higher presence of Diabetes and Hypertension. These two chronic diseases can lead to other illnesses, including Cardiovascular diseases. Access to Primary Care and Specialty Care is an issue, especially in Rural Communities, and therefore increases the impact that chronic diseases can have on at-risk populations.

	White	Black	Hispanic
Coryell	**61.2%**	**16.8%**	**16.6%**
Hamilton	**86.7%**	**1.1%**	**10.9%**
Bosque	**79.8%**	**2.1%**	**16.5%**
Hill	**72.6%**	**7.0%**	**18.9%**
Limestone	**60.8%**	**17.9%**	**19.9%**
Falls	**52.2%**	**25.8%**	**21.5%**
McLennan	**58.3%**	**15.1%**	**24.2%**

Source: www.quickfacts.census.gov

Insurance

RHP 16's population includes a broad variety of ages, socio-economic groups, and insured/non-insured individuals. As the number of residents who are 65 and older continues to grow, the utilization of Medicare resources grows. This growth is not only with the number of individuals, but also in the increase of chronic diseases, such as diabetes, cardiac health, circulatory diseases, and mental health issues. Likewise, the number of uninsured/underinsured is growing as unemployment remains high, and as small businesses choose to not offer health benefits.

With the implementation of the Affordable Care Act over the next several years, it is anticipated that more individuals will have access to some form of insurance, either through the expansion of Medicaid, should the State of Texas participate in the program, and/or through the development of Insurance Exchanges.

Using the Medicaid rolls from November, 2011, the number of Medicaid enrollees by County is reflected below, followed by the number of Medicare enrollees and the number of CHIP enrollees by County.

Medicaid November 2011

	Total Enrollment	Total Enrollment Children
Coryell	**6,030**	**4,057**
Hamilton	**1,060**	**602**
Bosque	**2,261**	**1,516**
Hill	**5,458**	**3,709**
Limestone	**3,638**	**2,370**
Falls	**2,862**	**1,699**
McLennan	**37,000**	**24,838**

Source: www.hhsc.tx.us **Medicaid Enrollment files**

Medicare Enrollment

	Elderly Medicare	Disabled Medicare
Coryell	4,671	779
Hamilton	1,451	143
Bosque	3,242	409
Hill	5,457	869
Limestone	3,257	918
Falls	2,435	443
McLennan	26,506	4,562

Source: www.county-health.findthedata.org

Texas Chip Enrollment July, 2012

	Total	New
Coryell	809	49
Hamilton	147	7
Bosque	370	19
Hill	742	35
Limestone	554	33
Falls	358	21
McLennan	4,624	291

Source: www.hhsc.state.tx.us/research/CHIP/MonthlyEnrollment/12_07.html

The United States Census Bureau provides further information on insurance through its' Small Area Health Insurance Estimates, having released the 2009 Health Insurance Coverage Status report in October, 2011. The report combines survey data with population estimates and administrative records from a variety of sources, including Medicaid, Children's Health Insurance Program (CHIP), the Census reports, and several others. The data can be reviewed by the number of insured and uninsured, by age group, by sex, and by income levels. For the purposes of this report, the total numbers and percentages by County are included.

Health Insurance Coverage Status

	Uninsured		Insured	
	#	%	#	%
Coryell	**16,043**	**24.7%**	**48,930**	**75.3%**
Hamilton	**1,878**	**31.2%**	**4,138**	**68.8%**
Bosque	**3,736**	**27.0%**	**10,117**	**73.0%**
Hill	**8,474**	**29.1%**	**20,622**	**70.9%**
Limestone	**5,121**	**28.0%**	**13,148**	**72.0%**
Falls	**4,007**	**29.2%**	**9,723**	**70.8%**
McLennan	**45,794**	**23.1%**	**152,878**	**76.9%**

Source: US Census Bureau, Small Area Health Insurance Estimates, <65 years, all income levels, male/female

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Current Healthcare Infrastructure

The Hospitals and Medical Centers operating within RHP 16 include two major urban Medical Centers and seven community hospitals operating in rural Communities:

- Coryell Memorial Healthcare System
  - 25 beds
  - Hospital Authority
- Hamilton General Hospital
  - 42 beds
  - Hospital District
- Goodall-Witcher Hospital
  - 33 beds

        - Not-for-profit
    - Hill Regional Hospital
        - 116 beds
        - Investor-owned Corporation
    - Lake Whitney Medical Center
        - 49 beds
        - Investor-owned Individual
    - Limestone Medical Center
        - 20 beds
        - Hospital District
    - Parkview Regional Hospital
        - 58 beds
        - Investor-owned Corporation
    - Falls Community Hospital and Clinic
        - 44 beds
        - Not-for-profit
    - Hillcrest Baptist Medical Center
        - 503
        - Not-for-profit, Church-related
    - Providence Healthcare Network
        - 303 beds
        - Not-for-profit, Church-related

In addition to Acute care, the operations of these facilities include Rural Health Clinics, Home Health Agencies, and other service lines to address the needs for Primary Care Access as well as for Specialty Care.

- Residential Care---respite, skilled nursing care, apartments
- Primary Care clinics
- Specialty Care clinics
- Mental Health clinics---Seniors, other Adults, Adolescents
- Outpatient Rehabilitation clinics
- Inpatient Rehabilitation units
- Cardiac Rehabilitation
- Sleep Labs
- Hospice
- Wound Care
- Other specialty care---Heart Centers, Stroke Centers

Further, Mental Health Authorities, Health Districts, Emergency Management Districts, and Cities and Counties are represented in the RHP 16 Regional Health Partnership.

The U.S. Department of Health and Human Services, through its' Health Resources and Services Administration (HRSA), designates Health Professional Shortage Areas (HPSA) as having a shortage of Primary Care Providers, and/or Dental and Mental Health Providers. HRSA also designates Medically Underserved Areas/Populations (MUA/P) as having too few Primary Care Providers, high infant mortality, high poverty, and/or high elderly population. RHP 16 has both HPSA designations and MUA/P designations in every county, whether for the entire county, or for special populations, as is the case for McLennan County. In particular, a shortage of Primary Care Providers and Mental Health Providers exists throughout RHP 16. At this time, RHP 16 providers are not participating in any initiatives funded by the US Dept. of Health and Human Services as indicated in the companion document.

Population per Primary Care Physician

	County	Texas	U.S.
Coryell	**3,177:1**	**1050:1**	**631:1**
Hamilton	**539:1**		
Bosque	**1,956:1**		
Hill	**1,622:1**	**1050:1**	**631:1**
Limestone	**1,391:1**		
Falls	**8,397:1**		
McLennan	**813:1**		

Source: www.countyhealthrankings.org

As the numbers indicate, five of the seven counties in RHP 16 suffer from a major shortage of Primary Care Physicians. Additionally, there are shortages of Specialty Clinics as well. Patients and families are required to travel long distances to access the care they need, which can be especially difficult for the poor and the elderly.

Healthy People 2020* has established the goal to "improve access to comprehensive, quality health care services". Healthy People 2020 also addresses the barriers to services: lack of available resources, cost, and lack of insurance coverage. Those who lack coverage are less likely to get care, and more likely to experience poor health status and pre-mature death.

According to the Henry J. Kaiser Foundation**, nearly one in five Americans lacks adequate access due to a shortage of primary care physicians in their communities.

*www.healthypeople.gov

**www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx

Medical School training programs report a decline in the number of students entering into primary care, for a variety of reasons. The Foundation reports that only about 8% of medical school graduates go into Family Medicine, which impacts communities everywhere, but especially in rural areas.

For RHP 16, already facing a shortage of Primary Care providers, the increasing shortage creates an even greater challenge. There are provisions in the Patient Protection and Affordable Care Act to increase training slots, and to offer financial incentives for Primary Care providers. However, it is not known at this time how those incentives will balance with the addition of individuals seeking care through the new insurance exchanges and/or Medicaid expansion.

As noted above, RHP 16 is a Mental Health Professional Shortage Area. Lack of access to Mental Health Professionals in the rural communities creates significant problems in terms of Emergency Room visits, untreated mental health conditions, and complications in treating medical conditions which are worsened by the presence of mental health issues. Another goal of Healthy People 2020 is to “improve mental health through prevention and by assuring access to appropriate, quality mental health services”. Healthy People 2020 addresses the close connection between mental and physical health, and how suffering from one makes it difficult for the patient to overcome the other.

Further, Healthy People 2020 points out the emergence of new mental health issues, to include the needs of Veterans who have experienced physical and mental trauma, and the needs of the Elderly, who are dealing with dementia and related disorders. RHP 16, with the presence of Ft. Hood, and with the number of Elderly living in Rural Communities, is a prime area for addressing these two growing issues.

According to an article in the San Antonio Business Journal, October 17, 2010, by W. Scott Bailey*, a study by the National Alliance on Mental Illness (NAMI) found that 833,000 Texans suffer from serious mental illness, but only 21% of that population is being served by a State mental health agency. The same article reposts that the Mental Health Association in Texas indicates that Mental Illness costs the State as much as $17 million annually due to lost productivity and family income.

According to NAMI, one in four adults and one in ten children are impacted by Mental Illness, and in a report published in November, 2011**, stated that Texas now ranks last in per capita funding for people with Mental Illness. This is despite an increase of 4.3% in funding over the last three years.

*Source: San Antonio Business Journal, October 17, 2010, W. Scott Bailey

** Source: The Texas Tribune, November 10, 2011, Claire Cordona,

In comments to the HHSC 2012 Summit on August 8, 2012, Octavio Martinez, MD, MPH, MHA, Executive Director of the Hogg Foundation for Mental Health, reported that only one third of adults and one fourth of children in Texas with serious mental illness receive services through the Community Mental Health System, and that most mild to moderate mental health conditions are seen in the Primary Care setting. Dr. Martinez also reported that patients with chronic medical conditions tend to have a high rate of behavioral health problems.

According to Dr. Martinez, less than fifty per cent of referrals for Specialty Mental Health care are pursued by patients due to lack of insurance, poverty, transportation, and cultural beliefs. He further pointed out that in Behavioral Health settings, more than 50% of medical conditions go unrecognized. The opportunities for dramatic improvement in the delivery of Mental Health care in Texas lie in the ability of the Hospitals, Primary Care providers, and Mental Health providers to develop a network of continuous care across all three domains.

Of the patients in RHP 16 needing Mental Health services, the majority are indigent, and issues include housing, food, and transportation. Additionally, most of these patients get their medical care through the local Emergency Room, as they are unable to access Primary Care Clinics, either due to the deterrents listed above, or others such as Clinic hours that conflict with work schedules.

Anticipated changes in the Region

During the next four years of the Waiver, changes are anticipated both in the population of the Region as well as in the number of insured. As the Baby Boomers become Medicare beneficiaries, the needs will increase for access to care, especially relating to chronic health needs. Transportation will become more of an issue, impacting the need for improved access at the Community level for both primary and specialty care. As pointed out above, Veterans are going to need better access to care as well, as many of them choose to retire in the Ft. Hood area, and therefore in RHP 16.

Projections by the Texas State Comptroller's Office show an increase in population of 21.2% for the Region by 2030. By county, the projected growth is as follows:

Texas County Population Projections

	2010	2020	2030
Coryell	**72,529**	**107,938**	**124,057**
Hamilton*	**8,043**	**9,005**	**9,294**
Bosque	**17,631**	**20,435**	**21,720**
Hill	**35,840**	**40,633**	**44,250**
Limestone	**22,287**	**25,643**	**26,648**
Falls	**16,782**	**21,495**	**22,886**
McLennan	**233,378**	**252,988**	**267,315**

***While this shows an increase in population in 2020 and 2030, other sources show a flat or decreasing population in Hamilton County.**

Source: Texas State Comptroller's Office www.window.state.tx.us/ecodata/popdata/popfiles.html

Further, as the roll out of the Medicaid Managed Care program extends through the Region, it is anticipated that more of the current 27% uninsured will move into some form of coverage, either through Medicare, Medicaid, or the Insurance Exchanges that are anticipated.

Key Health Challenges

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute have developed an excellent interactive program (County Health Rankings and Roadmaps) which ranks Counties and States according to numerous factors impacting the health of Communities. Utilizing data on Health Outcomes, the program looks at Mortality and Morbidity. In conjunction with those measures, the model also addresses Health Factors, including health behaviors, clinical care (access), socio-economic factors, and physical environment.

The rankings are then determined by County (see Data Sources p.17,Appendix). The purpose of using this model is to not only identify the major factors affecting the health of a Community; it also provides enough data to develop a roadmap to improve the overall health of that Community. RHP 16 has a variety of health issues to address, but as with all of Texas, the following stand out in particular:

Adult Diabetes	**9.9%**	**Range:**	**7.8--10.9%**
Adult Obesity	**28.1%**	**Range:**	**26.0--31.3%**
Low income Pre-school Obesity	**13.8%**	**Range:**	**7.3--19.5%**

Source: www.citydata.com

Obesity is an area of concern, both in Adults and in Children, as it can lead to Diabetes, Coronary Artery Disease, Circulatory Disease, and many other chronic conditions as well as premature death. According to the Texas Diabetes Council*, 9.7% of adults in Texas who are age 18 and above have been diagnosed with Diabetes (approximately 1.8 million adults). The comparative rate in the United States is 9.3% (approximately 22 million adults). The Council reports that while there is not a significant difference between males and females in the prevalence of Diabetes, the rate increases with age, impacting the elderly.

The prevalence of Diabetes among Blacks in Texas is significantly higher, at 16.5%, compared to other race/ethnic groups. Among Hispanics, the rate is 11%, and among Whites, it is 8.2%. In a 2009 survey by the Texas Diabetes Council, the information on Adults with Diabetes was collected, along with data for those less than 18 years of age. Among that population, it was estimated that 26,000 Texas youth had been diagnosed with either Type I or Type II Diabetes.

Providers in RHP 16 are dealing with the issue of Diabetes, and with Obesity, through Clinics, Educational programs, and in the case of Childhood Diabetes and Obesity, by working with the School Districts on education and/or through School-based Clinics. Opportunities exist for Providers to work with Educators on the issues of nutrition, exercise, and in general, living a healthy life. Additional diseases being addressed in the Region include Cardiovascular illnesses, Respiratory, Hypertension, and Congestive Heart Failure, among others.

The Texas Department of State Health Services provides data that indicates Potentially Preventable Hospitalizations, by County, listing these and other conditions (See Data Sources p.17, Appendix). The premise of these reports is that the referenced hospitalizations could have potentially been prevented if the patient had access to and complied with the appropriate outpatient care. The reports are a source for Providers to consider as they look at the need to address access, quality, cost effectiveness, and coordination of care.

Additionally, adding to the shortage of Primary Care and Specialty Providers in rural communities, many rural areas of Texas suffer from a lack of adequate Emergency

Medical Services (EMS). According to the Texas Elected Officials' Guide to Emergency Medical Services**, many rural areas of Texas are dependent on the availability of Community Volunteers, who contribute much time and energy to serve the needs of their fellow citizens. Compounding the problem is the lack of public transportation options in the rural areas which can drive higher EMS and ED utilization. EMS is a major factor in addressing access to quality healthcare for the citizens of Texas in general, and the citizens of RHP 16 specifically.

*www.texasdiabetescouncil.org

**TX EMS Elected Official Guide, pp. 13-18

In a related issue, according to the National Association of Community Health Centers* (NACHC), the lack of access to Primary Care providers is increasingly driving patients to rely on Emergency Departments (EDs) for non-urgent care. The NACHC reports that one third of all ED visits are non-urgent, and that more than $18 billion are spent annually for these visits.

The Galen Institute**, a not-for-profit health and tax policy research organization, likewise reports data that shows that Medicaid patients are twice as likely to use the ED for routine care, referencing a study in the *Annals of Emergency Medicine* ("National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries", Adit Gingle, MD).

Opportunities

Opportunities that exist for RHP 16 are numerous:

- Expansion of Primary Care in Communities
- Expansion of Specialty Services across the Region
- Coordination with Mental Health Providers to enhance access for all Counties
- Joint efforts within and across Communities to address major health issues such as Diabetes, Congestive Heart Failure, Respiratory Diseases, and Obesity
    - Development of registries
    - School-based clinics
    - Education for all age levels
    - Coordination with Physicians and other Providers, including use of protocols across the Region
- Development of models for use of Telehealth
- Local and Regional approaches to Emergency Medical Services, focusing on access and time to transfer
- Measuring, monitoring, and managing Patient Satisfaction

As the participants in RHP 16 approach these challenges together, the transformation of the healthcare delivery system in Central Texas will begin, and new opportunities will emerge. With the focus on access, quality, cost, and coordination of services across the Region, the Residents of these seven Counties will be the beneficiaries of the work that is accomplished.

* www.nachc.com

** www.galen.org

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CNA-001	Adult Diabetes rate is 9.9%; range is 7.8% to 10.9%; County specific data at CDC	www.citydata.com www.cdc.gov/diabetes/atlas
CNA-002	Obesity rate is 28.1% for adults; range is 26% to 31.3%	www.citydata.com
CNA-003	Low income Preschool Obesity rate is 13.8%; range is 7.3% to 19.5%	www.citydata.com; www.texasdiabetescouncil.org
CNA-004	Potentially Preventable Hospitalizations , including Diabetes with short-term and long-term complications	www.dshs.state.tx.us/ph; http://respurces.iom.edu/ widgets/vsrt/healthcare-waste.html
CNA-005	Shortage of Primary Care Providers in Region	www.countyhealthrankings; Health Resources and Services Administration
CNA-006	Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers	Health Resources and Services Administration; National Alliance on Mental Illness; Octavio Martinez, MD, HHSC 2012 Summit; Center for Health Care Strategies, www.chcs.org
CNA-007	Inappropriate utilization of Emergency Room	www.nachc.com; www.galen.org
CNA-008	Rural EMS service shortages (personnel and equipment)	TX EMS Elected Officials Guide, pp. 13-18
CNA-009	CMS 30-day Readmission Measures for AMI, HF, Pneumonia	www.cms.gov; www.hospitalcompare.hhs.gov
CNA-010	Measuring and monitoring patient satisfaction	www.hospitalcompare.hhs.gov; The American Journal of Managed Care, Vol. 17: 41-48, January, 2011
CNA-011	Projected population growth in Region	Texas State Comptroller's Office www.window.state.tx.us/ ecodata/popdata/popfiles.html
CNA-012	Medicare/ Medicaid Enrollment	www.hhsc.tx.us; www.county-health.findthedata.org

APPENDIX

Data Sources

1. quickfacts.census.gov U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
2. www.Countyhealthrankings.org Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Ranks Counties and States according to major health factors.
3. www.dshs.state.tx.us/ph Texas Department of State Health Services. Details potentially preventable hospitalizations.
4. www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc. Texas Department of State Health Services. Details demographics, socioeconomic issues, natality, communicable diseases reported, and mortality, by County.

Section IV. Stakeholder Engagement

RHP Participants Engagement

All participants and stakeholders are included on a general email list and receive weekly updates following the Anchor Conference Calls and any news related to the regional plan. Each participant has email and telephone access to the Anchor for questions related to project development and funding allocations. RHP 16 has also developed a website that includes plan updates, notices and a section for feedback related to recent plan drafts and executive committee decisions. During the June 2012 general stakeholder meeting, individuals were selected to serve on the RHP 16 Executive Committee and met as follows:

Executive Committee Meeting Dates

- June 15, 2012
- June 26, 2012
- July 6, 2012
- July 13, 2012
- July 20, 2012
- July 27, 2012
- August 17, 2012
- September 10, 2012
- January 28, 2013
- January 31, 2013
- February 1, 2013

Executive Committee for RHP 16

Eva Cruz-Hamby, Waco/McLennan County Public Health District
Christine Reeves, Executive Director, Heart of Texas Regional Advisory Council
Dr. Jim Morrison, CMO, Hillcrest Baptist Medical Center
Tom Thomas, Heart of Texas MHMR
David Byrom, CEO, Coryell Memorial Healthcare System (Anchor)
Michele Cathey, CEO, Hamilton General Hospital
Karen Richardson, CFO, Providence Medical Center
Kathy Lee, Director, Coryell Memorial Healthcare System

Public Comment Periods for Plan Review

- October 29 – November 2, 2012
- December 3 – December 7, 2012

All stakeholders including physician groups, county officials, public and private hospitals and other interested parties are included on a general email list and receive weekly and monthly updates including draft regional plans. All participants are encouraged to provide feedback. Stakeholders include physicians on staff at participating hospitals and various local entities who are involved in the project plans.

General Stakeholder Meeting Dates

- June 13, 2012 – Waco, Texas, Providence Medical Center
- August 12, 2012 – Waco, Texas, Hillcrest Medical Center
- September 13, 2012 - Waco, Texas, McLennan County Commissioners Courtroom

Stakeholders engaged who are not performing providers include:

Julie Gardner, Texas A&M Agri-Life Extension Services
Susan Ballabina, PhD, Texas A&M Agri-Life Extension Services
Mayor Malcolm Duncan, City of Waco
Sherry Williams, Director, Waco-McLennan County Public Health District
Kelly Craine, Preparedness Trainer/Planner, Waco-McLennan County Public Health District
Tiffani Johnson, Health Education Supervisor, Waco-McLennan County Public Health District
Hammad Akram, Epidemiologist, Waco-McLennan County Public Health District
Jacque Walker, Community Promotions Specialist, Waco-McLennan County Public Health District
Larry Groth, Waco City Manager
Roger Mumby, Gatesville City Manager
Andrea Gardner, Copperas Cove City Manager
Lynne Lockwood, Chief Administrator, McLennan County Judge's Office
Cole Word, Bosque County Judge
John Firth, Coryell County Judge
Justin W. Lewis, Hill County Judge
Randy Mills, Hamilton County Judge
Daniel Burkeen, Limestone County Judge
R. Steve Sharp, Falls County Judge
Daren Moore, Coryell County Commissioner
Jack Wall, Coryell County Commissioner
Steward Speer, Superintendent, Gatesville ISD
James Stefka, Director, East Texas Medical Center EMS
Ron Schwartz, VP and COO, East Texas Medical Center EMS
Christine Reeves, Executive Director, Heart of Texas Regional Advisory Committee
Ruth Ann Crow, Lake Whitney Medical Center
Allen Patterson, CFO, Waco Family Health Center
Roland Goertz, MD, MBA, Waco Family Health Center

Section V. DSRIP Projects

RHP 16 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 forum, participating providers in Pass 1 provided strategic projects to address the critical access to care hindrances and needed transformation in the delivery system. Additionally, collaborations were formed across RHP 16 in order to provide robust projects which have regional scopes. This benefits both providers and patients throughout RHP 16. Additionally, through proactive projects like Health Promotion at risk children and adults are the core target population. Engaging them in healthy living will enable them to reduce their care burden on medical services.

Projects not included in the RHP Plan:

1. Falls Community Hospital and Clinic -Expand access to specialty care
2. Coryell Memorial Hospital – Expand Chronic Care Management Models
3. Coryell Memorial Hospital – Redesign to Improve Patient Experience
4. Coryell Memorial Hospital – Conduct Medication Management
5. Coryell Memorial Hospital – Implement/ Expand Care Transitions Program
6. Hamilton County Hospital District-2.4 Redesign to improve patient experience
7. Hamilton County Hospital District-2.8 Apply process improvement methodology to improve quality/efficiency
8. Hamilton County Hospital District-2.11 Conduct medication management
9. Hillcrest Baptist Medical Center-Chronic Care Management (CHF Outreach Clinics)
10. Hillcrest Baptist Medical Center-Care Transitions (Project Red – Discharge Planning)
11. Hillcrest Baptist Medical Center-Process Improvement
12. Hillcrest Baptist Medical Center -Telemedicine Expansion
13. Waco-McLennan County Public Health District- Teen Pregnancy Prevention campaign
14. Waco-McLennan County Public Health District- Expand active health surveillance capabilities to include weekly visits to hospitals, major clinic facilities and other reporting entities

Based on the Community Needs Assessment, RHP 16 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 16 providers collaborated to implement projects across the region not just in their own facility. In order to impact the cost curve, providers see the need for taking care outside the hospital and back into the clinic and or the home. Providing care outside the hospital setting and engaging patients in their healthcare are themes of major projects across RHP 16. There are needs for expansion of primary and specialty care to stop the bleeding in rural areas, which will also provide the infrastructure outside the hospital to advise patients in their home community. As the dual eligible population continues to grow these delivery system reforms are essential to reducing the ever growing burden of Medicaid costs.

RHP 16 Providers Exempt from Category 4:

Reporting Status	Provider Name	Hospital County	RHP
Exempt	Goodall-Witcher Healthcare Foundation	Bosque	16
Exempt	Limestone Medical Center	Limestone	16
Exempt	Hamilton General Hospital	Hamilton	16
Exempt	Falls Community Hospital & Clinic	Falls	16
Exempt	Parkview Hospital	Wheeler	16

Project Valuation

After HHSC released the Pass 1 allocations, RHP 16 reflected on the artificially low allocations to providers who had been working toward robust projects that would not be supported by their low allocations. Therefore, Coryell Memorial Hospital, Hamilton General Hospital, Goodall-Witcher Healthcare Foundation, Hillcrest Baptist Medical Center, and Providence Health System collaborated across RHP 16. These collaborations support the larger investments which providers will have to make in order to improve access and engage in regional transformation. Additionally, the goals of the region were established and supported these projects which will build up the needed primary and specialty care infrastructures. While slight variances remain with regard to like projects, providers reported that variances exist around recruitment of physicians which is one of the largest costs. 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.

Category 1

Category 1 DSRIP Project Narrative-RHP-16
Central Counties Services – Project 081771001.1.1

Project Area, Option and Title: 1.11.2 - Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers.
RHP Project Identification Number: 081771001.1.1
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012 we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
- **Intervention:** This project will double our telepsychiatry use from 1 FTE to 2 FTEs by enabling up to 4 simultaneous telepsychiatry/telehealth users on a high quality telemedicine system. This project also funds a second FTE psychiatric provider, to improve both timely patient access to psychiatry services and medication compliance.
- **Project Status:** This project upgrades existing marginally-functioning telepsychiatry equipment. It is an expansion of current telepsychiatry services and will serve an additional 400 patients in DY5, compared to 100 patients now served by telepsychiatry.
- **Project Need:** CN.2.8 Lack of access for adult behavioral health care in Bell, Lampasas, and Milam Counties. The Center's current telemedicine equipment is unreliable and cumbersome to use. Improved telepsychiatry equipment will expand the number of patients served by telepsychiatry, thus improving access to residents *i*n rural areas who may not have means of transportation to receive psychiatric services.
- **Target Population:** This project's target population is adults with severe and persistent mental illness living in the more rural parts of our service area. 97% of the Center's patients are Medicaid (41.89%), uninsured, or indigent. We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project.
- **Category 1 or 2 Expected Project Benefit for Patients:** Improved access to psychiatry services via telemedicine technology. We are currently serving 121 persons per month (September 2012) via telepsychiatry and this project should enable us to increase the number of persons receiving psychiatric services via telepsychiatry to 200 persons per month in DY3; 300 persons per month by the end of DY4; and 400 persons per month by the end of DY5.
- **Category 3 Outcomes:** IT-6.2 : Other Improvement Target: TBD% of patients receiving psychiatric services via the improved telepsychiatry technology will be satisfied with quality of those services. The Center expects greater than 50% of the 900+ patients to be served by telepsychiatry under this project will be satisfied with the quality of the services they have received. Patient level of satisfaction with their services is a touchstone measure for the patient's confidence in the services they are receiving and how willing they are to adhere to their service

provider's directions regarding their medication, suggested behavioral/lifestyle changes encouraged by their provider, and their attendance/participation at their assigned service appointments.

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

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

Our Center obtained a Telecommunications Infrastructure Grant in 2001 to install a telemedicine system among its 13 facilities in our 5 county region. This analogue system presents difficulty with telepsychiatry services for psychiatrists who are outside of our service region, in that the video often pixilates such that the other person's image can't be seen. We also have had difficulty in which we get a picture, but no sound, so the psychiatrist has to manage the audio portion of the service via a speaker phone with long distance charges. Our current system cannot support more than one telemedicine provider on the system at one time.
The new system to be obtained under this project will have a digital, high definition signal rather than analogue signal and be much more crisp in both picture and audio. The new system would be engineered to manage 4 telemedicine sessions at once. It would be available for our Center's centralized intake services for adults with severe/persistent mental illness. New telemedicine transmission lines would separate our electronic telemedicine signals from our data and voice-over-internet-protocol (VOIP) phone system signals. This new, dedicated transmission lines would accommodate increased electronic transmissions of multiple, simultaneous telemedicine sessions with no degradation of audio/video signals. This upgraded system will also increase service-delivery efficiency by our current contract telepsychiatry providers. With increased productivity comes increased access (capacity) to psychiatry services. This project includes the expansion of telepsychiatry services by adding one FTE telemedicine psychiatrist and a remote site LVN service facilitator in DY3 through DY5.

Goals and Relationship to Regional Goals:

Project Goals:

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

This Project meets the following Regional Goals:

- Improving coordination with Mental Health Providers to enhance access for all Counties. (CAN p. 14)
- Development of models for use with Telehealth (CAN p.14)

The Center has several projects that are focused on increasing access to behavioral health services and providing levels of care that can help divert persons in behavioral health crisis from being admitted to a psychiatric hospital or incarcerated in a local jail due to the committing of minor offenses (RPH8-#081771001.2.3 - Social Rehab Day Services and RPH-8#081771001.1.4 - Crisis Respite Services (RPH8 #081771001.1.4, RPH16#081771001.1.2). All of these projects document the shortcomings of our current behavioral health system, and seek to put into place levels of safety-net infrastructure services to more adequately meet the behavioral health needs of our regional citizens. The more prevalent tele-psychiatry services are, the more community centers can share their specialized psychiatric staff, and the more future potential there is to also provide psychiatry service links to local jail booking areas and to small rural emergency departments that have no psychiatry access.

Challenges:
Our five counties have several phone grids which have to be used to get continuous high quality signals. We will need highly professional consultation on what parts of our current system (if any) can be used in the new system. The length of time to carry out this upgrade may be longer than we anticipate, and spread into DY3. Our main Center facility that houses the new video system core elements is in an older section of Temple where all utilities are above ground and subject to wind/weather damage from trees /branches falling. A power outage at our Temple main Center building would result in our telemedicine services being inoperable throughout our 5 county region. The Center is taking steps to insure the continuity of electrical supply (RPH8 #081771001.1.5, RPH16 #091771001.1.3) and the telemedicine system's availability at all times.

5 Year Expected Outcome for Provider and Patients:
The Center expects to improve our access to psychiatrists over the next five years. We intend the telemedicine system to deliver audio/visual access to the Center's remote locations at a high level of quality that is satisfactory for our patients' participation in our services delivered via technology by providers who live outside of our service area. We are expecting to serve 289 more people per month via telepsychiatry in DY5 than we are currently serving per month prior to this project. -that equals 3,468 more patients served (contains some duplication) in DY5 than our Center was serving prior to this project implementation. This upgrade of telemedicine equipment and transmission lines will also give improved access to our centralized intake service staff who will be able to connect with any Center clinic's telemedicine equipment to perform remote intake evaluations.

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

Rationale:

Community Need Addressed:
Community Need Area: CAN-006 Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers.

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

a. *Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.* We have an existing clinical/operations telemedicine protocol manual which we will update to reflect the changes in newly acquired equipment/systems.
b. *Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operation is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.* We have been operating a telemedicine system for several years and do not need to further pilot a telemedicine system.
c. *Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologist, etc.), peers or behavioral health providers.* Connections could e provider to provider, provider to patient, or peer to peer. We have 3 psychiatrists who are currently trained to provide telepsychiatry and provide such services regularly for our patients. We also currently have remote site staff trained to provide telepsychiatry assistance, which they are currently doing.
d. *Identify modifiers needed to track encounters performed via telehealth technology.* We have been providing telepsychiatry services and already have appropriate modifiers in place to bill and track services.
e. *Develop and implement data collection and reporting standards for electronically delivered services.* We are currently providing telepsychiatry services and have an adequate data collection and reporting system in place for electronically delivered services.
f. *Review the interventions() impact on access to specialty care and identify "lessons learned," opportunities to scale all or part of the interventions(s) to a broader patient population, and identify key challenges associated with expansion of the interventions(s), including special considerations for safety-net populations.* Our current telepsychiatry services are provided for patients with severe and persistent mental illness and increase our psychiatry capacity to see patients rapidly who are in the midst of a mental health crisis.
g. *Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully –functional telehealth, telemonitoring, telementoring, or telemedicine program.* Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations. We have been providing telepsychiatry services with three psychiatrists (each part time) and we see a need to expand our telepsychiatry services – we have included the hiring of one tele-psychiatrist FTE and one LVN in this project proposal so we can expand our telepsychiatry services.
h. *Assess impact of patient experience outcomes (e.g. preventable inpatient readmissions)* In DY-4 and DY-5 we are implementing Improvement Milestone 6 [I-X.1] to show an increase in the number of persons served via telepsychiatry as our method of showing the positive impact of services available via telepsychiatry.

This project is essential to our Center's ongoing ability to obtain and provide sufficient psychiatric services to meet the behavioral health service needs of the citizens in our 5-county service region. Our

Center is approximately 65 miles from Austin, Texas and over the years we have been able to employ psychiatrists and advanced nurse practitioners with psychiatric credentials from the Austin area to provide services in our Center. Over the last 10 years we have recruited 8 professional (psychiatrists and advanced nurse practitioners) staff and within 3 years left our Center with the complaint that they were tired of commuting and were seeking employment opportunities closer to their homes. We have been successful in recruiting telepsychiatry psychiatrists from the Dallas area and the Houston area who provide their services from their own homes. We have found that recruitment of psychiatrists from longer distances into our geographical area to be very difficult because they don't wish to move to our area. The use of contract telepsychiatrists is becoming a more common practice among community centers and some beginning psychiatrists are going into full time practice providing telepsychiatry services. We are also finding that some psychiatrists wish to "semi-retire", but do not want to commute out of their home area. As part of this project we intend to have at least two units of telepsychiatry equipment that could be deployed to psychiatrists' homes to facilitate their willingness to provide telepsychiatry services without the burden of technically supporting the specialized equipment. Having a highly efficient/effective telemedicine system will greatly increase our ability to contract for adequate psychiatric coverage which has been a problem in the past. This upgrade will give us the flexibility to have up to four external prescribers conducting telepsychiatry sessions at the same time (increased service capacity/access). Our most distant clinic is more than 80 miles from our largest clinic, and having this high-tech telemedicine system in place will eliminate the 3 hours of travel time needed by the psychiatrist to provide services in this most rural clinic, thus gaining three hours of direct clinic service capability that would have been consumed by the commuting time. With the availability of this very reliable, high technology telemedicine/telehealth system we will also be able to more productively use our prescribers' time that is available due to our patients not attending their service appointments. If a telemedicine prescriber has a patient no-show, then the scheduling staff can survey the other clinics to see if any of their schedules have backed-up and are in need of relief services. The prescribing staff who had a no-show patient could then remotely provide services to patients via the telemedicine system in the clinic that has a patient back-up. This will result in less inadvertent idle time of our most expensive staff due to patient no-shows and be responsive to patient needs in other locations.

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

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

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

Related Category 3 Outcome Measure(s):

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

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

Relationship to Other Projects:

This project is very closely related and interdependent with our Planning Protocol 1.10 Enhance Performance Improvement and Reporting Capacity project (RPH8 #081771001.1.5, RPH16 #081771001.1.3) to improve the operating efficiency (and capacity) of our behavioral health services delivered via telemedicine technology. Since behavioral health services delivered via telemedicine technology is heavily reliant on consistent access to the patient's electronic health record, our project that insures continuity of electronic health record access is also closely related to this project.

We also have a telehealth project in RHP 8 (#081771001.1.2) which will serve Bell, Lampasas and Milam County citizens - see Valuation paragraph.

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

As more and more community behavioral health centers and rural hospitals obtain telemedicine capacity, we expect that in the future we will be able to provide telepsychiatry support for these rural locations that do not have ready access to a psychiatrist. This technology may also be utilized for doing patient follow-up consultations with patients who are hospitalized in the state psychiatric hospital system. The Center for Life Resources also has a telemedicine improvement project (RPH8 #133339505.1.1) to better utilize telemedicine technology in meeting their patient's behavioral health service needs.

Central Counties Services is committed to improvement of services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 16.

Project Valuation:

The improved telemedicine system and additional telemedicine FTE in this project is trans-formational and of high value in that it will give us the means to overcome our psychiatric care shortage for our medically underserved behavioral health populations of our service region, which we have experienced for several years. We will now be able to electronically recruit psychiatric services instead of depending on our ability to physically recruit psychiatry services to our geographic service region. By DY5 we expect 280 more persons of our underserved behavioral health population to be served per month via our updated telepsychiatry system than we are capable of serving without this project. The valuation of this project includes the engineering and technical design of our new system; competitively acquiring the equipment; specialized technicians to install and test the equipment; and integrate all the equipment into a highly functional telemedicine system. The valuation of this project also includes the establishment of a new and separate T-1 line system for the exclusive use of the telemedicine technology system and its ongoing service costs for each year of the project (the longest point-to-point distance between our service sites is approximately 125 miles). The valuation includes a large portion of our Information Technology (IT) staff to coordinate the design and installation of the upgraded system, and to be trained how to technically operate and support the new system's functions. It also includes training our medical staff and contract medical staff on how to professionally use the system. It also includes professionally designed lighting at each site that yields a commercial TV quality of picture, and adds to the warmth of the visual images. Also the cost of the new transmission lines would be on-going after the upgrade is completed. The valuation contains mental health program indirect costs, as well as the Center's administrative cost rate. DYs 3-5 valuations include the equipment warranty/ maintenance contracts, training time for new system users, mental health program indirect costs and the Center's administrative cost rate. DYs 3-5 also include the cost of adding one FTE psychiatrist and one telemedicine support nurse to expand our telemedicine capability to improve timely accessibility to our behavioral health services. Without this telemedicine technology project and its improved access to services, we would see many more persons from our service region entering into psychiatric hospitals, emergency medicine departments and local jails; all of which are expensive to our communities, and which tax our small emergency departments' ability to respond to general health emergencies when they present in the local communities. These valuations represent 20.5% of the project's total valuation based on the percentage of population (Coryell & Hamilton Counties) from each region has in our 5-county service area; with 79.5% of the project's total valuation being assigned to RHP 8 (Project #081771001.1.1) (Bell, Lampasas,& Milam Counties),

Central Counties Services 081771001.1.1 (Project 1.11.2) Category 1 Milestones and Metrics			
081771001.1.1	**1.11.2**	**1.11.2.a - 1.11.2.h**	**Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers).**
Central Counties Services			**081771001.1.1**
Related Category 3 Outcome Measure (s):	**081771001.3.2**	**IT-6.2**	**Other Improvement Target: Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-4]: Selection, procurement and installation of telehealth, telemedicine, telementoring equipment. **Metric 1** [P-4.1]**:** Inventory of new equipment purchased. **Baseline/Goals:** Baseline - Center has an antiquated telemedicine system, parts of which may or may not be useable in a new system; Goal - procure a digital signal based high definition telemedicine system for the Center's clinics. **Data Source:** Equipment orders and receipts. **Milestone 1 Estimated Incentive Payment: $123,332**	**Milestone 4** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do study, act quality improvement cycles. **Baseline/Goals:** Baseline - Determine the types of information readily available in the Center's scheduling system and patient electronic health records that would be indicators for potential process improvement: Goal - Establish the items to be tracked and analyzed that informs the providers and managers how to improve the delivery of behavioral health services via	**Milestone 7** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. Project reports also may include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goals:** Baseline - Review the reports regarding the items chosen for tracking in DY3. Goal - Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve	**Milestone 9** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. Project reports also may include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goals:** Baseline - Review the reports regarding the items chosen for tracking in DY4. Goal - Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services provided by telemedicine technology. Revise the

Milestone 2 [P-5]: Procurement of Broadband Connection – new T-1 lines ordered and tested. **<u>Metric 1</u>** [P-5.1]: Documentation of presence of active broadband connection. **Baseline/Goals:** Baseline - Currently all data, phone and telemedicine signals are transmitted on a single T-1 line system; Goal - Establish a separate transmission line system for the telemedicine network to insure sufficient bandwidth for high quality audio/video service. **Data Source:** Service contracts for the transmission lines and test results insuring their proper functionality. **Milestone 2 Estimated Incentive Payment: $123,332** **Milestone 3** [P-8]: Training for current providers/peers on use of new equipment and software system. **<u>Metric 1</u>** [P-8.1]: Documentation of completions of training on use of equipment/software and the	telemedicine technology. **Data Source:** Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts, or monthly dashboards to drive improvement). Project reports may also include output measures which describe the number and type of telemental transactions which occur. **Milestone 4 Estimated Incentive Payment: $68962** **Milestone 5** [P-X.8] *(see page 7 of the Planning Protocol)*]: Hire personnel or teams to support and/or manage the project **<u>Metric 1</u>** [P-X.8]: Contract for one full-time-equivalent (FTE) telemedicine provider(s), and hire one LVN to assist with expanded remote site facilitation **Baseline/Goals:** Baseline - Center currently has three part-time telemedicine providers who provide one FTE of services;	the efficiency of documenting services provided by telemedicine technology. Revise the items to be tracked and reported upon for future improvement. **Data Source:** The Center's patient scheduling system, the patients' electronic health records and project reports focused on telemedicine services. **Milestone 7 Estimated Incentive Payment: $113,787** **Milestone 8** [I-X]: Increase the number of persons served via telepsychiatry. **<u>Metric 1</u>** [I-X.1]: Increase the number of persons served via telepsychiatry over the baseline. **Baseline/Goals:** Baseline – 121 persons per month receive telepsychiatry visits; Goal - Serve an average of 300 persons via telepsychiatry in each month of FY 2015, which represents an increase of 179 more persons served via telepsychiatry over the baseline. **Data Source:** Claims, and Encounter data, and patient	items to be tracked and reported upon for future improvement. **Data Source:** The Center's patient scheduling system, the patients' electronic health records and project reports focused on telemedicine services. **Milestone 9 Estimated Incentive Payment: $119,948** **Milestone 10** [I-X]: Increase the number of persons served via telepsychiatry. **<u>Metric 1</u>** [I- X.1]: Increase the number of persons served via per month over the baseline . **Baseline/Goals:** Baseline –121 persons per month receive telepsychiatry visits; Goal - Serve an average of 400 persons via telepsychiatry in each month FY 2016, which represents an increase of 279 more persons served via telepsychiatry over the baseline. **Data Source:** Claims, Encounter data and patient electronic health records **Milestone 10 Estimated Incentive Payment: $119,947**

Center's revised telemedicine protocol manual. **Baseline/Goals:** Baseline - Center currently has 3 telemedicine providers and 4 remote site facilitators that will need training on how to operate the new telemedicine system; Goal - Have all current telemedicine providers and remote site facilitators trained on how to operate the new telemedicine equipment/system. Expand the number of site facilitator staff who are trained to use the equipment to be back-up staff if the regular facilitator is absent. **Data Source:** Revised telemedicine protocol manual, Training rosters **Milestone 3 Estimated Incentive Payment: $123,332**	Goal - Center seeks to expand telemedicine services by contracting for one more FTE telemedicine providers (2 FTEs totally) to meet the expanding need for behavioral health telemedicine services for our area. One more LVN will be needed to provide remote site medical/medication assistance for the expanded telemedicine services. **Data Source**: Service contracts and Center Dept. of Human Resources hiring documentation. **Milestone 5: Estimated Incentive Payment: $68,962** **Milestone 6** [I-X] (Page *133 of the Planning Protocol)*: Increase the **average** number of persons served via telepsychiatry. **Metric 1** [I-X.1]: Increase the **average** number of persons served per month via telepsychiatry over the baseline measure (September 2012) **Baseline/Goals:** Baseline - It is 121 persons who received telepsychiatry services in	electronic health record data **Milestone 8 Estimated Incentive Payment: $113,787**	

	September 2012 prior to the implementation of this project. Goal -Serve an average of 200 persons per month via telepsychiatry in DY3, which represents an increase of 79 more persons served via telepsychiatry per month over the baseline (121). **Data Source**: Claims and Encounter Data, and patient electronic health records. **Milestone 6: Estimated Incentive Payment: $68,962**		
Year 2 Milestone Bundle Amount: $369,996	**Year 3 Estimated Milestone Bundle Amount: $206,886**	**Year 4 Estimated Milestone Bundle Amount: $227,574**	**Year 5 Estimated Milestone Bundle Amount: $239,895**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,044,351			

Category 1 Project Narrative – RHP 16
Central Counties Services – 081771001.1.2

Project Area, Option and Title: 1.13.1. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
RHP Project Identification Number: 081771001.1.2

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

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
- **Intervention:** This project provides 24/7 residential-based crisis respite (15 beds), transitional living (15 beds) and supportive day services at a properly equipped facility within our service area to persons with severe and persistent mental illness who have experienced a recent mental health crisis, in lieu of these persons being sent to the state psychiatric hospital system or incarcerated in local jails.
- **Project Status:** This is a new project.
- **Project Need:** CAN-006: Mental Health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers. The Center overused the state psychiatric hospitals by 10.87% in FY 2012. Our service area currently does not have crisis residential services.

- **Target Population:** 97% of all of the Center's patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population, and expect this project to admit 640 in DY4 and 800 in DY5. This project is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities and the cost of up to 4000 hospital ($461/day/FY'12 at Austin State Hospital – average length of stay = 21 days*)/incarceration ($50+/day with average time in pre-trial services is 145 days**) days will be avoided by these services in DY5.
  *Austin State Hospital Regional Planning Meeting Oct.31, 2012, pp.30, 35.
- **"A Simulation Modeling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness. David Hughes, et al, Criminal Justice and Behavior, Vol. 39 No 4 April, 2012, p. 438.
- **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to provide crisis services to patients in more appropriate and less costly setting than psychiatric hospitalization or incarceration (Improvement Milestone I-11.1 and I-11.2). The baseline cost savings will be

determined in DY3 and improved upon in DY4 and DY5. This project intends to provide 3,200 crisis respite bed days of service in DY4 and 4,000 bed days of crisis respite services in DY5. Assuming an average length of stay of 5 days per patient admission, there would be approximately 640 admissions in DY-4 and 800 admissions in DY-5year.

Category 3 Outcomes: IT-9.1: An expected outcome for this project is to reduce the mental health admissions/readmissions to criminal justice and psychiatric hospital settings with the percent of improvement to be determined once the baseline is set in DY3.

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

The Center is planning a multiphase project approach to address this unmet service need as soon as possible with interim arrangements while more desirable ways of addressing these unmet behavioral health needs gets worked out. The first step contracts for CRS with Heart of Texas Regional MHMR Services (HOTRMHMRS) in Waco Texas (40 miles north of Temple). While this CRS is not in our service region, it is closer than Austin State Hospital (68 miles from Temple). HOTRMHMRS has extra CRS capacity and can make 5-10 beds available to our Center, depending on their daily census. This will provide some immediate relief to our Center's recent overuse of our state psychiatric hospitals (See RHP Addendum #8). Within 3 months of project approval Coryell County will begin to

remodel, furnish, and equip the former Coryell County Hospital for interim use as transitional living services, with a target start date of Oct. 1, 2013. This project may also include partnering with the Coryell Memorial Healthcare System (CMHS) for medical screening, patient minor health issues treatment, and food services contracting. It will have 16 beds and can serve both male and female patients. During DY-2 the Center will convene the main stakeholders for behavioral health CRS, namely, every law enforcement agency, hospital emergency department, and the Bell, Coryell, Hamilton, Lampasas and Milam County Judges to ask them to support an intense needs gap analysis process on the amount of CRS needed by our service area and the best location of these services. This gap analysis process would track the number of persons who present or are brought to local emergency departments in mental health crisis, and if a CRS care level would have met their needs. We will also collect data on the number of persons in mental health crisis arrested for minor crimes who could benefit more from CRS than jail. This gap analysis process will also document if post-crisis respite service is needed by the person in crisis (e.g. housing, day support services, transportation, transitional living support, medical care, substance abuse services, medicine, etc.). The maximum capacity of CRS will be set by Health and Safety code and licensing requirements – likely 16 beds. 2 admissions/day would lead to someone having to be discharged by the 7th day to allow further admissions. If the patient is homeless, it is difficult to stabilize the patient and set up a new living situation in 7 days. The only way to have an effective, accessible CRS would be to also have step-down, transitional living services so patients who are stable, but homeless, could be in a transitional living setting a few more days while living arrangements are worked out.

Goals and Relationship to Regional Goals:

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

This Project Meets the Following Regional Goals:

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

Challenges: Perhaps the biggest challenge will be managing the gap analysis, local planning, program design/documentation, securing an appropriate facility meeting licensing and health/safety codes requirements of CRS, and staffing up/fully operationalizing the services by the end of DY-3 so project outcomes can be properly measured in DY-4 and DY-5. Our Center will do as much local organizational work with stakeholders, gap analysis partnering, and CRS planning as it can in early 2013 in order to have as much information in place as possible to expedite the actual establishment and operations of these crisis-responsive services for our area.

5-Year Expected Outcome for Provider and Patients:

In 5 years our Center intends to have fully functioning crisis respite services with step-down transitional living services available to our service area. It is also our goal to have strong working relationships with our local hospital emergency departments and our local law enforcement agencies

such that persons are identified in early stages of behavioral health crisis and assisted through these proposed services, rather than admitted to the state psychiatric hospital system or local jails. We would expect that psychiatric hospitalizations and the incarceration of persons with mental illness would decrease/100,000 population in our service area.

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

Rationale:
Community Need Addressed:
Community Need Area: CAN-006 -Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers. CAN-011 – Projected population growth in Region.
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The Center provided Crisis Stabilization Services from the late 1980's until June, 2,000 when the services closed due to higher service demand and less resources to provide them. The Center also provided transitional living services from the late 1980's until 1995 when these services had to close due to state funding reductions. Now Hamilton, Coryell, Bell, Lampasas and Milam Counties have no local mental health crisis residential services to aid persons in mental health crisis. Persons in a mental health crisis in our service region now must be guided to one of four options, namely, 1) admission to the state psychiatric hospital, 2) kept in local ED services for stabilization while waiting for a state psychiatric hospital bed (most recent severe case was for 13 days), 3) being jailed for a minor crime, or 4) release to community supports; at times, a less-than-desirable choice. Our county jails now track the number of inmates having a mental illness/take psychotropic medications and report that 28% of the inmates have mental health problems. The Center is allotted a portion of state psychiatric hospital days in proportion to its % of the state's population being in our service area and last fiscal year (9/1/11-8/31/12) our service area used 110.87% of the bed days allotted for our service area, thus demonstrating a much greater demand for resources than are available to respond to persons in our region who experience severe mental health crises. Comparing our use of bed days to Local Mental Health Authorities (LMHA) who have crisis residential services near us proves this point. The LMHA to the North used 99.27% of their bed days and the LMHA to the South used 71.9% in FY12. HB2292 in the 78th Texas Legislature required each LMHA to have a Jail Diversion Task Force to expedite the diversion of mentally ill persons arrested for minor crimes while in a mental health crisis. The Center's Community Jail Diversion Task Force consists of local law enforcement agencies,

community social service agencies and local Judges. This Task Force's jail diversion efforts are hampered by the lack of residential options needed to divert a mentally ill offender from incarceration.

Core Project Components:

a) *Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address indentified gaps.* There was much stakeholder support for crisis residential services prior to our having to close them due to state funding reductions.
b) *Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* There are no residential crisis stabilization or crisis respite services ; we have zero residential crisis capacity at this time.
c) *Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)*. Having operated crisis stabilization and transitional living services for 10+ years in the past, we know that these two levels of crisis residential services are needed in our area and were well received and supported by the hospital EDs and the law enforcement agencies in our service area. These partnering agencies were greatly disappointed and adversely affected when these services had to cease due to funding reductions – had to transport crisis patients to Austin State Hospital instead of local services.
d) *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Our past experience of providing residential crisis services and transitional living services, which were in separate communities, has brought us to the conclusion that these two levels of care can operate best if they are proximate to each other, perhaps in the same building, if possible. Having them in the same building would give more flexible use of staff and gain various operating efficiencies, such as meal preparation, laundry facilities, etc.
e) *Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* See Milestones 9 and 11. Our Center's project #08177101.1.5 – Enhance Improvement Capacity Through Technology – will also assist our Center with its commitment to continuous quality improvement.

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

impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

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

Related Category 3 Outcome Measures:
OD-9 – Right Care, Right Setting
IT-9.1 – Decrease in mental health admissions and readmissions to criminal justice and psychiatric hospital (Planning Protocol 1.13) settings. (Standalone measure)
This outcome measure is chosen because it directly addresses and measures the impact of this project's goal or purpose, namely to provide effective local crisis residential services that can be utilized by persons in behavioral health crisis in lieu of admissions and readmissions to more restrictive/expensive institutional levels of care in hospital emergency depts., psychiatric hospitals or local jails.

Relationship to other Projects:
This project is related to our Temple Day Services (RHP8 #081771001.2.3) which also has the purpose of lowering the frequency of admissions/readmissions to psychiatric hospitalization and /or incarceration. Our telemedicine project (#081771001.1.1; RHP8#08177101.1.2) is also intended to improve patients' access to psychiatric care and compliance with anti-psychotic medication, both of which are key elements in persons with severe and persistent mental illness maintaining stability in their community setting. The Center's "enhance improvement capacity through technology" project (#081771001.1.3; RHP8#081771001.1.5) has as its service objective to increase the number of timely follow-up visits with patients after they have been discharge from psychiatric hospitalization – also a very important service that is aimed at reducing hospital readmissions. The use of data dashboards created under this project will greatly assist the Center's work with Milestones 6, 9, and 11 to continuously improve our crisis respite services.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Bluebonnet Trails is also proposing 3 crisis respite services projects (#126844305.1.2, 126844305.1.3, 126844305.1.4) for Williamson and Burnet Counties.
The Center is committed to improving services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis allows providers to strengthen their partnerships and continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The project valuations takes into account that this project is of great value to our service region and is transformational in that these services are currently not available in our service region, and this

project will make crisis respite services available to all regional communities and the cost of up to 4000 hospital ($461/day/FY12 at Austin State Hospital – average length of stay = 21 days*)/incarceration ($50+/day with average time in pre-trial services is 145 days**) days will be avoided by these services in DY5. Assuming that all days of crisis respite services would take the place of days in the state hospital, this project would save the state of Texas $1,383,000 in DY-4 and $1,844,000 in DY-5.

DY-2 project valuation includes contracting costs for CRS from HOTRMHMRS, a minivan, costs to transport persons to/from CRS in Waco, costs for screening and follow-up for persons referred to HOTRMHMRS, renovation, furnishing and equipping costs to make the former Coryell County Hospital building useable for our service region and hiring/training costs for staff to provide these post-crisis, respite transitional living services. DY-2 also has costs for convening stakeholders multiple times, hiring consultants to complete the in-depth gap analysis/service planning implications and final project proposal required by this project. DY-3 valuation continues the HOTRMYMRS contract for CRS, and includes transitional living service costs, while ramping up operation of CRS within our service area, which involves acquiring office and patient area equipment/furnishings, vehicles, operating supplies, food storage/handling equipment, telemedicine equipment, phone, electronic health record access, and data services, etc. needed to start CRS in our service area (see Milestone 8). DY-3 also includes hiring/training crisis respite staff, including a psychiatric advance nurse practitioner, obtaining proper Dept. of State Health Services' site approval/licensing, the design and writing of service protocols and manuals. DY-4 and DY-5 valuation reflects the operations of the residential crisis services called for in the gap analysis, planning and design process. The DY-2-5 valuation includes Center indirect program and administrative overhead costs. This project's valuation also considers the psychiatric hospitalization and incarceration costs that can be saved by local access to CRS. If this project keeps half of its patients (10-15) out of psychiatric hospitals (15 days/admission) or jails (30 days/event), it will save our state/communities considerable financial and personnel costs. Admission/readmission to criminal justice settings is disruptive/deleterious to behavioral health crisis recovery. Studies of recidivistic criminal justice patients in Texas and other states show poorer physical health status, increased homelessness, increased use of ED and inpatient services. Services that keep persons from cycling through the criminal justice system help avert poor health/mental health outcomes, reduce long term medical costs and improve personal functioning. This valuation for DY-3-5 reflects 20.5% of the total valuation (Region 16 has 20.5% of our service region's population) while 79.5% of this project valuation will be reflected in our project submitted to Region 8.

Central Counties Services – 081771001.1.2 (Project 1.13.1) Category 1 Milestones and Metrics			
081771001.1.4	**1.13.1**		**Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system**
Central Counties Services			**081771001**
Related Category 3 Outcome Measure (s):	**081771001.3.7**	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-3] Develop implementation plans for needed crisis services **Metric 1**: [P-3.1] Produce Data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs (Economy of scale may lead to service region options rather than individual community options) **Baseline/Goal**: Baseline: Prior to this there was no data-driven crisis respite service plan available. Goal: A written, data-driven implementation crisis respite services plan would be presented and endorsed by the stakeholder group. **Data Source: :** Interviews with other LMHAs who have crisis residential services; Hospital Diversion Services- A Manual on Assisting in the Development of a Respite/Diversion Service in Your Area; Mental Health Peer-Operated Crisis Respite Programs – compiled	**Milestone 3:** [P-X.8] (See p. 7 of the Planning Protocol) Hire staff to implement the interim transitional living services at the former Coryell Memorial Hospital renovated quarters, which will serve the Center's patients from RPH 8 and RPH16 **Baseline/Goal**: Baseline: The Center does not currently have enough staff to operate the proposed crisis transitional living services. Goal: Hire sufficient staff to operate this crisis transitional living services for patients from RHP 8 and RHP 16. **Data Source:** Center Dept. of Human Resources hiring records **Milestone 3 Estimated Incentive Payment: $138,601** **Milestone 4:** [P-5] Develop administration of operational protocols and clinical guidelines for crisis respite/residential services	**Milestone 9:** [P-6] Evaluate and Continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement. **Baseline/Goal**: Baseline: – Utilize the reports and improvement tasks from DY3 to set improvement goals for DY4. Goal - Staff will sustain the improvements achieved in DY3 and achieve improvement in at least 3 areas of crisis respite identified by staff as problematic/lower achievement than desired. **Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvements to guide continuous quality improve-ment (i.e. how the project continuously used data such as weekly run charts or monthly dashboards to drive improvement) **Milestone 9 Estimated Incentive**	**Milestone 11:** [P-6] Evaluate and Continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement **Baseline/Goals:** Baseline: Utilize the reports and improvement tasks from DY-4 to set improvement goals for DY-5. Goal: Staff will sustain the improvements achieved in DY-4 and achieve improvement in at least 3 new areas of crisis respite identified by staff as problematic/lower achievement than desired. **Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvements to guide continuous quality improvement (i.e. how the project continuously used data such as weekly run charts or monthly dashboards to drive improvement) **Milestone 11: Estimated Incentive Payment: $438,730**

by the National Empowerment Center; Behavioral Health Crisis Study – Crisis System Overview and Exemplary Models – Colorado Division of Behavioral Health; Behavioral Health Crisis Services – Tennessee Dept. of Mental Health & Substance Abuse Services, etc. **Milestone 1 Estimated Incentive Payment: $245,599** **Milestone 2**: [P-X.8] (See p. 7 of the Planning Protocol) Hire staff to implement the interim contract crisis respite services contract with HOTRMHMRS **Baseline/Goal:** Baseline: The Center does not currently have sufficient staff to provide the transportation and support for persons sent to HOTRMHMRS for crisis respite services. Goal: Hire sufficient staff to provide transportation and support of area patients referred to HOTRMHMRS for crisis respite services. **Data Source:** Center Dept. of Human Resources hiring records **Milestone 2 Estimated Incentive Payment (maximum amount): $245,598**	**Baseline/Goal:** Baseline: The Center currently has no written administrative and clinical protocols/manual to guide the operation of crisis respite/residential services. Goal: The Center will have written administrative and clinical protocols prior to opening these crisis respite/residential services. **Data Source:** See Data Source information listed in Milestone 1. **Milestone 4 Estimated Incentive Payment: $138,601** **Milestone 5:** (P-4) Hire and train staff to implement identified crisis stabilization/respite/residential services **Metric 1:** [P-4.1] Number of staff hired and trained. **Baseline/Goal:** Baseline: The Center does not have sufficient staff working at the appropriate skill levels to operate a residential crisis services. Goal: The Center will develop a staffing pattern to appropriately operate its crisis respite services and then hire and train people to serve in these staff positions. **Data Source:** Staff roster training records, and training curricula	**Payment: $ 435,497** **Milestone 10** [I-X]: Provide crisis respite residential services **Metric 1** [I-X.1]: Provide crisis respite days of service for adult behavioral health patients. **Baseline/Goals:** Baseline: will be established in DY-3 (estimated to be a daily average census of 5) Goal: Provide 3,200 patient days of service in DY-4 **Data Source:** Claims encounters, and service event data from the Center's EHR system **Milestone ~~8~~ 10 Estimated Incentive Payment: $435,497**	**Milestone 12** [I-X]: Provide crisis respite residential services **Metric 1** [I-X.1]: Provide increased crisis respite days of service in DY5 **Baseline/Goals:** Baseline: Established in DY-3 (estimated to be an average daily census of 5) Goal: Provide 4,000 patient days of service. **Data Source:** Claims encounters, and service event data from the Center's EHR system **Milestone 12 ~~10~~ Estimated Incentive Payment: $438,730**

	Milestone 5 Estimated Incentive Payment: $138,601 **Milestone 6:** [P-6]: Evaluate and Continuously improve crisis services **<u>Metric 1</u>** [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement. **Baseline/Goal**: Baseline – No regular reports to monitor CRS operations. Goal - Develop reports that monitor key functions of the crisis respite service and when anomalies occur, problem-solving and corrective actions can be taken promptly. **Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvements to guide continuous quality improvement (i.e. how the project continuously used data such as weekly run charts or monthly dashboards to drive improvement) **Milestone 6 Estimated Incentive Payment: $138,601** **Milestone 7:** [P-X] (See p. 7 of the Planning Protocol): Establish a baseline in order to measure		

	improvement over self. **Metric 1** [P-X.6]: Determine the baseline of crisis respite days of service provided for adult behavioral health patients. **Baseline/Goal**: Baseline – this is a new service so the baseline number of crisis respite service days provided is not known. DY-3 is a transitional year for implementing the new crisis respite services (see Milestones 4 and 5) and the average daily census of crisis respite service will be ramping up during the course of the year. Goal: Determine the baseline average daily census for the new crisis respite service by using the average daily census (estimated to be 5) from the last 2 months of DY-3. **Data Source:** Claims encounters, and service event data from the Center's EHR system **Milestone 7 Estimated Incentive Payment: $138,600** **Milestone 8:** [P-X] (see p. 7 of Planning Protocol) Implement, adopt, upgrade, or improve technology to support the project		

	Metric 1: [P-X.9] Resize the Center's clinical data system to accommodate medical and counseling staff of the crisis respite program to have ready access to the Center's electronic health record (EHR) system and to accommodate the EHR capacity needed for processing up to a 1,000 admission/year (DY-5). This would include having telepsychiatry equipment to access psychiatry services when needed. This would include the equipment needed to insure continuous access to the local clinical EHR application, telepsychi-atry, telephone access to law enforcement and medical resources, security system, medication refrigeration, and other such equipment/technology to insure the safe, continuous operation of this service. **Baseline/Goal:** Baseline: The Center's EHR and technology systems are insufficient to support a free-standing crisis respite service operation. Goal: To acquire and install technology in the crisis respite service area to appropriately support the level of patient services expected for this operation. **Data Source**: Center purchase		

	orders, receipts and billing statements for completed work. **Milestone 8: Estimated Incentive Payment: $138,600**		
Year 2 Milestone Bundle Amount: $491,197	**Year 3 Estimated Milestone Bundle Amount: $831,604**	**Year 4 Estimated Milestone Bundle Amount: $870,993**	**Year 5 Estimated Milestone Bundle Amount: $877,460**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $3,071,254			

Category 1 Project Narrative – RHP 16
Central Counties Services – 081771001.1.3

Project Area, Option and Title: 1.10.2 - Enhance improvement capacity through technology
RHP Project Identification Number: 081771001.1.3

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

Project Summary

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
- **Intervention:** This project provides improved data management and organizational process improvement capacity which the Center wants to focus on reducing readmissions to state psychiatric hospitals and local jails by improving post discharge follow-up services. This project seeks to improve the efficiency of clinical service operations through improved technology, and thus increase the Center's service capacity.
- **Project Need:** CAN-006: Mental health issues related to access, shortage of mental health professionals, lack of insurances and transportation, need for coordination between providers. 41% of admissions to the state psychiatric hospital system in FY2012 were re-admissions and the Center overused its share of state psychiatric beds in FY2012 by 10.87%.
- **Target Population:** The focused target population for this project is persons with severe and persistent mental illness who have recently been discharged from a psychiatric hospital (496 in FY2012) or jail. 97% of all of the Center's patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population.
- **Category 1 or 2 Expected Project Benefit for Patients:** The Center will create data dashboards to monitor and guide the clinical improvement processes for the Center's 7 other direct service 1115 Waiver Service Enhancement Projects which will impact an additional 2,000 persons in DY4 and an additional 4,000 persons who will be served through these innovative/transformational behavior health projects implemented through DY-3-5.

- **Category 3 Outcomes:** IT-1.18: Improved post-hospital discharge follow-up services at 7 days and 30 days to engage the patients in ongoing mental health treatment and medication support. We will strive for prompt follow-up with over 1,200 discharged patients in DY-3 through DY-5, and in so doing, keep as many of these patients engaged in our behavioral health system of care.

Project Description:

This project seeks to establish a process improvement approach to increasing our Center's effective utilization of its talent and resources to serve persons in our local area who need behavioral health services, intellectual and developmentally disability services, and early childhood intervention services (addresses infant development/delay needs). For example, Central Counties Services (Center) had 496 state psychiatric hospital admissions in FY11. Of the 496 admissions, 12 were children under 18 years of age. 20 of these admissions were forensic admissions to restore competency to stand trial, and were discharged back to the referring County jail. 203 (41%) of these admissions were readmissions of people who had been previously hospitalized, while 293 (59%) were first admissions to the state psychiatric hospital system. In FY 11 between 9 and 10 patients are hospitalized each week, 4 of whom are re-admissions. Our Center wants to study the primary causes for these readmissions and through organizational/service process improvement efforts to lower these readmissions to the state psychiatric hospital system. Finding ways to improve our post-discharge patient follow-up/engagement will be one of these improvement efforts.

The key to such an effort is easy, efficient and reliable access to a highly sophisticated clinical data system in which Center staff enters real-time patient demographic and service data that documents the clinical and support activities of Center staff, patient response to these activities and how these service activities interact with the patient to support the patient's functional improvement. This project will regularly seek system improvement ideas and feedback from Center clinical line staff, support staff, clinical leadership staff, administrative staff and patients to harvest the creative ideas and insights of those who are closest to service production successes and failures. This project will include the implementation of sophisticated software tools and systems with the efficient and error reducing capability of auto-sharing/auto-filing patient demographic and event data across the Center's internal divisions so that no data needs to be entered more than once, and will have robust report writing capabilities. The project will include data/system analyst services that can design/redesign and implement data dashboards for the different parts and functions of our Center, to include the quality control/improvement strategies impacting the approximately 4,000 patients served through the Center's proposed 1115 Waiver projects. This project will establish data interfaces with other agencies (law enforcement, state psychiatric hospitals, local and regional health agencies, Temple Independent School District, etc.) in order to regularly draw information from them regarding factors that affect Center service access, delivery, and outcomes. This project will proactively explore ways that advancing technology can bring efficiencies to our Center operations, and consequently stretch our service dollars to increase our service access, quality, and capacity. This project will form the operational hub for gathering data and monitoring the Center's performance outcomes associated with its 8 Category 3 performance improvement plans. It

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

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

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to:

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

This Project Meets the Following Regional Goals:

- Coordination with Mental Health Providers to enhance access for all Counties

Challenges:

The activities planned for DY2 are complex to accomplish if project approval comes in late spring 2013. The Center recognizes this potential challenge and has already begun its work on Milestones 1 (data system planning/selection) to prepare the Center to take action

upon project approval notice. The Center will need to identify a source for the data analyst/system analyst support needed by this project. The Center will be hiring at least one staff person to assist with the data gathering, data monitoring, data analysis, and formulation of system improvement paths based on the analyzed data, so will insure that the person hired has the professional knowledge and skills to support this and the Center's 7 other system improvement projects.

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

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

Rationale:
Community Need Addressed:
Community Need Area: CAN-006 Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers.

The Center recognizes that technology and operating practices for our current behavioral health service environment are increasingly complex and intrusive to our historical operating style of delivering behavioral health services. Our staff say they are spending more time documenting patient work than they are in delivering actual patient services. The Center has tried to get the best functional use from its

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

This project does not supplant any services or funds currently provided to Central Counties Service from the U.S. Department of Health and Human Services. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

Project Components:

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

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

c) *Design data collection system to collect real-time data that is used to drive continuous quality improvement (possible examples include weekly run charts or monthly dashboards).* The Center will address this component in DY4 and DY5 through Milestone 6. The Center will also work with its leadership and Quality Management staff to determine what data will be monitored on the continuously evolving Dashboards that we design and put in place to guide and monitor our 7 direct care 1115 Waiver projects and general Center operations in DY4.

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

and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

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

Related Category 3 Outcome Measures:

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

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

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

Relationship to Other Projects:

This project relates to the Center's telemedicine project (#081771001.1.1; RHP 16 #081771001.1.1 serving 900+ patients in DYs-3-5) which seeks to use highly reliable telemedicine and high-speed clinical EHR technology to increase timely access to psychiatric services in our

service area. This project also relates to our School-based Mental Health project (RHP 8 #081771001.1.1 serving 420 children in DYs 3-5) which will need to flawlessly access the Center's EHR system in a remote wireless, secure manner to interact with the Center's data system and make entries into patient EHRs. This project also relates to our Crisis Respite Services Project (#08771001.1.2; RHP8#081771001.1.4 serving 1,200 patients in DY4 & 5) that will need to use the Center's new telemedicine technology, the EHR clinical data system and the VOIP telephone system in a quick and reliable manner. This project relates to all of our Category 3 Quality Improvement Outcome Projects (#081771001.3.1, #081771001.3.2, #081771001.3.3, #081771001.3.4, #081771001.3.5, #081771001.3.6, #081771001.3.7, and #081771001.3.8) which will depend on a robust, user-friendly, high-speed reliable data system to collect, monitor and manipulate data into reports that document our Center's accomplishments through these projects.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Our Center is not aware of other Performing Provider's Projects which relate to this project. The Center is committed to service improvement and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 16 (see Milestones 5, 7, 8, 9 and 10).

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

- Receiving our IT Department's technical support to this team process;
- Procuring, implementing and training IT staff needed to efficiently update our data system and stabilize its power supply to insure its 24/7 availability;
- Establishing the external data interfaces with key organizations in our service area;

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

This valuation reflects 20.5% of the total valuation (Region 16 contains 20.5% of our service region's population) while 79.5% of this project's valuation will be reflected in our project submitted to Region 8 (08177101.1.4).

Central Counties Services – 081771001.1.3 (Project 1.10.2) Category 1 Milestones and Metrics			
081771001.1.5	**1.10.2**		**Enhance improvement capacity through technology**
Central Counties Services			**081771001**
Related Category 3 Outcome Measure:	**081771001.3.3**	**IT-1.18**	**Follow-up after hospitalization for mental illness**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-X.7] (see Planning Protocol, page 7): Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/ process redesign. **Metric 1** [P-X.7.1]: Establish and utilize a technology assessment team to delineate the functional requirements for the Center's data management capabilities needed to support the Center's care delivery system and service improvement projects. The team will review data system vender's products to ascertain which vender has a system that best matches the list of technological system required and desirable performance capabilities **Baseline/Goal:** Baseline - Center does not have a technology improvement plan. Goal - Center would have a written list of technological system required and desirable performance capabilities and which data system best support these desired capabilities.	**Milestone 4** [P-5]: Enhance or expand the organizational infrastructure and resources to store, analyze and share patient experience data and/or quality measures data, as well as utilize them for quality improvement. **Metric 1** [P-5.1]: Increased collection of patient experience and/or quality measures data **Baseline/Goal**: Baseline - Number of patient experience or quality measures data being collected was established under Milestone 3 in DY2. Goal - Increase the number of patient experience or quality measures data being collected by 6 patient data measures. **Data Source**: The Center's patient EHR system. Patient survey results. Reports generated to document the progress/outcomes of the Center's other improvement/transformation projects. Documentation of methodology for patient experience and/or quality measures data collection, analysis, and reporting	**Milestone 6** [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures. **Metric 1** [I-8.1]: Submission of quality dashboard or scoreboards. **Baseline/Goal:** Baseline - The Center currently has no quality management dash boards for use by Center staff. Goal - Have at least ~~3~~ 8 quality dashboards to monitor data streams of information that ~~is~~ are key to our Center's improvement of its clinical operations and patient treatment outcomes, and the skillful, effective management of the Center's eight 1115 Waiver projects, particularly the timely clinical follow-up of patients being discharged from psychiatric facilities (estimated to be 400+ in DY-4) associated with this project. **Data Source:** Quality improvement data systems **Milestone 6 Estimated Incentive**	**Milestone 9** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline - Progress reports presented in DY3 and the improvement goal(s) that was mutually agreed to by the providers. Goal - Prepare and deliver reports/ presentations on the accomplishments/ lessons learned from its implementation of organizational/ service delivery system improvement projects **Data Source**: Documentation of semiannual meetings including meeting agendas, Center presentations/ slides

Data Source: Technology team meeting notes and their final list of technological system required and desirable performance capabilities. The technology assessment team list of required and desirable data system capabilities, their vender scoring grids, and their choice of venders to upgrade the Center's data management system. **Milestone 1 Estimated Incentive Payment: $120,080** **Milestone 2** [P-X.9] (see Planning Protocol, page 7): Implement, adopt, upgrade or improve technology to support the project **Metric 1** [P-X.9]: The acquisition and implementation of the chosen data system upgrade. **Baseline/Goal:** Baseline - Center has a data system that does not adequately support the Center's clinical and organizational management needs. Goal - Center will implement upgrade that will adequately support the Center's clinical and organizational management needs **Data Source:** Purchase orders, receipts, data system operating manuals	**Milestone 4 Estimated Incentive Payment: $52,653** **Milestone 5** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline -No organized forum for sharing or receiving health systems improvement project outcomes. Goal - Will have an organized forum for sharing its improvement project outcomes and hearing reports of improvement project outcomes that may be adapted to the Center's operations **Data Source**: Documentation of semiannual meetings including meeting agendas, Center	**Payment: $47,919 ~~71,879~~** **Milestone 7** [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline - Have its progress reports presented in DY3 and the improvement goal(s) that was mutually agreed to by the providers. Goal - Prepare and deliver reports/ presentations on the accomplishments/ lessons learned from its implementation of organizational/ service delivery system improvement projects **Data Source**: Documentation of semi- annual meetings including meeting agendas, Center presentations/slides from presentations and/or meeting notes **Milestone 7 Estimated Incentive**	from presentations and/or meeting notes **Milestone 9 Estimated Incentive Payment: $54,701** **Milestone 10** [I-X]: Provide behavioral health services. **Metric 1** [I-X.1]: Provide documentation of increased behavioral health encounters. resulting from increased organizational efficiency. **Baseline/Goal:** Baseline - the number of behavioral health service encounters delivered in DY3; Goal - 4,000 behavioral health encounters over baseline. **Data Source:** Standards will be set and routinely monitored through our electronic health record system **Milestone 10 Estimated Incentive Payment: $54,701**

Milestone 2 Estimated Incentive Payment: $120,080 **Milestone 3** [P-X.6] (see Planning Protocol, page 7): Establish a baseline, in order to measure improvements over self. **Metric 1** [P-X.6.1]: Establish a baseline of the number of quality measures and/or patient experience data currently being collected to be used as the baseline for Milestone P-5 to be implemented in DY3. **Baseline/Goal:** Baseline - Center does not currently have a master list of the quality measures and/or patient experience data. Goal - Center will have a master list of quality measures and/or patient experience data being collected **Data Source**: The technology assessment team's data system list of required and desirable data system functions/capabilities, information gathered from the Center's Quality Management Dept. **Milestone 3 Estimated Incentive Payment: $120,079**	presentations/slides from presentations and/or meeting notes **Milestone 5 Estimated Incentive Payment: $52,652**	**Payment: $47,919** ~~**71,878**~~ **Milestone 8** [I-X]: Provide behavioral health services. **Metric 1** [I-X.1]: Provide documentation of increased behavioral health encounters resulting from increased organizational efficiency. **Baseline/Goal:** Baseline - the number of behavioral health service encounters delivered in DY3; Goal - 2,000 behavioral health encounters over baseline. **Data Source:** Standards will be set and routinely monitored through our electronic health record system **Milestone 8 Estimated Incentive Payment: $47,919**	
Year 2 Milestone Bundle Amount: $360,239	**Year 3 Estimated Milestone Bundle Amount: $105,305**	**Year 4 Estimated Milestone Bundle Amount: $143,757**	**Year 5 Estimated Milestone Bundle Amount: $109,402**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $718,703			

Category 1: Infrastructure Development
Project Option: 1.1.2 Expand Existing Primary Care Capacity
Coryell Memorial Hospital/134772611
Old: 134772611.1.1/New: 134772611.1.4 Expand Primary Care
Project Summary – Pass 3b

- Provider: Coryell Memorial Healthcare System (CMHS). Coryell Memorial Hospital is a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). CMHS operates two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County, RHP 8). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. The population per Primary Care Physician in Coryell County is 3,177:1 which is significantly higher than the Texas and U.S. ratios. The population of Coryell County in 2010 was 72,529 and is projected to grow each year through at least 2020. The Medicaid, uninsured and indigent population of Coryell County was approximately 22,500 in 2012.
- Interventions: This project will expand access to primary care providers within Coryell County by adding additional providers including physicians and mid-levels which will also include an expansion of existing space. At the same time, emergency room utilization for non-emergent or urgent care is approximately 38% of total visits. This project seeks to improve the ability to deliver preventive services to the target population but also provide better access for urgent care.
- Need for Project: Coryell Medical Clinic represents 5 primary care physicians (PCPs) and 1 mid-level practitioner. CMHS serves a population of 72,529 and is the only acute care facility in the county. Of the 5 PCPs at CMHS, one works part-time while another will be leaving in January 2013 to serve in the Texas Legislature, spending less time in the clinic. CMHS will also evaluate additional space in DY2 for existing physicians and mid-levels in underserved areas of the county. CMS funding will allow CMHS to hire additional practitioners to serve a growing population as well as those who currently do not have access to care.
- Medicaid and Uninsured Target Population: The target population is patients that would benefit from extended access for non-emergent/ urgent and preventive care services. This project will target the adult Medicaid, Indigent, and Uninsured population (for adult Category 3 outcome measures) although an expansion would benefit the population of the entire county.
- Category 1 or 2 expected patient benefits: The project seeks to add 2 additional primary care providers to serve the target population (22,500), support an after-hours clinic, and possibly expand into an underserved area. CMHS will target an additional 800 clinic visits in DY4 and 1400 clinic visits in DY5 using DY2 clinic visits as baseline (based on the amount of time it may require to recruit additional providers).
- Category 3 outcomes: Improve utilization of the following primary care prevention screenings:
  IT-12.1 Breast Cancer Screening, IT-12.2 Cervical Cancer Screening, IT-12.3 Colorectal Cancer Screening, IT-12.7 Controlling high blood pressure

Category 1: Infrastructure Development
Project Option: 1.1.2 Expand Existing Primary Care Capacity
Coryell Memorial Healthcare System/134772611
Old: 134772611.1.1/ New: 134772611.1.4 Expand Primary Care

Project Description

Coryell Memorial Healthcare System (CMHS) will expand existing primary care capacity in Coryell County to provide "the right care at the right time in the right setting" so that patients can be treated in a proactive, efficient manner. This will be accomplished by hiring and training additional physicians and midlevel practitioners to meet the needs of the population that typically does not have access to a primary care physician. CMHS will extend clinic hours to provide better access to preventive and urgent care services to avoid costly and unnecessary trips to the emergency room. CMHS will triage patient appointments to ensure that same day appoint slots are available for most urgent patients. The target population is patients that would benefit from extended access for non-emergent/ urgent and preventive care services. This project will specifically target the Medicaid, Indigent and Uninsured population of Coryell County (22,500) although an expansion would benefit the entire county. The additional primary care providers (including mid-levels) will care for the outpatient and inpatient population at CMHS as well as increase outreach efforts in the community to promote prevention and wellness. The project seeks to add 2 additional primary care providers to serve the Medicaid, Indigent, and Uninsured population who will also support an after-hours clinic and increase access to preventive services in the clinic. CMHS will target an additional 800 clinic visits in DY4 and 1400 clinic visits in DY5 using DY2 clinic visits as baseline (based on the amount of time it may require to recruit additional providers). The number of primary care providers by population in Coryell County is considerably lower than the rest of the region, especially in the southern region of the county which is near a highly populated area. Because of this, CMHS will also evaluate in DY2 the possibility of expanding primary care services to underserved areas of the county to increase utilization of preventive care services but also provide urgent care for those who typically visit the emergency room for non-emergent care.

Goals:

- Improved quality and health outcomes
- Expand capacity to care for more children and young adults
- Develop processes that will improve the number of patients in the target population who receive recommended preventive cancer screenings
- Effectively monitor and treat patients in the target population with high blood pressure

Relationship to Regional Goals:
The goals of RHP 16 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. RHP16 has chosen to focus on increasing the capacity of primary care and increasing strategies related to disease prevention. We anticipate that all the projects will reduce the burden on Emergency Departments and improve health outcomes across the region. RHP 16 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. 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 16, 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.

Challenges: In Coryell County, low income, uninsured and minority populations more often have multiple chronic conditions. Without regular primary care, these conditions are more likely to become acute, putting patients at risk for disability and premature death. Delays and long wait times to see a physician negatively impact a patient's willingness to seek preventive care. According to the U.S. Census Bureau, more than 15% of Texas is considered rural. A small percentage of America's family practice physicians actually choose to practice in rural areas. Recruiting physicians to a rural area will be time consuming, expensive and difficult to achieve.

5-year expected outcome*:* Patients and future patients of Coryell Medical Clinic will receive timely preventive care appointments, follow-up care for chronic conditions, and better access to urgent care. With the additional capacity, we anticipate an increase in primary care encounters for patients in Coryell County.

Starting Point/ Baseline
Coryell Medical Clinic (CMC) currently employs 5 physicians. Patient volume is growing but adequate accessibility and appointment availability will be difficult to maintain. Because Coryell County is a medically underserved population, not only do we need additional primary care for our current population but the ability to serve more patients as the county continues to grow (30% in 2020). Initially, clinic hours will be extended in DY4 - DY5 as additional providers are employed beginning in DY3 and then increase as needed based on availability of existing and new physicians.

Rationale
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. For certain segments of the population, it is culturally

acceptable to seek non emergent care in the emergency room. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing these access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Healthy People 2020 outline several goals and objectives that also align with the goals of transformation waiver over the next 4 years: 1) patients should have a source of ongoing care; 2) have a usual primary care provider (PCP); 3) reduce avoidable hospitalizations. By increasing the number of available healthcare providers and resources to support a growing population in Coryell County, these goals can be achieved.
Current Medicaid and Uninsured Population for Coryell County:
Medicaid: 6,078
Uninsured: 16,043
Indigent Healthcare: 375

Project Components:

The required core components will be fulfilled as follows:

a) Expand primary care clinic space – existing space and additional space in the primary care clinic will be utilized to expand primary care for additional practitioners
b) Expand primary care clinic hours – in order to address overutilization in the emergency room for non-emergent care, clinic hours will be expanded as needed to provide better access in the primary care clinic
c) Expand primary care clinic staffing – to meet the demand for additional hours, patient follow-up, and available appointments, CMHS will add additional staff to meet or exceed patient's expectations. In addition, CMHS will pilot the "Community Paramedic" program to fill gaps in care related to rural and remote areas of the county that will form a bridge between the community and health care providers. The Community Paramedic is considered an extension to the primary care provider and will deliver services in the home such as case management, medication administration, and basic education and training. Community paramedics will report back to the physician with a health status report on each patient.

Unique community need identification numbers the project addresses:

- CNA-005 – Primary care shortage area
- CNA-008 – Population growth

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

Expansion of primary care is absolutely necessary for system wide improvement. With this expansion, more patients have access to preventive care, which increases opportunities to prevent disease and further deterioration of health status and will keep people out of the hospital. It is especially important for inpatients to get follow-up appointments after a hospital discharge for optimal recovery and to avoid readmission. The Community Paramedic program has not been implemented in any county of RHP 16 and would demonstrate a new initiative for the region and possibly most of Central Texas.

Process Milestones:

P-4. 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.

P-4.1.a. Data Source: Clinic Documentation

P-5. Train/ hire additional primary care providers and staff/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.

P-5.1.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.

Improvement Milestones:

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

I-12.1.b. Data Source: Registry, EHR, claims or other Performing Provider source

Related Category 3 Outcome Measure(s)

Through expanding primary care capacity, patients will have more access to primary care which will improve patient experience, improve preventive screenings and outcomes.

OD-1 Primary Care and Chronic Disease Management

IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012) (Standalone measure)

OD-12 Primary Care and Primary Prevention

IT-12.1 Breast Cancer Screening (HEDIS 2012) (non- standalone measure)

IT-12.2 Cervical Cancer Screening (HEDIS 2012) (non- standalone measure)
IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (non- standalone measure)

Reasons for selecting the outcomes measures:
High blood pressure increases the risk for heart disease and stroke, the first and third leading cause of death in America. High blood pressure can also lead to kidney problems, vision and heart failure. Early detection of cancer may also lead to better outcomes including improved quality of life and life expectancy.

Relationship to other Projects

This project will assist in our efforts to develop a patient centered medical home model by providing better access to primary care and a medical home (134772611.2.1). Primary Care providers may also work closely with the health promotion and disease prevention teams as a bridge between self-management and clinical based care (134772611.2.2 and 134772611.2.3).

Relationship to other Performing Providers' Projects in the RHP

Although several other performing providers in RHP 16 are also expanding primary care coverage in their communities, it is important to the patient to receive care closer to home and within 30 miles or less due to lack of personal transportation, financial barriers, and the fact that few public transportation options exist. Coryell County is considered rural and therefore many citizens may have to travel distances greater than 30 miles to receive primary care if it is not available locally. The expansion of primary care will target patients within the CMHS service area.

Plan for Learning Collaborative

CMHS will meet monthly to discuss the current status of projects related to expansion of primary care. Learning collaborations offer the team an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
5. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
6. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).

7. It should use metrics to measure its success such as:
    - Rate of testing
    - Rate of spread
    - Time from idea to full implementation
    - Commitment rate (rate at which 50% of organizations take action for any specific request)
    - Number of questions asked per day

Project Valuation

The project seeks to increase the number of primary care providers by 2 in order to serve the target population of 22,000 Medicaid and Uninsured in the outpatient and inpatient setting, support an after-hours clinic, and possibly expand to an underserved area within the county. CMHS will target an additional 800 clinic visits in DY4 and 1400 clinic visits in DY5 using DY2 clinic visits as baseline (based on the amount of time it may require to recruit additional providers as well as the fact providers may not be working in the clinic full time but serving patients elsewhere in the community). Coryell County is considered an HPSA (physician shortage area). Expanding the hours of service and locations for providers will provide greater access to care for the target population. In addition, patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, home health, case management and mental health services. In 2011, CMHS experienced over 4,000 non emergent visits to the emergency room. Each visit has an associated charge of $1,100. Redirecting those patients would provide a cost savings of over $4,000,000 in the emergency room. In addition, patients who are able to access primary care can avoid potential hospital readmissions due to cardiac related health conditions. For example, according to Medicare Hospital Compare data, the US and local rate of readmissions for heart failure patients is 24.7%. In 2010, high blood pressure was projected to cost the United States $93.5 billion in health care services, medications, and missed days of work.[1]

[1] (Heidenreich PA, Trogdon JG, Khavjou OA, Butler J, Dracup K, Ezekowitz MD, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. *Circulation*. 2011;123:933-44. Epub 2011 Jan 24.)

Old:134772611.1.1/ New:134772611.1.4	1.1.2	1.1.2 (A-C)	Expand Existing Primary Care Capacity	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*Old: 134772611.3.1/ New:134772611.3.13 Old:134772611.3.2/ New:134772611.3.14 Old: 134772611.3.3/ New:134772611.3.15 Old: 134772611.3.4 New:134772611.3.16*	*IT-12.1 IT-12.2 IT-12.3 IT-1.7*	*Breast Cancer Screening(Non- standalone measure) Cervical Cancer Screening (Non- standalone measure) Colorectal Cancer Screening (Non- standalone measure) 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 [P-5]: Train/ hire additional primary care providers and staff/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Metric: Documentation of increased number of providers and staff and/or clinic sites. Goal: 1 additional primary care provider Data Source [P-5.1.a]: 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** [P-5]: Train/ hire additional primary care providers and staff/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Metric: Documentation of increased number of providers and staff and/or clinic sites. Goal: 1 additional primary care provider. Data Source [P-5.1.a]: 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 4** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hour Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline: 44 hours/ wk Goal: Increase clinic hours by minimum 10 hours each week Data Source: [P-4.1.a]: Clinic Documentation Milestone 4 Estimated Incentive Payment: $605,479.50 **Milestone 5** [I-12]:Increase	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: Increase in visits from 800 additional visits in DY4 to 1,400 visits in DY5 Data Source: [I-12.1.b]: Register, EHR, claims or other Performing Provider source Milestone 6 Estimated Incentive Payment: $1,000,357

Old:134772611.1.1/ New:134772611.1.4	1.1.2	1.1.2 (A-C)	Expand Existing Primary Care Capacity	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*Old: 134772611.3.1/ New:134772611.3.13 Old:134772611.3.2/ New:134772611.3.14 Old: 134772611.3.3/ New:134772611.3.15 Old: 134772611.3.4 New:134772611.3.16*	*IT-12.1 IT-12.2 IT-12.3 IT-1.7*	*Breast Cancer Screening(Non- standalone measure) Cervical Cancer Screening (Non- standalone measure) Colorectal Cancer Screening (Non- standalone measure) 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 Estimated Incentive Payment: $1,106,791	Milestone 2 Estimated Incentive Payment: $603,724.50 **Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hour Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline: 40 hours Goal: Increase clinic hours by 4 hours each week Data Source: [P-4.1.a]: Clinic Documentation Milestone 3 Estimated		primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY3) Goal: Increase volume of primary care visits (800 additional visits) Data Source: [I-12.1.b]: Register, EHR, claims or other Performing Provider source Milestone 5 Estimated Incentive Payment:	

Old:134772611.1.1/ New:134772611.1.4	**1.1.2**	**1.1.2 (A-C)**	**Expand Existing Primary Care Capacity**	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*Old: 134772611.3.1/ New:134772611.3.13 Old:134772611.3.2/ New:134772611.3.14 Old: 134772611.3.3/ New:134772611.3.15 Old: 134772611.3.4 New:134772611.3.16*	*IT-12.1 IT-12.2 IT-12.3 IT-1.7*	*Breast Cancer Screening(Non- standalone measure) Cervical Cancer Screening (Non- standalone measure) Colorectal Cancer Screening (Non- standalone measure) 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)**
	Incentive Payment: $603,724.50		$605,479.50	
Year 2 Estimated Milestone Bundle Amount: $1,106,791	Year 3 Estimated Milestone Bundle Amount: $1,207,449		Year 4 Estimated Milestone Bundle Amount: $1,210,959	Year 5 Estimated Milestone Bundle Amount: $1,000,357
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,525,556				

Category 1: Infrastructure Development
Project Option: 1.9.2 Improve access to specialty care
Coryell Memorial Healthcare System/134772611
Old: 134772611.1.2/New: 134772611.1.5 Expand Specialty Care Capacity
Project Summary – Pass 3b

- Provider: Coryell Memorial Healthcare System (CMHS). CMHS operates a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). CMHS also owns two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County, RHP 8). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. The population per Primary Care Physician in Coryell County is 3,177:1 which is significantly higher than the Texas and U.S. ratios. Coryell County is also considered a medically underserved area/population. The population of Coryell County in 2010 was 72,529 and is projected to grow each year through at least 2020.
- Interventions: This project will expand access to specialists within Coryell County by increasing the number of specialists offering services in Coryell County as well as provide additional clinic access by extending the number of hours of service availability.
- Need for Project: Coryell County has the second highest population in RHP 16 and lacks access to specialty services including oncology, pulmonary and cardiac rehab, mental health, allergists, and certain pediatric subspecialists. Considering the fact that many residents of Coryell County live more than 50 miles from an urban area, additional specialists within the county will greatly impact our ability to serve the target population and reduce the amount of state funds needed to provide transportation to larger, urban areas.
- Medicaid and Uninsured Target Population: The target population is our patients that would benefit from extended access to specialists that would improve our ability to treat patients with chronic illnesses. The Medicaid and Indigent population of Coryell County was approximately 6,500 in 2012. Another 16,000 are uninsured. CMHS will target patients that are seen in our emergency room who need a specialty referral following discharge and those treated in the clinic who are least likely to travel for specialty consultations and ongoing treatment. According to the U.S. Government Accountability Office, 84% of the Medicaid and CHIP population have “Some to Great Difficulty” getting a specialty referral.
- Category 1 or 2 expected patient benefits: The project seeks to increase the number of specialists who conduct outpatient clinics by an additional 2 specialties in DY4 and another 2 specialties in DY5. The exact specialties will be determined using a specialty care gap assessment. Although the exact number of patient visits for the new specialties is unknown, we are targeting the current and future Medicaid and Indigent population which at this time is approximately 6,500. It is anticipated that at least 5-10% will require specialty care during the next 3 years.
- Category 3 outcomes: IT 3.9. Our goal is to reduce 30 day Potentially Preventable Readmissions - All-Cause 30 day readmission rate, as a result of improved local access to certain specialists.

Category 1: Infrastructure Development
Project Option: 1.9.2 Improve access to specialty care
Coryell Memorial Healthcare System/134772611
Old: 134772611.1.2/New: 134772611.1.5 Expand Specialty Care Capacity

Project Description

Coryell Memorial Healthcare System (CMHS) will expand specialty care capacity in Gatesville, Texas, by providing remodeling existing space and providing additional clinical resources for physicians and midlevel practitioners to meet the needs of the population that typically does not have access to specialty care. This project will expand access to specialists within Coryell County by increasing the type of specialty services provided in Coryell County as well as provide additional clinic access by extending the number of hours of service availability. Initially, we will identify the specialty services that are most critical to our population. We will then develop a clinical schedule that will increase the number of hours that are available to care for our patients and increase the number of specialists providing services in the local clinics. Some of the providers may work full-time in the clinic, particularly those specializing in mental health counseling, health and wellness and rehabilitation. We will implement transparent, standardized referral processes across the system and conduct quality improvement activities that will identify project impacts, "lessons learned" and opportunities to expand the project to a broader population. We will provide better access for our patients so they can avoid costly trips to physicians and other providers located outside the county in order to improve the health of our community.

The target population is our patients that would benefit from extended access to specialists , particularly those with chronic illnesses or conditions that could be eliminated with additional care by a specialist. The Medicaid and Indigent population of Coryell County was approximately 6,500 in 2012. Another 16,000 are uninsured. CMHS will target patients that are seen in our emergency room who need a specialty referral following discharge and those treated in the clinic who are least likely to travel for specialty consultations and ongoing treatment. According to the U.S. Government Accountability Office, 84% of the Medicaid and CHIP population have "Some to Great Difficulty" getting a specialty referral.

The project seeks to increase the number of specialists who conduct outpatient clinics by an additional 2 specialties in DY4 and another 2 specialties in DY5. The exact specialties will be determined using a specialty care gap assessment. Although the exact number of patient visits for the new specialties is unknown, it is anticipated that at least 5-10% of the target population will require specialty care during the next 3 years. At this time, we believe that the population would benefit from a local cardiac and pulmonary rehabilitation program, allergists, mental health counseling services, health and wellness experts, and certain pediatric subspecialties.

Goals:

- Conduct a gap analysis to determine the specialty care needs of the community
- Expanded number of specialty providers and/or clinic hours for highest demand specialties.
- Goal is to increase the number of available services in the county to at least 4 additional specialties
- Address the shortage of specialists in a growing geographic area

Relationship to Regional Goals:

The goals of RHP 16 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. RHP16 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 16 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP project, improve access to specialty care, will begin to build the infrastructure needed to provide local care coordination, chronic disease management and care transitions which are projects of the future. In increasing the capacity of specialty care, the cost of care will be impacted. RHP 16 has identified multiple projects that seek to bend the cost curve which is foundational to the transformation of the healthcare system for patients and for providers.

Challenges: The lack of available specialists, the distance required to travel to remote areas, and lack of sufficient space and facilities to adequately care for the population. According to the American Academy of Pediatrics, approximately 1 in 3 children travel more than 40 miles to seek treatment for developmental issues, neurodevelopment disabilities and nephrology and wait times for appointments can exceed 3 months. This causes frustration for both the families and primary care providers making the referral.

5-year expected outcome: Better coordination of specialty services between primary care clinic and specialty clinic which will ultimately reduce patients who rely on emergency rooms and EMS transportation for specialty care. Specialty care will be timely and easier to access for patients with limited transportation options.

Starting Point/ Baseline

CMHS currently refers patients to physicians located more than 35 miles outside of the county and more than 70 miles for patients who reside in the most remote sections of the county. Currently, the county is served by only one full-time general surgeon and one full-time radiologist. This is not sufficient to care for a county population second in size to the entire region (population 72,000) and provide the level of services for those unable to afford or have access to suitable transportation over great distances from rural areas. The demand for services is reflected in the number of patients who are referred from our clinic to other physicians, the minority population and the

number of citizens with Medicaid or those who are uninsured. CMHS will identify the specialties in greatest demand in DY2, including those that will have the most significant impact on the health of the community, and begin expansion in DY3 – DY4.

Rationale:

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. Current Medicaid, Indigent and Uninsured Population for Coryell County:
Medicaid: 6,078
Uninsured: 16,043
Indigent Healthcare: 375

Project Components:

The core components of this category will be fulfilled as follows:

a) Increase service availability with extended hours – Coryell Memorial Healthcare System (CMHS) will conduct a study to determine the specialties needed locally and the hours that would satisfy the demand
b) Increase number of specialty clinic locations – CMHS will work with local specialists to expand their existing locations to areas in the county that will be more accessible to the patients
c) Implement transparent, standardized referrals across the system – CMHS will develop a process for the primary care clinics to have access to a specialty clinic referral system that will expedite patient care and improve access.
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.

Unique community need identification numbers the project addresses:

- CNA - 006 – Population growth
- CNA - 004 – Potentially Preventable Hospitalizations
- CNA - 009 – CMS 30-day readmission measures

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

This initiative builds on an identified need in the community (improve access) to provide services locally due to the rural areas of the county and because it is a medically underserved population. Transportation is an issue for the Medicaid and indigent

populations (most will have to travel more than 30 miles to visit a specialist) as well as missed time at work therefore we believe patients have a much greater likelihood of receiving the care they need if transportation is not an issue and they do not have to reduce the number of hours they work each week.

Process Milestones selected:

P-1: 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)
P-1.1.b. Data Source: Needs Assessment

P-11: Launch/ expand a specialty care clinic (e.g., pain management clinic)
P-11.1. Metric: Establish/ expand specialty care clinics
P-11.1.c. Data Source: Documentation of new/ expanded specialty care clinic.

Improve Milestones selected:
I-23: Increase specialty clinic volume of visits and evidence of improved access for patients seeking services
I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
I.23.1.b: Data Source: Registry, EHR, claims or other Performing Provider Source.

Related Category 3 Outcome Measure(s)

OD-3 Potentially Preventable Readmissions
IT-3.1 All Cause 30 day readmission rate
a) Numerator: The outcome for this measure is unplanned all-cause 30-day readmissions.
b) Denominator: Admissions to acute care facilities

Reasons for selecting the outcomes measure:
Acute costs range from unscheduled primary care visits to emergency room, inpatient or intensive care visits. Even after treatment for an acute episode of care, respiratory, physical, social and emotional impairment may persist for an extended period of time for certain chronic conditions. Patients who do not have access to successful treatment programs and resources have a more rapid decline, worse quality of life and decreased performance. Management of chronic conditions improves long-term health status and lowers long term related health costs associated with complications.

Relationship to other Projects

Local specialists will be able to better coordinate care and provide health status reports to the patient's primary care clinic (134772611.1.4, 134772611.2.5).

Relationship to other Performing Providers' Projects in the RHP

This project will support the needs of the communities within Coryell County.

Plan for Learning Collaborative

CMHS will meet monthly to discuss the current status of projects related to expansion of specialty care. Learning collaborations offer the team an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
5. It should employ individuals (regional "innovator agents") to travel from site to site in the network to (a) rapidly answer practical questions about implementation and (b) harvest good ideas and practices that they systematically spread to others. The regional "innovator agents" should all attend the same initial training in improvement tools and skills organized by the State or RHP and should receive periodic continuing education on improvement.
6. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
7. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).
8. It should use metrics to measure its success such as:

- Rate of testing
- Rate of spread
- Time from idea to full implementation
- Commitment rate (rate at which 50% of organizations take action for any specific request)
- Number of questions asked per day
- Network affinity/reported affection for the network

Project Valuation

The project seeks to increase the number of specialists who conduct outpatient clinics by an additional 2 specialties in DY4 and another 2 specialties in DY5. The exact specialties will be determined using a specialty care gap assessment but will compliment other programs that target the prevention and treatment of chronic illnesses and community wellness. Although the exact number of patient visits for the new specialties is unknown, we are targeting the current number of Medicaid, Indigent, and Uninsured in Coryell County which at this time is approximately 22,000. It is anticipated that at least 5-10% will require specialty care during the next 3 years. CMHS hopes to achieve cost savings related to travel expenses, improve compliance with follow-up care and treatment plans following hospital discharge, and reduce the amount of time it takes to schedule an appointment with a specialist. Specialists will require additional space within the existing clinic for consultations and treatment.

Coryell County is considered an HPSA (physician shortage area). Expanding the hours of service and locations for specialists will provide greater access to care for the target population. In addition, patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, home health, case management and mental health services. For example, in 2010, Coryell Memorial experienced 85 admissions due to COPD (average hospital charge of $14,621), 117 admissions due to CHF (average hospital charge of $18,662) and 259 admissions due to Diabetes with Long Term Complications (average hospital charge of $20,014). Providing additional specialty services locally should lead to lower hospitalization costs, better access to care and improved quality of life.

Old: 134772611.1.2/ New: 134772611.1.5	1.9.2	1.9.2.A-D	EXPAND SPECIALTY CARE CAPACITY	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*Old:134772611.3.5/ New:134772611.3.17*	*Potentially Preventable Readmissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 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]: Metric: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: Specialty care gap assessment by end of DY 2. Data Source: [P-1.1.b]: Needs Assessment Milestone 1 Estimated Incentive Payment: $1,277,066	**Milestone 2** [P-11]: Launch/ expand a specialty care clinic (e.g., pain management clinic) Metric 1 [P-11.1]: Establish/ expand specialty care clinics Baseline: Number of patients referred to another county for specialty care. Goal: 5% of patients referred for specialty care served locally. Data Source: [P-11.1.c]: Documentation of new/ expanded specialty care clinic. Milestone 2 Estimated Incentive Payment: $1,393,210		**Milestone 3** [P-11]: Launch/ expand a specialty care clinic (e.g., pain management clinic) Metric 1 [P-11.1]: Metric: Establish/ expand specialty care clinics Goal: 8% of patients referred for specialty care served locally. Data Source: [P-11.1.c]: Documentation of new/ expanded specialty care clinic. Milestone 3 Estimated Incentive Payment: $698,630 **Milestone 4 [**I-23]: Increase specialty 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	**Milestone 5 [**I-23]: Increase specialty 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: 10% increase Goal: Increase visits by 20% Data Source: [I.23.1.b]: Registry, EHR, claims or other Performing Provider Source. Milestone 5 Estimated Incentive Payment: $1,154,259

Old: 134772611.1.2/ New: 134772611.1.5	1.9.2	1.9.2.A-D	EXPAND SPECIALTY CARE CAPACITY	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*Old:134772611.3.5/ New:134772611.3.17*	*Potentially Preventable Readmissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			reporting period. Baseline: Number of visits in DY3 Goal: Increase visits by 10% Data Source: [I.23.1.b]: Registry, EHR, claims or other Performing Provider Source. Milestone 4 Estimated Incentive Payment: $698,630	
Year 2 Estimated Milestone Bundle Amount: $1,277,066	Year 3 Estimated Milestone Bundle Amount: $1,393,210		Year 4 Estimated Milestone Bundle Amount: $1,397,260	Year 5 Estimated Milestone Bundle Amount: $1,154,259
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $5,221,795				

Category 1: Infrastructure Development

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

Coryell Memorial Hospital/ 134772611

134772611.1.3 Introduce, Expand, or Enhance Telemedicine/Telehealth

Project Summary

- Provider: Coryell Memorial Healthcare System (CMHS). CMHS operates a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). CMHS also owns two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County, RHP 8). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. The population per Primary Care Physician in Coryell County is 3,177:1 which is significantly higher than the Texas and U.S. ratios. Coryell County is also considered a medically underserved area/population. The population of Coryell County in 2010 was 72,529 and is projected to grow each year through at least 2020. As of May 2012 (http://www.hhsc.state.tx.us/research/MedicaidEnrollment/me-results.asp), the number of residents in Coryell County with Medicaid was 6,078 and the number of uninsured was over 16,000.
- Interventions: This project will be part of the regional project submitted by Providence Healthcare Network for Region 16 to introduce a Telemedicine/Telehealth program in order to provide specialty psychiatric care in the Emergency Department. The project will provide improved access to psychiatric care in a timelier manner.
- Need for Project: Coryell County has the second highest population in RHP 16 and lacks access to multiple specialists, including psychiatry. Coryell County is designated as a HPSA/MUA with very few specialists in the county for treatment of mental health/ behavioral health disorders. When patients arrive at the emergency department for psychiatric care, they are subject to long waits to be referred for appropriate treatment.
- Medicaid and Uninsured Target Population: The target population is Medicaid, Uninsured, and Indigent patients that utilize the Emergency Department for psychiatric and behavioral health needs. In 2011, CMHS treated approximately 8,500 patients in the emergency room and a significant percentage would have benefitted from a psychiatric consultation that did not include long delays or wait times in the emergency room or transfers to another facility.
- Category 1 or 2 expected patient benefits: The project seeks to provide better access to appropriate psychiatric care in a timelier manner, thereby improving access for patients seeking services in DY4 and DY5. In DY3 we will establish the baseline for number of telehealth services provided that will be used as the basis for our DY4 and DY5 goals. Our goal for DY4 is to increase usage of telehealth for psychiatric treatment by 30% over the baseline rate established in DY3. In DY5 we expect to increase usage of telehealth for psychiatric treatment by 60% over the baseline rate established in DY3.
- Category 3 outcomes: IT-1.20 The goal is to increase the percentage of patients who received follow-up within 7 and 30 days of their telemedicine consultation in the emergency department by TBD % over baseline.

Pass 2
Category 1: Infrastructure Development
Coryell Memorial Hospital/ 134772611
134772611.1.3 Introduce, Expand, or Enhance Telemedicine/Telehealth
Project Option: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.

Project Description

Coryell Memorial Healthcare System (CMHS) will partner with Providence Healthcare Network (PHN) to introduce a telemedicine program in order to provide mental health services for Emergency Department patients and eventually expand as a referral source for identified shortage areas, medical education and training. Coryell County is designated as a HPSA and the closest specialty services are 35 miles away. Patients are subject to long waits to be referred to the appropriate facility for urgent and routine care. Implementation of the telemedicine program will allow these patients to be seen by a specialist in a timely manner and allow the patient to be referred for appropriate treatment. In addition to these services, telemedicine can be used for patient consultations, remote patient monitoring, medical education and consumer medical and health information.

Providence Healthcare Network will provide telemedicine units for CMHS with the initial intent to provide behavioral health screenings and treatment more timely, efficiently, and cost effectively. When potential psychiatric patients present in any emergency department in the region, telemedicine capability can be used to perform first QMHP screenings, followed by psychiatric physician screenings, if necessary, to determine appropriate treatment for the patient. In addition to the benefit of more timely and appropriate treatment for the patient, use of telemedicine for behavioral health patients will provide needed support to emergency physicians in each facility, ensure appropriate throughput of these patients, reduce the burden on the local psychiatric physicians and reduce law enforcement and other costs related to sometimes unnecessary transfers or forensic detail for psychiatric patients. CMHS will provide trained individuals, space and ongoing support to ensure patients receive the services they need through the telemedicine program.

The target population is Medicaid, Uninsured, and Indigent patients that utilize the Emergency Department for psychiatric and behavioral health needs. In 2011 we treated more than 8,500 patients and a significant percentage had a primary or secondary diagnosis for mental health issues in our emergency department and inpatient. Some of these patients opt out of mental health screening and treatment due to the lack of local providers and timely appointments. The program will benefit a much larger population as improved technology, trained staff and equipment will be available to all patients.

Goals:

- Increase access to care
- Support long distance patient and professional health related education
- Reduced costs associated with missed appointments and travel
- Improve patient satisfaction

Relationship to Regional Goals:

CMHS will work with PHN to ensure the development of a comprehensive, global solution for RHP 16 using telemedicine and telehealth via electronic communications to improve the health of the population. The goals of RHP 16 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. We anticipate that this particular project will reduce the burden on Emergency Departments and improve mental health outcomes across the region. RHP 16 has a number of collaborations which invests resources into our rural communities. This project is collaboration between multiple healthcare providers that will begin to build the infrastructure needed in our healthcare system to be the backbone for improved care coordination, chronic disease management and care transitions.

5 yr Expected Outcomes:
By DY5, we expect to have a fully integrated telemedicine program to provide consistent healthcare using telehealth for our patient population.

Challenges:
Several major challenges to this project include lack of regional behavioral health providers and availability and backlog in wait times for behavioral health consultations or appointments.

Starting Point/Baseline
A formal telemedicine program with regional emphasis does not formally exist at this time. Collaboration of resources will play an integral role in establishing a baseline rate for the patient population that the project is intended to serve. Formal baseline data will be established in DY3.

Rationale
There is a severe shortage of specialty care providers in Region 16, specifically for behavioral health consultations and services. Most of the resources for behavioral health are located in the more densely populated area of the region. In order to alleviate the burden of having to travel long distances for specialty care in Coryell County, establishing a telemedicine approach to their care will allow for greater expansion of specialty care services throughout the region.

The telemedicine program will be initially based in the emergency department and provide patient consultations by behavioral health specialists using telecommunications, eventually expanding to other areas of the facility. The program will also include a component of quality improvement so that we are able to identify the project impacts, identify "lessons learned," identify opportunities to scale the project to a broader patient population, and identify key challenges associated with expansion of the project.

Project Components:
The required core components will be fulfilled as follows:
a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications

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

Unique community need identification numbers the project addresses:
CNA-006 – Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Telemedicine does not exist at CMHS nor any other facility or clinic in the county. CMHS serves several rural communities that are located even further from a tertiary care facility or multi-specialty clinic and specialty services do not exist in these areas. Telemedicine would improve access to certain medical specialties that do not have providers who can travel to remote areas. This initiative would also provide funding for the equipment and technology required to support a telemedicine/ telehealth program.

Process Milestones:

[P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need

Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents

Goal: Implement the telehealth program for psychiatric care
Data source: Program materials

Metric 2 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation

Goal: Implement the telehealth program for psychiatric care
Data source: log of tele-services by type of health care professionals and type of service

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

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

Goal: Implement training and education programs for healthcare community
Data Source: Program materials

[P-11]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon

several improvements (simple initiatives that all providers can do to "raise the floor' for performance). Each participating provider should publicly commit to implementing these improvements.

Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Goal: Agree to and implement improvements

Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Improvement Milestones:

[I-17]: Improved access to specialists care or other needed services, e.g. community-based nursing, case management, patient education, counseling, etc.

Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program.

Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services.

Denominator: Number of residents in HPSA

Goal: Increase usage of telehealth for psychiatric treatment

Data source: EHR

Related Category 3 Outcome Measure(s)

OD-1 Primary Care and Chronic Disease Management

IT-1.20 Other Outcome Improvement Target:

Follow-up after emergency department visit for Mental Illness

a. Numerator:
   - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
   - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
b. Denominator: Members 6 years and older as of the date of ED visit who were seen in the emergency department setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator of this measure is based on ED visits, not members. Include all ED visits for members who have more than one ED visit on or between January 1 and December 1 of the measurement year.
c. Data Source: EHR, Claims
d. Rationale/Evidence: This measure assesses the percentage of ED visits for members 6 years of age and older who were seen for treatment of mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

   Rate 1: The percentage of members who received follow-up within 30 days of ED visit

Rate 2: The percentage of members who received follow-up within 7 days of ED visit

Region 16 is a Mental Health Professional Shortage Area. Lack of access to mental health professionals in rural communities creates significant problems in terms of emergency department visits, untreated mental health conditions, and complications in treating medical conditions which are worsened by the presence of mental health issues. The implementation of the telemedicine project will greatly enhance the ability of our population with behavioral health needs to access the care that is required to care for their illness. The real-time interaction with a behavioral health specialist could enable the health care team to address the patient problem before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectation of our healthcare system. Receiving a real-time interaction with a behavioral health specialist will also allow patients to be referred and understand the need for additional care, reducing the risk of the patient not receiving appropriate follow-up care following their ED visit.

Relationship to other Projects

A telemedicine program will assist all areas of CMHS including the emergency room, primary and specialty clinic (Medical Home, Expansion of Specialty Care), and other programs that serve patients will mental health and substance abuse issues.

Relationship to Other Performing Providers' Projects in the RHP

CMHS will develop the infrastructure, policies and procedures to implement a robust telemedicine program for psychiatric services and will be expanded as necessary to meet the needs of the community. This is a regional project supported by the implementation of a telemedicine program by PHN who will provide professional support. This is not a duplication of payment as CMHS will provide the space, emergency room personnel and administrative support for the program in Coryell County for services provided to patients seen in Coryell County.

Plan of Learning Collaborative

CMHS will meet monthly with PHN and other participants to discuss the current status of projects related to expansion of telemedicine/ telehealth services. Learning collaborations offer the team an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
5. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
6. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).
7. It should use metrics to measure its success such as:

- Rate of testing
- Rate of spread
- Time from idea to full implementation
- Commitment rate (rate at which 50% of organizations take action for any specific request)
- Number of questions asked per day

Project Valuation

This is a collaborative project that has been valued at $4,693,316. In determining the value of this project, we considered the extent to which increased access to specialty care will address the community's needs, the population which the project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, we considered the value to the community of a project such as this, which will be specifically targeted to psychiatric telemedicine specialty service needs of the community. CMHS does not have a psychiatrist or mental health counselor on staff at the hospital who is available to see patients in the emergency room. The lack of mental health services can be costly on multiple levels including patient transfers to other facilities, incorrect diagnosis, and decreased quality of life. Patients served by this project will be the Medicaid, Uninsured, and Indigent population (Coryell County = 22,000) who utilize the emergency room due to behavioral health disorders. In FY 2011, CMHS treated more than 8,500 patients in the ER (39% were Medicaid, Indigent and Uninsured) and a significant percentage had a primary or secondary diagnosis for mental health issues in our emergency department and inpatient. Some of these patients opt out of mental health screening and treatment due to the lack of local providers and timely appointments.

The project seeks to provide better access to appropriate psychiatric care in a timelier manner, thereby improving access for patients seeking services in DY4 and DY5. Providence Medical Center in Waco, Texas, will be responsible for the behavioral health providers to support the project. In DY3 we will establish the baseline for number of telehealth services provided that will be used as the basis for our DY4 and DY5 goals. Our goal for DY4 is to increase usage of telehealth for psychiatric treatment by 30% over the baseline rate established in DY3. In DY5 we expect to increase usage of telehealth for psychiatric treatment by 60% over the baseline rate established in DY3. CMHS anticipates increased patient satisfaction both for the patient being treated and/or transferred due to timely behavioral health consultations and for the other patients waiting in the emergency room. Cost savings will be achieved due to the decreased need for patients to be transferred to other facilities and timely diagnosis of the patient's illness.

It is important to note several issues concerning behavioral health disorders. First, patients with mental health issues frequently access emergency rooms in community hospitals for treatment.[2] Behavioral health disorders also frequently co-occur with other medical conditions such as diabetes, cancer and heart disease. It has been determined that one-fifth of patients who are hospitalized due to a heart attack suffer from major depression. [3] Improving access to mental health specialists would

[2] Cunningham, Peter; McKenzie, Kelly and Taylor, Erin Fries. "The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illness," Health Affairs 25:3 (May/ June 2006), 697.

[3] Institute of Medicine. Improving the Quality of Health Care for Mental and Substance Abuse Disorder in U.S. Community Hospitals, 2004 at http://dev.ahrq.gov/data/hcup/factbk10.

not only impact patients in the emergency room but would benefit patients who are hospitalized with other conditions. A telemedicine program that will deliver psychiatric care to rural areas would also benefit local employers by lowering absenteeism within the workplace and improve employee productivity due to mental illness. Due to the shortage of mental health providers in Coryell County, it is difficult to schedule timely appointments for evaluation and follow-up. Two hundred seventeen million days of work are lost annually due to the decline in productivity related to mental illness and substance abuse. This equates to $17 billion each year in the United States. [4]

[4] National Business Group on Health, "An Employer's Guide to Behavioral Health Sevices," p.3.

134772611.1.3	1.7.1	1.7.1A 1.7.1B	INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-1.20*	*134772611.3.9*	*Other outcome improvement target:* *Follow-up after emergency department visit 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-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents Goal: Implement the telehealth program for psychiatric care Data source: Program materials Metric 2 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation Goal: Implement the telehealth program for psychiatric care Data source: log of tele-services by type of health care professionals and type of service Milestone 1 Estimated Incentive	**Milestone 2** [P-6]: Implement or expand medical education and specialized training programs via telehealth program. Metric 1 [P-6.1]: Submission and number of distinct curriculums delivered Goal: Implement training and education programs for healthcare community Data Source: Program materials Milestone 1 Estimated Incentive Payment*:* $ 629,350.50 **Milestone 3** [P-11]: 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		**Milestone 4** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program. Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services. Denominator: Number of residents in HPSA Goal: Increase usage of telehealth for psychiatric treatment by 30% over baseline rate established in DY3 Data source: EHR	**Milestone 6** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program. Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services. Denominator: Number of residents in HPSA Goal: Increase usage of telehealth for psychiatric treatment by 60% over baseline rate established in DY3 Data source: EHR

134772611.1.3	1.7.1	1.7.1A 1.7.1B	INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-1.20*	*134772611.3.9*	*Other outcome improvement target:* *Follow-up after emergency department visit 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)**
Payment: $ 1,093,824	(simple initiatives that all providers can do to "raise the floor' for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Agree to and implement improvements Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 3 Estimated Incentive Payment: $629,350.50		Milestone 3 Estimated Incentive Payment: $639,036 **Milestone 5** [P-11]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor' for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Agree to and implement improvements Data Source: Documentation	Milestone 6 Estimated Incentive Payment: $531,359.50 **Milestone 7** [P-11]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor' for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Agree to and implement improvements Data Source: Documentation

134772611.1.3	1.7.1	1.7.1A 1.7.1B	INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-1.20*	*134772611.3.9*	*Other outcome improvement target:* *Follow-up after emergency department visit 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)**
			of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 5 Estimated Incentive Payment: $639,036	of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 7 Estimated Incentive Payment: $531,359.50
Year 2 Estimated Milestone Bundle Amount: $1,093,824	Year 3 Estimated Milestone Bundle Amount: $1,258,701		Year 4 Estimated Milestone Bundle Amount: $1,278,072	Year 5 Estimated Milestone Bundle Amount: $1,062,719
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,693,316				

Summary Information:

Pass 3B Project – 137075109.1.4

- Provider: Goodall-Witcher Hospital Authority is a 33-bed sole community hospital in Clifton, Texas serving a 989 square miles and a county population of 18,000. Goodall-Witcher Hospital Authority also owns and operates a rural health clinic, nursing facility, home health agency and a wellness center.

- Intervention(s): This project is to recruit and retain primary care providers to improve access to care for our patients and residents.

- Need for the project: We currently have 5 primary care physicians with a 1,956:1 physician to resident ratio.

- Medicaid and Uninsured Target population: The target population is our county and market area. Goodall-Witcher Hospital Authority currently serves a population that consists of 7,100 covered by Medicaid or Uninsured.

- Category 1 or 2 expected patient benefits: This project seeks to add 3 additional primary care providers by DY5, thus increasing access to appropriate care in a more cost effective setting with an emphasis on patient time sensitivity. By DY5 we expect to increase the primary care clinic volume by 25%.

- Category 3 outcomes: IT 6.1 Our goal is to have a percentage improvement of patient satisfaction in receiving timely care, appointments, and information. The specific percentage improvement will be determined in DY4 over the baseline that will be established in DY3.

Pass 3B

Category 1: Infrastructure Development

Identifying Project and Provider Information:

1.1 Expand Primary Care Capacity
(137075109) 1.1.2 Expand Existing Primary Care Capacity
Old: 137075109.1.1
New: 137075109.1.4

Goodall-Witcher Hospital Authority

Required core project components:
a) Expand primary care clinic space
b) Expand primary care clinic hours
c) Expand primary care clinic staffing

Project Description:
Goodall-Witcher Hospital Authority is proposing this project to expand the capacity of primary care to better accommodate the needs of the 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. This project will focus only on core project component (c) Expand primary care clinic staffing. We are not including core project component (a) Expand primary care clinic space because a new clinic was built and opened in 2009 at our facility that offers adequate space for an expansion of providers. We are also not including core project component (b) Expand primary care clinic hours because we are currently open to see patients six days per week and feel this is adequate for our patient population at this time.

This project is directly associated with our regional needs assessment CNA-005: Shortage of Primary Care Providers in our Region. According to our community needs assessment, we have a direct need for these providers. We currently face issues of limited access due to a patient/physician ratio of 1956:1. Our clinic has over 36,000 active patient charts that access primary care through our clinic. Being the only healthcare facility in the county, we service a population of over 18,000 residents, with 40% having Medicaid or uninsured and 21% of our residents 65 years or older.

Goals: Our project goal is to recruit a general surgeon and two primary care providers with at least one of them practicing obstetrics. The additional providers will allow us to expand the current clinic volume.

Challenges: Recruitment of healthcare providers can be challenging to rural areas. Smaller size and modest assets face tough competition compared to the urban opportunities. Medicaid, Medicare and uninsured percentages tend to be higher since rural populations are typically older and have lower incomes than urban populations. Economic factors, cultural and social differences, and educational shortcomings can all be impediments to the desire for providers to choose to administer healthcare in a rural setting. In Bosque County, low income households, an increased elderly population, and 40% being Medicaid or uninsured but having multiple chronic issues keep doctors from relocating here. With our current shortage of providers causing longer wait times in the clinic, many of these patients do not seek preventative care but wait until their conditions worsen to go to the ER. Recruiting physicians to rural areas such as Clifton are time consuming and often unsuccessful because of the limited amenities a smaller town can offer compared to an urban area for their families. Also, rural areas have very few options of employment for the physician's spouse. With more than 15% of Texas' population living in rural areas, it is imperative to recruit providers that can provide quality healthcare to these residents.

Expected 5-year Outcome: Providing local and immediate access to an increased number of qualified healthcare providers in a primary care setting should reduce costs and improve coordinated care and appropriate follow-up care. By adding additional providers, improvements will include available appointment times, increased patient awareness of available services and overall primary care capacity. This will allow our patients to receive better health outcomes, have improved patient satisfaction, maintain appropriate utilization and experience reduced costs of services. By DY5 we expect to have increased our provider group by 3 and increase the primary care clinic volume by 25%.

Starting Point/Baseline:

The baseline number of providers is the current provider group that contains 8 providers. In our last Fiscal Year (July 1, 2011-June 30, 2012) the clinic volume was 27,000. This project will begin in DY2 and will provide for an orderly growth of primary care providers to join the existing group of eight primary care providers. Our hospital and clinic are the only rural obstetrical practice for one hundred miles in a north-to-south radius as well as a one hundred mile radius from east-to-west. Recruiting and retaining additional providers will lead to improved access and delivery of healthcare.

Rationale:

Additional staff members and providers are necessary to increase capacity to deliver care. Rural communities rely on their local healthcare providers for both emergent and non-emergent care. The American Hospital Association states that rural Americans are more likely to be uninsured and to have lower incomes, and they are, on average, older and less healthy than Americans living in

metropolitan areas. (http://www.aha.org/research/reports/tw/11apr-tw-rural.pdf. 1 October 2012). Therefore it is critical to provide a continuum of care to this population in order to prevent high costs of health issues not detected or prevented at an earlier stage. Expanding primary care capacity by recruiting and retaining primary care providers leads to a healthier population with decreased associated health costs.

The milestones of our project are:

- [P-5]: Hiring additional primary care providers and staff with the metric [P-5.1] Documentation of increased number of providers and staff
- [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services, with the metric of [I-12.1]: Documentation of increased number of visits.

This project is also directly associated with our regional needs assessment CNA-005: Shortage of Primary Care Providers in our Region. According to County Health Rankings and Roadmaps, the ratio of Bosque county primary physicians to residents is 1,956:1, compared to the national benchmark of 631:1. This project will increase our capacity and better meet the health needs of our community.

Related Category 3 Outcome Measure(s):
We have chosen patient satisfactions as our category 3 outcome measure. It is measured as follows:

IT-6.1-Percent improvement over baseline of patient satisfaction scores for the following patient satisfaction domains that the provider has targeted:
Patients:

(1) Are getting timely care, appointments, and information

Improving a patient satisfaction tool will give us appropriate feedback on both the positive and negative aspects experienced by our patients. The goal of increasing our primary care capacity is to improve the patient experience, thereby allowing the patient to fully engage and focus on their health outcomes. Early prevention and detection will greatly decrease both costs and anxiety. Lower income populations don't always feel they have a system advocate but the survey will provide a tool for their experiences to be counted. The satisfaction survey will be a direct measurement tool of our strengths and weaknesses. Our goal will be a satisfaction score of TBA with a direct intervention and follow-up for negative ratings.

Relationship to other Projects:
Increasing our primary care providers will increase the number of referrals that are generated from our clinic for specialty care. The need for our project to Expand Specialty Care Capacity (137075109.1.3) will be greater with an increase in primary care providers in our county.

Relationship to Other Performing Providers' Projects in the RHP:
The recruitment and retention of providers is the number one need of RHP16 as well as the Goodall-Witcher Healthcare Community Needs Assessment. Therefore, this project reflects a strong relationship to both needs of the area as well as the local community. With a greater access to healthcare, patients will be better identified and served through other project initiatives including the collaborative mental health telemedicine project (137075109.1.2).

Plan for Learning Collaborative:
N/A

Project Valuation: Goodall-Witcher Hospital Authority will provide the local funding for the project. The valuation will consist of successfully recruiting and retaining the medical staff. Our telephone survey will be completed by an independent company specializing in quality care improvement surveys. It is intended to provide both positive and negative comments from all patients that access care through Clifton Medical Clinic. The goal will allow direct patient feedback regarding ease of obtaining an appointment, courtesy of registration staff, respect for patients' privacy, knowledge, skills, and courtesy of nursing, laboratory, radiology and provider staff. We will conduct fifty surveys per month per provider to assess the satisfaction of our patients. The patients we serve are from our rural community and are typically from an economically and socially underprivileged population. By utilizing a quality improvement tool, areas of preventative care can be discussed at time of survey with patients. Our community assessment supports methods to engage our citizens in regards to their healthcare needs.

The baseline number of providers is the current provider group that contains 8 providers. In our last Fiscal Year (July 1, 2011-June 30, 2012) the clinic volume was 27,000. By DY5 we expect to have increased our provider group by 3 and increase the primary care clinic volume by 25%.

New: 137075109.1.4 Old: 137075109.1.1	1.1.2	1.1.2 C	Expand Primary Care Capacity	
Goodall-Witcher Hospital Authority				137075109
OD-6	*IT-6.1*	New: 137075109.3.4 Old: 137075109.3.1	**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-5. Hire Additional primary care providers and staff P-5.1. Metric: Documentation of increased number of providers and staff Baseline/Goal: Goodall-Witcher Hospital Authority contracts with Clifton Physicians Group. The group consists of 8 medical providers with a need for a general surgeon, primary care or a primary care with obstetrics. Data Source: Addition of new provider Milestone 1 Estimated	**Milestone 2** P-5. Hire Additional primary care providers and staff P-5.1. Metric: Documentation of increased number of providers and staff Baseline/Goal: Goodall-Witcher Hospital Authority contracts with Clifton Physicians Group. The group consists of 8 medical providers with a need for a general surgeon, primary care or a primary care with obstetric. Data Source: Addition of new provider Milestone 2 Estimated		**Milestone 3** P-5. Hire Additional primary care providers and staff P-5.1. Metric: Documentation of increased number of providers and staff Baseline/Goal: Goodall-Witcher Hospital Authority contracts with Clifton Physicians Group. The group consists of 8 medical providers with a need for a general surgeon, primary care or a primary care with obstetric. Data Source: Addition of new provider Milestone 3 Estimated	**Milestone 5** P-5. Hire Additional primary care providers and staff P-5.1. Metric: Documentation of increased number of providers and staff Baseline/Goal: Goodall-Witcher Hospital Authority contracts with Clifton Physicians Group. The group consists of 8 medical providers with a need for a general surgeon, primary care or a primary care with obstetric. Data Source: Addition of new provider Milestone 5 Estimated

New: 137075109.1.4 Old: 137075109.1.1	1.1.2	1.1.2 C	Expand Primary Care Capacity	
Goodall-Witcher Hospital Authority				137075109
OD-6	*IT-6.1*	New: 137075109.3.4 Old: 137075109.3.1	**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)**
Incentive Payment *(maximum amount):* 554,203	Incentive Payment: $642,392		Incentive Payment: $324,516 **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. Goal: Increase clinic volume by 3% over baseline a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This	Incentive Payment: $278,038 **Milestone 6** 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. Goal: Increase clinic volume by 5% over baseline a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This

New: 137075109.1.4 Old: 137075109.1.1	1.1.2	1.1.2 C	Expand Primary Care Capacity	
Goodall-Witcher Hospital Authority				137075109
OD-6	*IT-6.1*	New: 137075109.3.4 Old: 137075109.3.1	**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)**
			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 4 Estimated Incentive Payment: $324,516	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 6 Estimated Incentive Payment: $278,038
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $554,203	Year 3 Estimated Milestone Bundle Amount: 642,392		Year 4 Estimated Milestone Bundle Amount: $649,032	Year 5 Estimated Milestone Bundle Amount: $556,076

New: 137075109.1.4 Old: 137075109.1.1	1.1.2	1.1.2 C	Expand Primary Care Capacity
Goodall-Witcher Hospital Authority			137075109
OD-6	*IT-6.1*	New: 137075109.3.4 Old: 137075109.3.1	**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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,401,703			

Summary Information:

Pass 3B Project: 137075109.1.5

- Provider: Goodall-Witcher Hospital Authority is a 33-bed sole community hospital in Clifton, Texas serving a 989 square miles and a county population of 18,000. Goodall-Witcher Hospital Authority also owns and operates a rural health clinic, nursing facility, home health agency and a wellness center.

- Intervention(s): This project will be a part of the regional project submitted by Providence Healthcare Network for Region 16 to establish a telemedicine program in order to provide specialty psychiatric care for Emergency Department patients.

- Need for the project: Our rural community has limited to no access to behavior health services. Patients currently have to travel over 35 miles to receive specialty care. Many needing these services access our ER causing delay in services in a more costly setting. This will also assist local law enforcement with many of the issues arising from individuals in custody that suffer from behavioral health needs.

- Medicaid and Uninsured Target population: The target population is our county and market area. Goodall-Witcher Hospital Authority currently serves a population that consists of 7,100 covered by Medicaid or Uninsured.

- Category 1 or 2 expected patient benefits: As cited in the Community Needs Assessment, a study by the National Alliance on Mental Illness (NAMI) found that one in four adults and one in ten children are impacted by Mental Illness. The estimated number for our population of 18,423 is 1,842 children and 4,605 adults. From 7/1/11-6/30/12 Goodall-Witcher Hospital's Emergency Department treated 305 patients with a primary diagnosis code for mental health issues in our emergency department. The goal of this project is to ensure that patients with behavioral health concerns are able to access timely, quality services through the use of telehealth and specialist providers. We will be working collaboratively with other regional providers. We will establish baseline number of telehealth services provided in DY3 to be used as the basis for our DY4 and DY5 goals. Our goal is to increase access and utilization by 25% in DY4 over the established baseline rate and 50% in DY5 over the baseline rate established in DY3.

- Category 3 outcomes: IT 6.1 Our goal is to have a percentage improvement of Emergency Room patient satisfaction in receiving timely care, appointments, and information. The specific percentage improvement will be determined in DY4 over the baseline of DY3.

Pass 3B
Category 1: Infrastructure Development

1.7 *Introduce, Expand, or Enhance Telemedicine/Telehealth*
(137075109) *1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region*
Old: 137075109.1.2
New: 137075109.1.5

Goodall-Witcher Hospital Authority

Required core project components:
a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications
b) 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.

Project Description
Goodall-Witcher Hospital Authority will be a participant in Providence Healthcare Network's regional DSRIP plan to introduce a telemedicine program for RHP 16. We will integrate the telemedicine program into our emergency department to provide specialty psychiatric care for behavioral health patients in Bosque County. In addition to the benefit of more timely and appropriate treatment for the patient, use of telemedicine for behavioral health patients will provide needed support to emergency physicians in our facility, ensure appropriate throughput of these patients, reduce the burden on the local physicians and reduce law enforcement and other costs related to sometimes unnecessary transfers or forensic detail for psychiatric patients. It is anticipated that the primary population benefiting from this project will be Medicaid eligible or indigent patients. As cited in the Community Needs Assessment, a study by the National Alliance on Mental Illness (NAMI) found that one in four adults and one in ten children are

impacted by Mental Illness. The estimated number for our population of 18,423 is 1,842 children and 4,605 adults. Only 21% of the Texas state population is being served by a State mental health agency leaving the other 79% of our population (estimated at 14,554 for our county) without a reliable source of consistent mental health care. The project specifically addresses the Community Needs Assessment identification number CNA-006 – Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers.

Goals: The goal of this project is to ensure that patients with behavioral health concerns are able to access timely, quality services through the use of telehealth and specialist providers. Our county does not offer psychiatric services and the closest services are 35 miles away. When patients come to the emergency department for psychiatric care, they are subject to long waits to be referred to the appropriate facility for care. Implementation of the telemedicine program will allow these patients to be seen by a psychiatrist in a timely manner and allow the patient to be referred for appropriate treatment.

Challenges: Some major challenges to this project include lack of regional behavioral health service availability and backlog in wait times for behavioral health consultations or appointments. Goodall-Witcher Hospital Authority will work with Providence Memorial Hospital to ensure that this issue is dealt with through a comprehensive, global solution that requires coordination and cooperation of the parties. Additional challenges include educating providers and nurses on utilization and operation of the technology correctly. The implementation will be completed in stages in order to address all questions and concerns during the initial implementation.

Expected 5-Year Outcome: By DY5 we expect to have a fully integrated telemedicine program to provide consistent psychiatric care for our patient population In DY2 we will work with Providence Healthcare Network to establish the telemedicine program in the Goodall-Witcher Hospital's Emergency Department. In DY3 we will provide the telehealth services in the ED and expect to serve 15% of the behavioral health patients that present in that setting. We will also establish the baseline for number of telehealth services provided that will be used as the basis for our DY4 and DY5 goals. Our goal for DY4 is to increase usage of telehealth for psychiatric treatment by 25% over the baseline rate established in DY3 and 50% increase in DY5 over the established baseline in DY3.

Starting Point/Baseline

A telemedicine program does not formally exist at this time. Baseline data will be established in DY3. From 7/1/11-6/30/12 Goodall-Witcher Hospital's Emergency Department treated 305 patients with a primary diagnosis code for mental health issues in our emergency department. Collaboration of program data will play an integral role in establishing a baseline rate for the patient population that the project is intended to serve. Formal baseline data will be established in DY3 after the program has been implemented.

Rationale

There is a severe shortage of specialty care providers in Region 16, specifically for behavioral health consultations and services. Most of the resources for behavioral health are located in the more densely populated area of the region. In order to alleviate the burden of having to travel long distances for psychiatric care on the behavioral health patients in our county, establishing a telemedicine approach to their care will allow for greater expansion of behavioral health services throughout the region. This information is supported in our Community Needs Assessment and particularly addressed by CNA-006. The telemedicine program will be based in the emergency department and provide patient consultations by behavioral health specialists using telecommunications.

In DY2 we will work with Providence Healthcare Network to implement the telemedicine program specifically for behavioral health services in the emergency department. In DY3 we intend to have the program fully implemented and measure the quantity of services provided. DY4 and DY5 will be devoted to improving the access to behavioral health services for the targeted population. The program will also include a component of quality improvement so that we are able to identify the project impacts, identify "lessons learned," identify opportunities to scale the project to a broader patient population, and identify key challenges associated with expansion of the project.

Related Category 3 Outcome Measure(s)

OD-1 Primary Care and Chronic Disease Management
IT-1.20 Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental Illness

e. Numerator:
    - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
    - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
f. Denominator: Members 6 years and older as of the date of ED visit who were seen in the emergency department setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The

denominator of this measure is based on ED visits, not members. Include all ED visits for members who have more than one ED visit on or between January 1 and December 1 of the measurement year.

g. Data Source: EHR, Claims
h. Rationale/Evidence: This measure assesses the percentage of ED visits for members 6 years of age and older who were seen for treatment of mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
   Rate 1: The percentage of members who received follow-up within 30 days of ED visit
   Rate 2: The percentage of members who received follow-up within 7 days of discharge

Region 16 is a Mental Health Professional Shortage Area. Lack of access to mental health professionals in rural communities creates significant problems in terms of emergency department visits, untreated mental health conditions, and complications in treating medical conditions which are worsened by the presence of mental health issues. The implementation of the telemedicine project will greatly enhance the ability of our population with behavioral health needs to access the care that is required to care for their illness. The real-time interaction with a behavioral health specialist could enable the health care team to address the patient problem before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectation of our healthcare system. Receiving a real-time interaction with a behavioral health specialist will also allow patients to be referred and understand the need for additional care, reducing the risk of the patient not receiving appropriate follow-up care following their ED visit.

Relationship to other Projects

The projects developed by Goodall-Witcher Hospital Authority, including the Expansion of Primary Care, provide for the overall access to timely and appropriate care to our service area and community.

Relationship to Other Performing Providers' Projects in the RHP

This project is a companion project to the Providence Memorial Hospital project to Expand Specialty Care Capacity – Psychiatric Telemedicine. Their implementation of additional specialty care services will allow our facility to utilize their telemedicine department to have access to their psychiatric services.

Plan of Learning Collaborative

Since this project is being posed as a companion project with Providence Memorial Hospital, there is a significant opportunity to promote mutual learning within our region. A forum for collaboration will be determined by all parties involved from Region 16.

Project Valuation

In determining the value of this project, we considered the extent to which increased access to specialty care will address the community's needs, the population which the project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, we considered the value to the community of a project such as this, which will be specifically targeted to psychiatric telemedicine specialty services needs of the community.

As cited in the Community Needs Assessment, a study by the National Alliance on Mental Illness (NAMI) found that one in four adults and one in ten children are impacted by Mental Illness. The estimated number for our population of 18,423 is 1,842 children and 4,605 adults. From 7/1/11-6/30/12 Goodall-Witcher Hospital's Emergency Department treated 305 patients with a primary diagnosis code for mental health issues in our emergency department. The goal of this project is to ensure that patients with behavioral health concerns are able to access timely, quality services through the use of telehealth and specialist providers. We will be working collaboratively with other regional providers. We will establish baseline number of telehealth services provided in DY3 to be used as the basis for our DY4 and DY5 goals. Our goal is to increase access and utilization by 25% in DY4 over the established baseline rate and 50% in DY5 over the baseline rate established in DY3.

New: 137075109.1.5 Old: 137075109.1.2	*1.7.1*	*1.7.1A* *1.7.1B*	*INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH*	
Goodall-Witcher Hospital Authority				137075109
Related Category 3 Outcome Measure(s):	*IT-1.20*	New: 137075109.3.5 Old: 137075109.3.2	*Other Outcome Improvement Target:* *Follow-up after emergency department visit 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-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents Baseline: From 7/1/11-6/30/12 we treated 305 patients in the ED with a primary diagnosis code for mental health issues Goal: Implement the telehealth program for psychiatric care Data source: Program materials Milestone 1 Estimated Incentive Payment *(maximum amount): $204,179*	**Milestone 2** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need Metric 2 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation Baseline: Establish the baseline rate of services provided for DY4 and DY5 improvement milestones ne since no program currently exists Goal: Implement the telehealth program for psychiatric care Data source: log of tele-services by type of health care professionals and type of service Milestone 2 Estimated Incentive Payment:236,671		**Milestone 3** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program. Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services. Denominator: Number of residents in HPSA Goal: Increase usage of telehealth for psychiatric treatment by 25% over baseline rate established in DY3	**Milestone 4**[I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program. Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services. Denominator: Number of residents in HPSA Goal: Increase usage of telehealth for psychiatric treatment by 50% over baseline rate established in DY3

New: 137075109.1.5 **Old: 137075109.1.2**	***1.7.1***	***1.7.1A*** ***1.7.1B***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
Goodall-Witcher Hospital Authority				137075109
Related Category 3 Outcome Measure(s):	*IT-1.20*	New: 137075109.3.5 Old: 137075109.3.2	*Other Outcome Improvement Target:* *Follow-up after emergency department visit 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)**
			Data source: EHR Milestone3 Estimated Incentive Payment: $239,117	Data source: EHR Milestone 4 Estimated Incentive Payment: $204,870
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $204,179	Year 3 Estimated Milestone Bundle Amount: $236,671		Year 4 Estimated Milestone Bundle Amount: $239,117	Year 5 Estimated Milestone Bundle Amount: $204,870
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $884,837				

Summary Information:

Pass 2 Project

- Provider: Goodall-Witcher Hospital Authority is a 33-bed sole community hospital in Clifton, Texas serving a 989 square miles and a county population of 18,000. Goodall-Witcher Hospital Authority also owns and operates a rural health clinic, nursing facility, home health agency and a wellness center.

- Intervention(s): Goodall-Witcher Hospital Authority's goal is to expand specialty care capacity and access by providing space and additional resources for physicians and midlevel practitioners to meet the needs of our market that may not have access to specialty care.

- Need for the project: Our rural community has limited and inadequate access to specialty care which contributes to the limited scope and size of safety net health systems. Patients currently travel over 35 miles to receive specialty care and many of our targeted population do not have the resources or affordability to travel.

- Medicaid and Uninsured Target population: The target population is our county and market area. Goodall-Witcher Hospital Authority currently serves a population that consists of 7,100 covered by Medicaid or Uninsured.

- Category 1 or 2 expected patient benefits: The goal of this project is to increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties of our target population. The gap analysis from DY2 will determine those specialties that are most needed in our target population. By DY5 we expect to increase our specialty care clinic volume by 25% over our baseline. Improving access to specialty care will enable our patients to receive specialty services in a cost effective setting to both the patient and the health delivery system.

- Category 3 outcomes: IT 6.1 Our goal is to have a percentage improvement of clinic patient satisfaction in receiving timely care, appointments, and information. The specific percentage improvement will be determined in DY4 after the establishment of our baseline in DY3.

Pass 2

Category 1: Infrastructure Development

Identifying Project and Provider Information:

1.9 Expand Specialty Care Capacity
(137075109) 1.9.2 Improve Specialty Care Capacity
137075109.1.3

Goodall-Witcher Hospital Authority

Required core project components:
a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system.
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.

Project Description:
Our project is to expand specialty care capacity and access by providing space and additional resources for physicians and midlevel practitioners to meet the needs of our market that may not have access to specialty care. According to our community needs assessment, we have a need for specialty providers. We will first conduct a gap analysis to identify which specialties are needed to meet the needs of our population. We will utilize the results to provide the required amount of time and specialties to meet our goals for expanding specialty care in our community. We will also implement transparent, standardized referrals across the system and) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. We achieve our goal by expanding or increasing the amount of time a specialty is offered and/or by offering new specialties in our community and continuously improve the delivery and access of specialty care. Our clinic has over 36,000 active patient charts that access primary care through our clinic. Being the only healthcare facility in the county, we service a population of over 18,000 residents, with 40%

having Medicaid or uninsured and 21% of our residents 65 years or older. Providing local access to qualified healthcare providers in various specialties should reduce costs, improve coordinated care, and appropriate follow-up care. Additionally, it will provide specialty care services to a population that may not have the means to travel to larger cities for this care. This in turn will improve the health of our population and reduce the cost of care by staying closer to home.

Goals:

- Conduct a gap analysis to determine the specialty care needs of our community.
- Expand the number of specialty providers and/or clinic hours for the specialties with the highest demand.

Relationship to Regional Goals: Region 16 goals are to transform health care in the total population by focusing on "right care, right place, and right time." Our projects are to expand services that are currently not offered in our community or not offered at an adequate amount of time to meet the needs of our community or the region. By expanding primary care providers and expanding access to high demand specialties we are able to treat and provide preventative care in the clinic setting instead of the higher cost ER setting.

Challenges: The lack of specialist available, distance required to travel to the rural areas, and the lack of desire for the specialists to be out of their established clinics.

5 year expected outcome: Improved coordination of specialty care with primary care. This should improve patient satisfaction as well as reduce the number of individuals seeking care in more expensive settings or at higher cost. We also anticipate timelier access to specialty care for those that do not have the means to travel to other markets. We will conduct a Gap analysis in DY2 to determine the type of specialties to add to our specialty clinic and the number of hours the current specialties and new specialties should be offered each month. We will also establish the baseline for the specialty care clinic volume in DY2. In DY3 and DY4 we will expand the hours and number of specialties offered in our specialty care clinic. By DY5 we expect to increase our specialty care clinic volume by 25% over our baseline.

Starting Point/Baseline:

Goodall-Witcher Hospital Authority currently offers a very limited number of specialty services. Most patients are referred to physicians 35 miles away or even further in many cases. Currently, our county is served by an orthopedist approximately 2 hours a week, a cardiologist for approximately 2 hours a week, a clinical psychologist 3 hours a month and 1 optometrist 4 a week. From 11/1/2011 through 10/31/2012 we had 380 visits by our specialists in our clinic but made over 1,300 referrals to various specialists outside our clinic. This is not a sufficient to care for the rising age of our population and due to the limited number of specialties and hours many patients have to travel, this creates costly hardships. .

Rationale:
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. Rural communities rely on their local healthcare systems for many of their primary and specialty care needs. The American Hospital Association states that rural Americans are more likely to be uninsured and to have lower incomes, and they are, on average, older and less healthy than Americans living in metropolitan areas. (http://www.aha.org/research/reports/tw/11apr-tw-rural.pdf. 1 October 2012). Therefore it is critical to provide a continuum of care to this population in order to prevent high costs of health issues not treated with the appropriate care, at the appropriate time, in the appropriate setting. Many of the Medicaid and uninsured population do not have access to specialty care causing them to not get the appropriate care in a timely manner. They will then seek care in the ER after their conditions has worsen causing a possible hospitalization that could have be potentially prevented had the patient had access to specialty care at an earlier date. CNA- 004 Potentially Preventable Hospitalization specifically names Diabetes but many other health issues can be potentially prevented if the patient at access to specialist. Goodall-Witcher had 203 patients hospitalization related to cardiac related issues from July 1, 2011-June 30, 2012 and 16% of those were covered by Medicaid or uninsured. Expanding specialty care capacity by recruiting, contracting and/or partnering with specialty care providers leads to a healthier population with decreased associated health costs.

Process Milestones:

P-1. Milestone: Conduct specialty care gap assessment based on community need

P-1.1. Metric: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

a. Data Source: Needs Assessment

b. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access.

P-12. Milestone: 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

P-12.1. Metric: Documentation of specialty care access plan

a. Data Source: Documentation of Provider plan

b. Rationale/Evidence: TBD by Performing Provider.

Improvement Milestones:

I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).

a. Total number of visits for reporting period

b. Data Source: Registry, EHR, claims or other Performing Provider source

c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.

Unique community need identification numbers the project addresses:

- CNA-004 – Potentially Preventable Hospitalizations
- CNA-011 – Population growth.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will allow improved access to the specialty care needs to a growing population of underinsured and Medicaid by serving them locally and ultimately, increase our capacity and to better meet the health needs of our community. This population also faces transportation issues and the loss of income from missing work for travel to a larger city for specialty care. Currently most will travel greater than 35 miles for this care and have to take off from work to attend their appointments. These barriers increase the likelihood of appointments and follow-up being missed and thus the appropriate care not received. Removing these barriers will allow better follow-up care in the clinic and reduce the potentially preventable hospitalization associated with not getting the appropriate care at the appropriate time.

Related Category 3 Outcome Measure(s):
We have chosen OD-6 Patient Satisfaction as our category 3 outcome measure. It is measured as follows:

IT-6.1-Percent improvement over baseline of patient satisfaction scores for the following patient satisfaction domains that the provider has targeted:
Patients:

(3) patient's rating of doctor access to specialist

Improving a patient satisfaction tool will give us appropriate feedback on both the positive and negative aspects experienced by our patients. The goal of expanding access to specialty care is to improve the patient experience, thereby allowing the patient to fully engage and focus on their health outcomes. Timely treatment of medical issues by specialist will greatly decrease both costs and anxiety. Lower income populations don't always feel they have a system advocate but the survey will provide a tool for their experiences to be counted. The satisfaction survey will be a direct measurement tool of our strengths and weaknesses. Our satisfaction goal will be determined after the baseline period with a direct intervention and follow-up for negative ratings.

Relationship to other Projects:
Expanding Specialist in our community can assist local primary care providers in better continuum of care model. They can work closely to better coordinate care for the patients of our clinic.

Relationship to Other Performing Providers' Projects in the RHP:
None

Plan for Learning Collaborative:
N/A

Project Valuation: Goodall-Witcher Hospital Authority will provide the local funding for the project. The valuation will consist of successfully expanding access to specialty care for our target population including Medicaid recipients. Increasing the access to timely and appropriate specialty care will allow patients to receive care in a less costly setting. We utilize a telephone survey through an independent company specializing in quality care improvement surveys. It is intended to provide both positive and negative comments from all patients that access care through Clifton Medical Clinic. The goal will allow direct patient feedback. The patients we serve are from our rural community and are typically from an economically and socially underprivileged population. By utilizing a quality improvement tool, areas of preventative care can be discussed at time of survey with patients. Our community assessment supports methods to engage our citizens in regards to their healthcare needs.

137075109.1.3.	1.9.2	1.9.2 A 1.9.2 B	Expand Specialty Care Capacity
Goodall-Witcher Hospital Authority			137075109
OD-6	*IT-6.1*	137075109.3.3	**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. Conduct specialty care gap assessment on community need. P-1.1 Metric: Documentation of gap assessment. Demonstrate improvement over prior year (baseline for DY2) Baseline: Currently, our county is served by an orthopedist approximately 2 hours a week, a cardiologist for approximately 2 hours a week, a clinical psychologist 3 hours a month and 1 optometrist 4 a week, Establish baseline number for specialty care clinic volume Goal: Gap Assessment competed. Data Source: P-1.1.b: Need Assessment	**Milestone 2** P-11. Launch/expand a specialty care clinic (e.g., pain management clinic) P-11.1 Metric: Establish/expand specialty care clinic. Baseline: Currently, our county is served by an orthopedist approximately 2 hours a week, a cardiologist for approximately 2 hours a week, a clinical psychologist 3 hours a month and 1 optometrist 4 a week Goal: Establish number of hours and number of specialists needed as identified from Gap analysis Data Source: P-11.1.c: Documentation of new/expanded specialty care clinic	**Milestone 3** P-11. Launch/expand a specialty care clinic (e.g., pain management clinic) P-11.1 Metric: Establish/expand specialty care clinic. Baseline: Currently, our county is served by an orthopedist approximately 2 hours a week, a cardiologist for approximately 2 hours a week, a clinical psychologist 3 hours a month and 1 optometrist 4 a week Goal: Increase number of hours and add an additional specialty Data Source: P-11.1.c: Documentation of new/expanded specialty care clinic Milestone 3 Estimated Incentive	**Milestone 4:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source Goal: Increase specialty care clinic volume of visits by 25% over baseline established in DY2 Milestone 4 Estimated Incentive Payment: $251,783

137075109.1.3.	1.9.2	1.9.2 A 1.9.2 B	Expand Specialty Care Capacity	
Goodall-Witcher Hospital Authority				137075109
OD-6	*IT-6.1*	137075109.3.3	**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 *(maximum amount):* $252,245	Milestone 2 Estimated Incentive Payment: $293,524		Payment: $299,262	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $252,245	Year 3 Estimated Milestone Bundle Amount: $293,524		Year 4 Estimated Milestone Bundle Amount: $299,262	Year 5 Estimated Milestone Bundle Amount: $251,783
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,096,814				

Summary Information:

Pass 3B Project: 121792903.1.3

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): This project will expand our primary care capacity to provide improved access to primary care services. The project will add three additional providers and increase the clinic hours.
- Need for the project: Our Emergency Department is currently overloaded with caring for non-urgent medical needs. Currently 60% of the cases seen in the ED are non-emergent. Expanding access to primary care services will reduce this burden and cost associated with non-urgent care in the ED.
- Medicaid and Uninsured Target population: The target population is our patients that utilize the Emergency Department for non-urgent care needs. Approximately 47% of the patients treated in the Emergency Department are either Medicaid or uninsured, so we expect that they comprise roughly half of the targeted population that will be able to be better served in the primary care setting.
- Category 1 or 2 expected patient benefits: Our clinics had a total of 29,716 visits and over 8,700 unique patients in Fiscal Year 2012 (October 2011-September 2012). The project seeks to provide three additional primary care providers and increase clinic hours by 10%, thereby improving access for patients seeking services and increasing the primary care clinic volume of visits by 3% (891 visits) in DY4 and 5% (1485 visits) over baseline by DY5.
- Category 3 outcomes: IT-9.2 Our goal is to reduce Emergency Department visits, specifically a reduction of non-emergent visits, by TBD % below baseline by DY5.

Pass 3B
Category 1: Infrastructure Development

Hamilton General Hospital
TPI 121792903
Unique RHP Project Identification Number:
New: 121792903.1.3
Old: 121792903.1.1
Project Title 1.1 *Expand Primary Care Capacity*
Project Option 1.1.2 Expand 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*

Project Description

Hamilton County Hospital District will expand the capacity of primary care to better accommodate the needs of the patient population in our service area. This expansion will give patients enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Project Goals: Our intent is to expand primary care clinic hours (1.1.2b) and expand primary care clinic staffing (1.1.2c). (As noted below in the rationale, the required core project component (a) to expand primary care clinic space is not included in the project because a clinic expansion five years ago adequately expanded our clinic space to include additional providers.) The project specifically addresses the Community Needs Assessment identification number CNA-005 – Shortage of Primary Care Providers in the region.

Challenges: The challenges that are presented with this project include the cost and burden of recruiting providers to a rural primary care practice. It would be difficult for the clinic to expand hours and increase volume without additional primary care providers. We also anticipate challenges in re-directing our patient population to utilize our expanded hours and additional provider for their non-urgent healthcare needs instead of the Emergency Department. We will provide patient education materials and individualized teaching to patients identified as having high ED utilization.

Expected 5-year Outcome: By DY5 we will increase clinic hours by 10% and add three additional providers to our clinic. The goal of extended hours and expanding staffing is to increase our clinic visit volume by 3% (891 visits) by DY4 and by 5% (1485 visits) over our baseline by DY5.

Starting Point/Baseline

Hamilton Healthcare System operates two Rural Health Clinics in RHP 16. Clinic A is open 39 hours per week and Clinic B is open 37 hours per week. Our clinics are currently staffed with 11 providers. The current clinic hours and provider data is current as of August 2012. Our clinics had a total of 29,716 visits and over 8,700 unique patients in Fiscal Year 2012 (October 2011-September 2012). In the same time period, we had 5560 emergency department visits and 3340 of the visits were non-urgent, making our non-urgent utilization rate 60%. Expanding primary care clinic hours and staff will allow us to Reduce ED Utilization (Category 3 – IT-9.2).

Rationale

Access to quality primary and preventive care is the first step toward improving health which leads to reducing costs associated with potentially preventable events. The 2012 population of Hamilton County was 8,517 and the county is designated as Medically Underserved Population for Low Income. Our Medicaid enrollment as of November 2011 was over 1,600 and our Medicare enrollment is over 1,500. The County's population age 65 and over is 25.1%, over twice the State of Texas at 10.5%. As noted in the LA Times, the aged and disabled populations are more expensive to treat and therefore result in a heavier burden for public payers. Our emergency department had 3340 non-emergent visits from October 2011-September 2012. The emergency department also sees high utilization by the Medicaid and uninsured population. In our 2012 Fiscal Year, 47% of the patients treated in the emergency department were Medicaid and uninsured. They also accounted for 43% of the charges but only 22% of the collections in the same year. Our average charge for an emergency room visit is $1,464 compared to the average clinic charge of $180. If we redirected just 500 non-emergent visits per year from the ED to the clinic the savings would amount to $642,000. The savings is realized by the hospital, tax payers, government funded insurance and the patients that are unable to afford insurance. Expanding the clinic hours and number of providers will provide a better resource for the Medicaid and uninsured population to receive appropriate care in the appropriate setting, thereby reducing the need for them to utilize the emergency department for non-urgent medical issues and reducing the cost of care. We believe HPSA and claims data support the need to expand primary care in our community and it is further supported by the Community Needs Assessment (CNA-005).

Delays in care can also increase the acuity of acute care episodes than if a patient had been seen and treated earlier. Availability of access to primary care allows for a smoother transition of care from an acute setting. We will promote the use of primary care by educating the public on the appropriate setting for care and ensuring a positive patient experience. In the past 12 months the

healthcare system has seen over 900 new patients in our clinics for primary and preventive care visits. This demand is challenging and continues to stress the system. Expanding the clinic hours (P-4.1) will allow the community to utilize the clinic for their non-emergent needs instead of the emergency department. The need for additional providers (P-5.1) is also evident by the number of new patients that are cared for by our current providers each year. Both of these goals directly affect the improvement milestone identified as relevant for our population and increase primary care clinic volume of visits (I-12.1) to ensure people in our community get timely quality care in the most cost effective and appropriate setting.

The required core project component (a) to expand primary care clinic space is not included in the project because a clinic expansion five years ago adequately expanded our clinic space to include additional providers. Also, expansion of the clinic hours does not require any additional space to operate.

This project is the cornerstone to transforming healthcare in our communities. As you can see in the Related Categories below, without adequate access to primary care providers these other programs lose their effectiveness and cost containment is not possible.

Related Category 3 Outcome Measure(s)

OD-9 Right Care, Right Setting
IT-9.2 ED Appropriate utilization

- Reduce all ED visits

Reducing Emergency Department visits is the goal of this project because of the high utilization of our ED for non-emergent cases. 60% of our Emergency Department visits for FY 2012 were non-emergent visits. Reducing non-emergent ED visits is an achievable outcome measure since the project will expand primary care clinic hours, expand primary care clinic staffing and increase primary clinic volume of visits to ensure people in our community get timely quality care in the most cost effective and appropriate setting. The need for improving ED utilization is referenced in the Community Needs Assessment (CNA-007).

Relationship to other Projects

Expansion of Primary Care Capacity project will enable the success for other projects initiated in the RHP plan. For our facility, the Primary Care Expansion project (121792903.1.3) is a piece that will work with the other RHP projects of Chronic Care Management (121792903.2.7), Heart Failure Program (121792903.2.6) and Care Transitions (121792903.2.8). The success of these three Category

2 projects is dependent on correct utilization and access of healthcare resources in our system. Each of these projects together are vital in meeting the Transformation Waiver goals.

Project Valuation

The valuation for this project is $6,397,395 which is supported by the community need for access to quality primary care for the Medicaid and uninsured population, the aging population served, the cost factors and barriers to find providers for rural counties, and local IGT funding which will support this initiative.

Our clinics had a total of 29,716 visits and over 8,700 unique patients in Fiscal Year 2012 (October 2011-September 2012). The project seeks to provide three additional primary care providers and increase clinic hours by 10%, thereby improving access for patients seeking services and increasing the primary care clinic volume of visits by 3% (891 visits) in DY4 and 5% (1485 visits) over baseline by DY5.

The weight of the project is based on the weight given to each of the following criteria from the standardized tool used to weight each project:

1) Achieves waiver goals - The increase in clinic hours and providers will meet the waiver goals of assuring patients receive high-quality and patient-centered care in the most cost effective ways, improve the health care infrastructure to better serve the Medicaid and uninsured residents of our county, further develop and maintain a coordinated care delivery system, and improve outcomes while containing cost growth.
2) Addresses community need(s) – Increasing the number of providers for our community will directly address the Community Needs Assessment (CNA-005). Also expanding the hours for our clinics will give community members more options for utilizing the clinic for their non-emergent needs rather than the emergency department as addressed in the Community Needs Assessment (CNA-007).
3) Project scope – The scope of this project is large considering the percent of our population the project is intended on impacting. Increasing the clinic hours and providers allows a greater percentage of our population to utilize our Rural Health Clinics for their health care needs. It will also save the health care system and the county money from the decreased utilization of the emergency department for non-emergency cases.
4) Project investment – The project will require a large investment due to the expansion of providers to our health care system.

NEW: 121792903.1.3 ***OLD: 121792903.1.1***	***1.1.2***	***1.1.2B*** ***1.1.2C***	***EXPAND PRIMARY CARE CAPACITY***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-9.2*	*New: 121792903.3.13* *Old: 121792903.3.1*	*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-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: 11 providers Goal: Add one additional provider Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. Milestone 1 Estimated Incentive Payment: $1,476,223	**Milestone 2** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline: Clinic A: 39 hours, Clinic B: 37 hours Goal: Increase clinic hours over baseline by 5% Data Source: Clinic documentation Milestone 2 Estimated Incentive Payment: $1,711,135		**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: 11 providers Goal: Add one additional provider Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. Milestone 3 Estimated Incentive Payment: $576,273.67 **Milestone 4** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours	**Milestone 6** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Baseline: 11 providers Goal: Add one additional provider Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. Milestone 6 Estimated Incentive Payment: $740,608 **Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved

NEW: 121792903.1.3 ***OLD: 121792903.1.1***	***1.1.2***	***1.1.2B*** ***1.1.2C***	***EXPAND PRIMARY CARE CAPACITY***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-9.2*	*New: 121792903.3.13* *Old: 121792903.3.1*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline: Clinic A: 39 hours, Clinic B: 37 hours Goal: Increase clinic hours over baseline by 10%Data Source: Clinic documentation Milestone 4 Estimated Incentive Payment: $576,273.66 **Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 29716 clinic visits in FY 2011-2012 (10/1/11-9/30/12) Goal: Increase primary care clinic volume over baseline by 3% (891 visits)	access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase primary care clinic volume by 5% (1485 visits) over baseline Data Source: Registry, EHR, claims or other Performing Provider source Milestone 7 Estimated Incentive Payment: $740,608

NEW: 121792903.1.3 ***OLD: 121792903.1.1***	***1.1.2***	***1.1.2B*** ***1.1.2C***	***EXPAND PRIMARY CARE CAPACITY***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-9.2*	*New: 121792903.3.13* *Old: 121792903.3.1*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Data Source: Registry, EHR, claims or other Performing Provider source Milestone 5 Estimated Incentive Payment: $576,273.66	
Year 2 Estimated Milestone Bundle Amount: $1,476,223	Year 3 Estimated Milestone Bundle Amount: $1,711,135		Year 4 Estimated Milestone Bundle Amount: $1,728,821	Year 5 Estimated Milestone Bundle Amount: $1,481,216
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,397,395				

Summary Information:

Pass 3B Project: 121792903.1.4

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General
  Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): This project will be part of the regional project submitted by Providence Healthcare Network for Region 16 to introduce a Telemedicine/Telehealth program in order to provide specialty psychiatric care in the Emergency Department. The project will provide improved access to psychiatric care in a timelier manner.
- Need for the project: There is a severe shortage of specialty care providers in Region 16, specifically for behavioral health consultations and services. When patients come to the emergency department for psychiatric care, they are subject to long waits to be referred for appropriate treatment.
- Medicaid and Uninsured Target population: The target population is our patients that utilize the Emergency Department for psychiatric and behavioral health needs. In 2011 we treated 179 patients with a primary diagnosis code for mental health issues in our emergency department and inpatient and 49% were Medicaid or uninsured.
- Category 1 or 2 expected patient benefits: The project seeks to provide better access to appropriate psychiatric care in a timelier manner, thereby improving access for patients seeking services in DY4 and DY5. In DY3 we will establish the baseline for number of telehealth services provided that will be used as the basis for our DY4 and DY5 goals. Our goal for DY4 is to increase usage of telehealth for psychiatric treatment by 25% over the baseline rate established in DY3. In DY5 we expect to increase usage of telehealth for psychiatric treatment by 50% over the baseline rate established in DY3.
- Category 3 outcomes: IT-1.20 Our goal is to increase the percentage of patients who received follow-up within 7 and 30 days of their telemedicine consultation in the emergency department by TBD % over baseline.

Pass 3B
Category 1: Infrastructure Development

Hamilton General Hospital
TPI 121792903
Unique RHP Project Identification Number:
New: 121792903.1.4
Old: 121792903.1.2
Project Title 1.7 *Introduce, Expand, or Enhance Telemedicine/Telehealth*
Project Option 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region

Required core project components:
a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications
b) 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.

Project Description
Hamilton General Hospital will be a participant in Providence Healthcare Network's regional DSRIP plan to introduce a telemedicine program for RHP 16. We will integrate the telemedicine program into our Emergency Department to provide specialty psychiatric care for behavioral health patients in Hamilton County. In addition to the benefit of more timely and appropriate treatment for the patient, use of telemedicine for behavioral health patients will provide needed support to emergency physicians in our facility, ensure appropriate throughput of these patients, reduce the burden on the local physicians and reduce law enforcement and other costs related to sometimes unnecessary transfers or forensic detail for psychiatric patients. It is anticipated that the primary population benefiting from this project will be Medicaid eligible or indigent patients. As cited in the Community Needs Assessment, a study by the National Alliance on Mental Illness (NAMI) found that one in four adults and one in ten children are impacted by Mental Illness. The estimated number for our population of 8,600 is 182 children and 1694 adults. Only 21% of the Texas state population is being served by a State mental health agency leaving the other 79% of our population (estimated at 1482 for our

county) without a reliable source of consistent mental health care. The project specifically addresses the Community Needs Assessment identification number CNA-006 – Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers.

Project Goals: The goal of this project is to ensure that patients with behavioral health concerns are able to access timely, quality services through the use of telehealth and specialist providers. Our county does not offer psychiatry services and the closest services are 70 miles away. When patients come to the emergency department for psychiatric care, they are subject to long waits to be referred to the appropriate facility for care. In 2011, we treated 179 patients with a primary diagnosis code for mental health issues in our emergency department and inpatient and 49% were either Medicaid or uninsured. Implementation of the telemedicine program will allow these patients to be seen by a psychiatrist in a timely manner and allow the patient to be referred for appropriate treatment.

Challenges: Some major challenges to this project include the lack of regional behavioral health service availability and backlog in wait times for behavioral health consultations or appointments. Hamilton General Hospital will work with Providence Healthcare Network to ensure that this issue is dealt with through a comprehensive, global solution that requires coordination and cooperation of the parties. Other challenges include educating physicians and nursing staff to utilize this technology appropriately and effectively. We anticipate to roll out the technology in waves to ensure all questions and concerns are addressed for a successful implementation.

Expected 5-year Outcome: Implementing the telemedicine program in the Emergency Department will allow us to effectively treat our behavioral health patients in a timely manner. By DY5 we expect to have a fully integrated telemedicine program to provide consistent psychiatric care for our patient population. In DY2 we will work with Providence Healthcare Network to establish the telemedicine program in the Hamilton General Hospital Emergency Department. In DY3 we will provide the telehealth services in the ED and expect to serve 15% of the behavioral health patients that present in that setting. We will also establish the baseline for number of telehealth services provided that will be used as the basis for our DY4 and DY5 goals. Our goal for DY4 is to increase usage of telehealth for psychiatric treatment by 25% over the baseline rate established in DY3. In DY5 we expect to increase usage of telehealth for psychiatric treatment by 50% over the baseline rate established in DY3.

Starting Point/Baseline

A formal telemedicine program with regional emphasis does not formally exist at this time. In 2011 Hamilton General Hospital treated 179 patients with a primary diagnosis code for mental health issues in our emergency department and inpatient setting.

Collaboration of program data will play an integral role in establishing a baseline rate for the patient population that the project is intended to serve. Formal baseline data will be established in DY3 after the program has been implemented.

Rationale

The implementation of the telemedicine program will address both of the core project components outlined in the Regional Healthcare Partnership Planning Protocol. There is a severe shortage of specialty care providers in Region 16, specifically for behavioral health consultations and services. Most of the behavioral health services are located in the more densely populated area of the region. In order to alleviate the burden of having to travel long distances for psychiatric care on the behavioral health patients in our county, establishing a telemedicine approach to their care will allow for greater expansion of behavioral health services throughout the region. This information is supported in our Community Needs Assessment and particularly addressed by CNA-006.

Because most of our mental health crisis patients seek care in our emergency department, the telemedicine program will be based there and provide patient consultations by behavioral health specialists using telecommunications. The emergency department is the targeted area because of the high utilization by the Medicaid and uninsured population. In our 2012 Fiscal Year (October 2011-September 2012), 47% of the patients treated in the emergency department were Medicaid and uninsured. They also accounted for 43% of the charges but only 22% of the collections in the same year. Implementing the telemedicine program will provide a better resource for the Medicaid and uninsured population to receive appropriate care following their emergency department encounter, thereby reducing the need for them to utilize the emergency department for further non-urgent mental health needs in the future.

In DY2 we will work with Providence Healthcare Network to implement the telemedicine program specifically for behavioral health services in the emergency department. In DY3 we intend to have the program fully implemented and measure the quantity of services provided. DY4 and DY5 will be devoted to improving the access to behavioral health services for the targeted population. The program will also include a component of quality improvement so that we are able to identify the project impacts, identify "lessons learned," identify opportunities to scale the project to a broader patient population, and identify key challenges associated with expansion of the project.

Related Category 3 Outcome Measure(s)

OD-1 Primary Care and Chronic Disease Management
IT-1.20 Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental Illness

i. Numerator:
   - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
   - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.

j. Denominator: Members 6 years and older as of the date of ED visit who were seen in the emergency department setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator of this measure is based on ED visits, not members. Include all ED visits for members who have more than one ED visit on or between January 1 and December 1 of the measurement year.

k. Data Source: EHR, Claims

l. Rationale/Evidence: This measure assesses the percentage of ED visits for members 6 years of age and older who were seen for treatment of mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
   Rate 1: The percentage of members who received follow-up within 30 days of ED visit
   Rate 2: The percentage of members who received follow-up within 7 days of ED visit

Region 16 is a Mental Health Professional Shortage Area. Lack of access to mental health professionals in rural communities creates significant problems in terms of emergency department visits, untreated mental health conditions, and complications in treating medical conditions which are worsened by the presence of mental health issues. The implementation of the telemedicine project will greatly enhance the ability of our population with behavioral health needs to access the care that is required to care for their illness. The real-time interaction with a behavioral health specialist could enable the health care team to address the patient problem before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectation of our healthcare system. Receiving a real-time interaction with a behavioral health specialist will also allow patients to be referred and understand the need for additional care, reducing the risk of the patient not receiving appropriate follow-up care following their ED visit.

Relationship to other Projects

The projects that Hamilton General Hospital is focused on for the waiver are all in support of the waiver initiatives and each play an integral role in improving the care for the community we serve. We strive to expand our services to serve the population in the most efficient and cost effective way and to get the best outcomes for our patient population.

Relationship to Other Performing Providers' Projects in the RHP

This project is a companion project to the Providence Healthcare Network project to Expand Specialty Care Capacity – Psychiatric Telemedicine. Their implementation of additional specialty care services will allow our facility to utilize their telemedicine department to have access to their psychiatric services.

Plan of Learning Collaborative

Since this project is being posed as a companion project with Providence Healthcare Network, there is a significant opportunity to promote collaborative learning around our projects. The intent is to periodically identify and agree upon improvements to the project that will further develop the telemedicine program and enhance the care of behavioral health patients in Region 16.

Project Valuation

This is a collaborative project with Providence Healthcare Network that has been valued at $1,862,095. In determining the value of this project, we considered the extent to which increased access to specialty care will address the community's needs, the population which the project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, we considered the value to the community of a project such as this, which will be specifically targeted to psychiatric telemedicine specialty services needs of the community.

The target population is our patients that utilize the Emergency Department for psychiatric and behavioral health needs. In 2011 we treated 179 patients with a primary diagnosis code for mental health issues in our emergency department and inpatient and 49% were Medicaid or uninsured. The project seeks to provide better access to appropriate psychiatric care in a timelier manner, thereby improving access for patients seeking services in DY4 and DY5. In DY3 we will establish the baseline for number of telehealth services provided that will be used as the basis for our DY4 and DY5 goals. Our goal for DY4 is to increase usage of telehealth for psychiatric treatment by 25% over the baseline rate established in DY3. In DY5 we expect to increase usage of telehealth for psychiatric treatment by 50% over the baseline rate established in DY3.

NEW: 121792903.1.4 ***OLD: 121792903.1.2***	***1.7.1***	***1.7.1E*** ***1.7.1F***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-1.20*	*New: 121792903.3.14* *Old: 121792903.3.8*	*Other outcome improvement target:* *Follow-up after emergency department visit 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-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents Baseline: In 2011 Hamilton General Hospital treated 179 patients in the ED and inpatient setting with a primary diagnosis code for mental health issues. Goal: Implement the telehealth program for psychiatric care; Data source: Program materials Milestone 1 Estimated Incentive Payment: $ 409,082	**Milestone 2** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need Metric 2 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation Goal: Provide telehealth service to 15% of our behavioral health patients who present in the ED; Establish the baseline rate of services provided for DY4 and DY5 improvement milestones Data source: log of tele-services by type of health care professionals and type of service Milestone 2 Estimated Incentive Payment: $500,165		**Milestone 3** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program. Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services. Denominator: Number of residents in HPSA Goal: Increase usage of telehealth for psychiatric treatment by 25% over baseline rate established in DY3 Data source: EHR Milestone 3 Estimated Incentive Payment: $511,625	**Milestone 4** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.2]: Improved access to health care services for residents of communities that did not have such services locally before the program. Numerator: Number of unique patients from geographically underserved area, HPSA, that receive each type of telemedicine or telehealth services. Denominator: Number of residents in HPSA Goal: Increase usage of telehealth for psychiatric treatment by 50% over baseline rate established in DY3 Data source: EHR Milestone 4 Estimated Incentive Payment: $441,223

NEW: 121792903.1.4 ***OLD: 121792903.1.2***	***1.7.1***	***1.7.1E*** ***1.7.1F***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-1.20*	*New:* *121792903.3.14* *Old: 121792903.3.8*	*Other outcome improvement target:* *Follow-up after emergency department visit 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)**
Year 2 Estimated Milestone Bundle Amount: $409,082	Year 3 Estimated Milestone Bundle Amount: $500,166		Year 4 Estimated Milestone Bundle Amount: $511,626	Year 5 Estimated Milestone Bundle Amount: $441,223
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,862,097				

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.1.1

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will expand the hours of operation, locations of service and types of supports offered in the five rural counties in the catchment area. The expansion is specifically for child and adolescent services. It is anticipated that an additional 375 individuals will be served in the project, with 100 being served in YR 3, 150 in YR 4, and 200 in YR 5.

- Need for the project: Currently child and adolescent services are very limited in these areas. This expansion will reduce the number of children being treated at local emergency departments, in psychiatric inpatient settings, reduce juvenile justice involvement and out of home placements.

- Medicaid and Uninsured Target population: This population generally has either Medicaid or CHIP. It is estimated that between 85-90% will be covered under one of these forms of insurance with the remaining population being uninsured.

- Category 1 or 2 expected patient benefits: It is expected that these children and families will see marked improvement in functioning with fewer negative outcomes.

- Category 3 outcomes: IT 6.1, Improved Patient Satisfaction. It is expected that the children and families involved in the program will see better overall functioning which in turn will lead to greater satisfaction on their part.

A.

B. Category 1: Infrastructure Development

Identifying Project and Provider Information: The project option is 1.12.2; Enhance service availability to appropriate levels of behavioral health care. Child and Adolescent Behavioral Health Service Expansion. 084859002.1.1 - HOTRMHMR/084859002.

Project Description: The Center will expand services to children and adolescents in the region by expanding hours of operation, adding additional clinicians and expanding services into the rural counties surrounding McLennan County. Additional hours and staff will result in greater access to behavioral health services and will increase capacity to provide counseling, case management, parenting, and psychiatric services to children and families not currently served. Additionally the Center will institute a crisis respite program in conjunction with the expansion of outpatient services in an effort to divert psychiatric hospitalizations. Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specified need for care has been identified. Currently, many children are not able to access these services due to limited hours of operation, lack of available clinicians and access based on county location. Because of these barriers many children in need of services and supports are unable to access them leading to more significant issues in the future. The goal of this project is to increase access to needed services and supports for children and adolescents with behavioral health needs. By increasing available hours of operation, numbers of children served, the provision of crisis respite services and by expanding service capacity in the rural counties it is expected that there will be a decrease in emergency room visits, psychiatric inpatient hospitalizations, reduced involvement in the juvenile justice system and out of home residential placements. This project ties in with the five year plan to significantly enhance patient satisfaction based on better access to behavioral health supports for children and their families thereby resulting in more positive outcomes. The goals of this project reflect the regional goal associated with increasing access to needed behavioral healthcare services.

Starting Point / Baseline: The HOTRMHMR currently serves an average of 210 children/adolescents every month (10-1-2012). Due to limited capacity, however, many families interested in having their children receive the intensive services provided at HOTRMHMR Center are referred to less-intensive outside providers. Currently, behavioral healthcare services to children and adolescents in the Center's five rural counties are extremely limited. This expansion will allow for greater access to services to individuals in all six of the Center's counties.

Rationale: Statewide estimates indicate that only about 25% of the children and adolescents needing behavioral health services are currently able to access those services (CNA-005). Children and adolescents who have unmet behavioral health needs have a higher rate of suicide, greater involvement in the juvenile justice system, increased utilization of emergency departments services, increased utilization of inpatient psychiatric hospitalizations and an increase in out of home residential placements (CNA-006). The project option is 1.12.2. Specifically, the Center will expand the number of community based settings where behavioral health services may be delivered in underserved areas. Because children's behavioral health services are underserved in all six of the Center's counties, services to children and their families will be expanded in all areas. In McLennan County services will be increased and hours of operation will be expanded for greater access. In the five rural counties children's services will be expanded to include additional psychiatric services, case management and outpatient therapy. Process milestones will include P-3, P-4, P-5, P-6 and P-7. Improvement Milestones will include I-11. Milestones not included were based on project design.

Related Category 3 Outcome Measure: The Category 3 Outcome Measure selected is OD – 6; Patient Satisfaction. This measure was selected as a way of determining the satisfaction of parents related their child's improvement in functioning. That improved functioning

leads to better outcomes in a variety of areas. The need for intensive services and supports for children has been identified as a significant priority for the region. Category 1 and 2 projects directly ties into the anticipated outcome of improved clinical functioning.

Relationship to Other Projects: This project supports other identified Category 2 projects of the HOTRMHMR Center. Creating healthy children and families has the long-term outcome of reducing other more costly treatment alternatives in the future. Category 4 is not applicable.

Relationship to Other Performing Providers' Projects in the RHP: No other providers in the region are proposing a project that directly ties into this project.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to expanded behavioral services for children and adolescents. In Texas all LMHA's currently engage in collaborative learning through the behavioral health consortium. This group meets at least every three months.

Project Valuation: The valuation of this project was based on current cost of serving individuals in the HOTRMHMR Center combined with savings achieved by reducing inpatient hospitalizations, juvenile justice involvement, out of home placements and emergency department visits. The project size was determined utilizing waiting list numbers, state and local need assessments and underserved populations in rural communities.

084859002.1.1	***1.12.2***	***1.12.2***	***CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICE EXPANSION***	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-6	*[unique Category 3 IT identifier(s)]* ***IT-6.1***	084859002.3.1	***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-3 **Metric 1 – P-3.1** **Baseline/Goal:** P-3 Develop administrative protocols and clinical guidelines for projects selected. P-3.1 Produce a manual of operations for project detailing administrative protocols. **Data Source:** Develop manual of operations. **Milestone 1 - Incentive Payment *(maximum amount):*** $ 30,702.50 **Milestone 2** – *P-4* **Metric 2**– *4.1* **Baseline/Goal:** P-4 Hire and train staff to operate and manage project. P-4.1 Hire and train staff.	**Milestone 5 – P-7** **Metric 5 – P-7.1** **Baseline/Goal:** P-7 Evaluate and continuously improve services. P-7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycle. **Data Source:** Demonstrate CQI. **Milestone5 - Estimated Incentive Payment:** $ 138,195 **Milestone 6 – I-11** **Metric 6**– I-11.1 **Baseline/Goal:** I-11 Increased utilization of community behavioral healthcare. I-11.1 Enroll and serve an additional one hundred (100) children in this project.		**Milestone 7 – P-7** **Metric 7 – P-7.1** **Baseline/Goal:** P-7 Evaluate and continuously improve services. P-7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycle. **Data Source:** Demonstrate CQI. **Milestone 7 -Estimated Incentive Payment:** $ 165,834 **Milestone 8 – I-11** **Metric 8**– I-11.1 **Baseline/Goal:** I-11 Increased utilization of community behavioral healthcare. I-11.1 Enroll and serve an additional one hundred and twenty-five (125) children in	**Milestone 9 – P-7** **Metric 9 – P-7.1** **Baseline/Goal:** P-7 Evaluate and continuously improve services. P-7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycle. **Data Source:** Demonstrate CQI. **Milestone 9- Estimated Incentive Payment:** $ 189,603.50 **Milestone 10 – I-11** **Metric 10**– I-11.1 **Baseline/Goal:** I-11 Increased utilization of community behavioral healthcare. I-11.1 Enroll and serve an additional one hundred and fifty (150) children in this

084859002.1.1	***1.12.2***	***1.12.2***	***CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICE EXPANSION***	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-6	*[unique Category 3 IT identifier(s)]* ***IT-6.1***	084859002.3.1	***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)**
Data Source: Personnel files. **Milestone 2 Payment:** *$30,702.50* **Milestone 3** – *P-5* **Metric 3** – *P-5.1* **Baseline/Goal:** P-5 – Establish extended hours. P-5.1 Identify areas for establishment of extended hours. **Data Source:** Establish sites and hours of service for new services. **Milestone 3 Payment:** *$30,702.50* **Milestone** *4 – P-6* **Metric 4**– *P-6.1* **Baseline/Goal:** P-6 – Establish behavioral health in new community –based settings in underserved areas. P-6.1 Establish services in five	**Data Source:** HOTRMHMR Center clinical system records. **Milestone 6 Estimated Incentive Payment:** $ 138,195		this project. **Data Source:** HOTRMHMR Center clinical system records. **Milestone 8 Estimated Incentive Payment:** $ 165,834	project. **Data Source:** HOTRMHMR Center clinical system records. **Milestone 10- Estimated Incentive Payment:** $ 189,603.50

084859002.1.1	***1.12.2***	***1.12.2***	***CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICE EXPANSION***	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-6	*[unique Category 3 IT identifier(s)]* ***IT-6.1***	084859002.3.1	***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)**
rural counties served by the HOTRMHMR Center. **Data Source:** Establish services in five rural counties. **Milestone 4 Payment:** *$30,702.50*				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $122,810	Year 3 Estimated Milestone Bundle Amount: $ 276,390		Year 4 Estimated Milestone Bundle Amount: $ 331,668	Year 5 Estimated Milestone Bundle Amount: $ 379,207
$1,110,075				

Pass 3 Project

- Provider: Hillcrest Baptist Medical Center *(TPI 138962907*) is a Private, Non-Profit Hospital in Waco, TX. HBMC is a faith-based institution that serves as the primary safety net hospital and only Level 2 trauma center in a 40-mile radius. HBMC is in McLennan County with a population of 225,000 and serves an above state average number of Medicaid and indigent patients.
- Intervention(s): This project will introduce and expand specialty care coverage for patients in Limestone County, including multiple possible areas such as orthopedics, ENT, urology, gastroenterology, and neurology (pain management).
- Need for the project: Over 800 Limestone County residents were admitted to HBMC last year, which is 40 miles or more away from their homes. They have a critical access hospital in Limestone Medical Center, but they have very limited specialist availability currently. As such, a large number of their indigent and elderly population receive inadequate interventional and follow up care resulting in greater illness and more inpatient or acute care services at HBMC.
- Medicaid and Uninsured Target population: The target population is patients that live in Limestone County, especially those that are admitted as inpatients to HBMC. The population has a lower median income than the regional average along with a higher uninsured rate. This population struggles to find ways to travel 90 or more miles round trip per specialty care visit, so they stand to benefit the greatest from this project. Of the roughly 800 inpatient admissions, over 40% or 346 were either Medicaid or indigent. Also, there were 807 outpatient encounters through the Emergency Department, with 51% or 409 were indigent or Medicaid patients.
- Category 1 or 2 expected patient benefits: The project seeks to establish a baseline number for specialty care access then seeks to increase the availability for patients by 25% and 50% respectively in DY 4 and 5 of the project.
- Category 3 outcomes: IT-3.1 All Cause 30 day Readmission Rate. Our goal is to reduce the 30-day readmission rate for Limestone County patients at Hillcrest Baptist Medical Center. We will need to establish the program and measure the baseline rates for these patients, then plan to show improvement in the overall rate for DY 4 and 5.

Pass 3
Project Option: 1.9.2 (Pass 3) – Expand Specialty Care

Unique Project ID: 138962907.1.1
Performing Provider Name/TPI: Hillcrest Baptist Medical Center (TPI: 138962907)

Project Description

The project would increase access to specialty care for patients in Limestone County. Hillcrest Baptist Medical Center (HBMC) will expand coverage by partnering with Limestone Medical Center in order to provide the physicians and staff necessary to see patients out in the rural communities located in Limestone County. Currently, Patients must drive over 40 miles one way to see specialists or seek follow-up care after an acute episode. There is very limited specialist coverage, so the project will conduct a gap analysis and then work to meet the needs of the residents of those communities. HBMC had over 800 discharges in fiscal year 2012 from Limestone County, plus an additional 800 plus outpatient procedures for this same group. The goal is to increase the number of specialists along with the variety practicing regularly in Limestone County.

The population in Limestone County is below the regional average on median household income and percent of the population with a bachelor's degree, according to the RHP 16 Community Needs Assessment. This rural population of over 22,000 people does not often have the means to drive so far for regular medical care, and they are very often unable to afford the half day or more off of work that would be required for even the most basic specialist appointment. Limestone Medical Center was recently awarded Critical Access Hospital status, which further supports the need to increase resources and access to specialty medical care in this poorer, isolated region.

Over 70% of the admissions to Limestone Medical Center were Medicare patients, which is a particularly vulnerable group that requires higher than average specialty access in order to avoid preventable complications from their acute and chronic conditions. HBMC will arrange for physician coverage, billing, project planning, staffing, and facilities required to meet the specialty needs of the communities in these areas.

Hillcrest's Specialty Expansion in Limestone County will include:

- Physicians, Providers, necessary support staff to see patients in Limestone County
- Office space and infrastructure required to schedule appointments, referrals, register patients, and document medical records.
- Project coordination, measuring, planning, and recruitment of physicians

Target Population

Patients from all zip codes in Limestone County, Texas. There were 346 emergency visits and 409 inpatient discharges for both indigent and Medicaid patients from Limestone County in FY 2012. This does not include visits to other providers in RHP 16, so initial and follow up coverage in Limestone County could potentially have an impact for the 755 inpatient and outpatient indigent/Medicaid visits last year.

Goals and Relationship to Regional Goals

The goal of this project is provide more appropriate and timely medical care to the patients from RHP 16 that live and work in Limestone County. The triple aim of right care, right place, and right time are all addressed as a part of this project. The 85 plus mile round trip required by patients to seek specialty care is burdensome and leads to dramatically lower compliance rates for patients with chronic conditions or those managing post-acute treatment demands. It is much more efficient for the provider to come where a large number of patients are, rather than having that same large number of sick, financially-challenged people all make such a long and burdensome trip. HBMC serves as the region's trauma hospital and primary safety net facility, so often these patients end up in the Emergency Department and/or being admitted as inpatients in the acute setting because their needs were not addressed in a more appropriate setting. An analysis will done to identify specific needs, but the goal is to increase access to specialty care office hours by 25% and 50% in Limestone County. We anticipate that such a dramatic increase in the amount and type of specialty coverage will have a positive effect on emergency department inappropriate utilization, readmissions, potentially preventable admission, and potentially preventable complications. The project will focus specifically on the 30-day readmission rate for Limestone County patients that are discharged from HBMC. The Medicare Advisory Payment Council has found that as many as 76% of readmissions within 30 days are preventable. This project will address that disparity by providing significantly more resources to these patients in the community where they live and at a time when they need it most. This project is truly a collaborative effort between HBMC and the RHP 16 partners at Limestone Medical Center. The region will be served by the cooperative relationship that this project seeks to capitalize on in order to better serve patients across the region and not just in HBMC's immediate local community.

Challenges: The lack of available specialists, the distance required to travel to remote areas, and lack of sufficient space and facilities to adequately care for the population.

5-year expected outcome: Better coordination of specialty services between primary care clinic and specialty clinic which will ultimately reduce patients who rely on emergency rooms and EMS transportation for specialty care. Specialty care will be timely and easier to access for patients with limited transportation options.

Starting Point/ Baseline

Currently HBMC doesn't have any official specialty coverage arrangements or programs, so the baseline for DY 2 is 0.

Rationale:

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

Project Components:

The core components of this category will be fulfilled as follows:

a) Increase service availability with extended hours – HBMC will conduct a study to determine the specialties needed locally and the hours that would satisfy the demand
b) Increase number of specialty clinic locations – HBMC will work with local specialists to expand their existing locations to areas in the county that will be more accessible to the patients
c) Implement transparent, standardized referrals across the system – HBMC will develop a process for the primary care clinics to have access to a specialty clinic referral system that will expedite patient care and improve access.
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.

Unique community need identification numbers the project addresses:

- CNA-004 – Potentially Preventable Hospitalizations , including Diabetes with short-term and long-term complications
- CNA-007 - Inappropriate utilization of Emergency Room
- CNA0-009 - CMS 30-day Readmission Measures for AMI, HF, Pneumonia

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

This initiative builds on an identified need in the community to provide services locally due to the rural areas of the county and because it is a medically underserved population. Transportation is an issue for the Medicaid and indigent populations (most will have to travel more than 30 miles to visit a specialist) as well as missed time at work therefore we believe patients have a much greater likelihood of receiving the care they need if transportation is not an issue and they do not have to reduce the number of hours they work each week.

Process Milestones selected:

P-1. 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)

P-1.1.b. Data Source: Needs Assessment

P-11. Launch/ expand a specialty care clinic (e.g., pain management clinic)

P-11.1. Metric: Establish/ expand specialty care clinics

P-11.1.c. Data Source: Documentation of new/ expanded specialty care clinic.

Improve Milestones selected:

I-23: Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).

Goal: Increase by 25% over baseline for DY 4 and 50% over baseline in DY 5.

a. Total number of visits for reporting period
b. Data Source: Registry, EHR, claims or other Performing Provider source
c. Data Source: Registry, EHR, claims or other Performing Provider source

Related Category 3 Outcome Measure(s)

OD-3 All Cause 30-day Readmission Rate

138962907.3.4

IT-3.1 All Cause 30-day Readmission Rate

a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.
b. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

Reasons for selecting the outcomes measure: The wide variety of community needs that could be addressed would best be measured by a measurement of the all cause readmission rates of Limestone County patients at HBMC. The improvement in this rate would signify that patients are receiving the necessary care in their community and not having to return to the safety net facility over 40 miles away in Waco.

Relationship to other Projects
None

Relationship to other Performing Providers' Projects in the RHP
There will likely be some interaction with the Wound Care project being conducted by Limestone Medical Center. There will likely be a need for certain patients to need specialty care and be prescribed wound care follow up.

Plan for Learning Collaborative
HBMC will meet quarterly to discuss the current status of RHP 16 projects related to expansion of specialty care. Learning collaborations offer the team an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it quarterly.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
5. It will employ individuals to travel from site to site in the network to (a) rapidly answer practical questions about implementation and (b) harvest good ideas and practices that they systematically spread to others. The regional "innovator agents" should all attend the same initial training in improvement tools and skills organized by the State or RHP and should receive periodic continuing education on improvement.
6. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
7. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).
8. It should use metrics to measure its success such as:
    - Rate of testing
    - Rate of spread
    - Time from idea to full implementation
    - Commitment rate (rate at which 50% of organizations take action for any specific request)
    - Number of questions asked per day

Project Valuation

$3,259,006

Of the roughly 800 inpatient admissions from Limestone County, over 40% or 346 were either Medicaid or Indigent. Also, there were 807 outpatient encounters through the Emergency Department, with 51%, or 409, being Indigent and/or Medicaid patients. These numbers only include Hillcrest patients, but the project will help the Medicaid and Indigent populations that might end up at one of our regional partners' facilities. Limestone County has a great community need for the expansion of specialty care hours of service and locations which provide greater access to care for the target population. In addition, patients will experience greater coordination of care with specialty care available in the community where they live, which makes it much more convenient and likely to occur. There are also likely benefits in ED utilization, preventable admission, preventable readmission, and overall chronic care management. The costs associated with EMS transport, increased inpatient LOS costs, additional procedure costs, complications from chronic conditions, and the limited ability to pay all contributed to the priority value and cost benefits of the stated value. The population includes above state and national average numbers of uninsured, Medicaid, and Medicare patients which have median household incomes below the regional and state averages. This is a rural, underserved community with limited means and resources, so the valuation accurately reflects the combined costs and benefits of providing a higher level of access and care to such a community.

138962907.1.1	***1.9.2 A-D***	***138962907.1.1***	***EXPAND SPECIALTY CARE CAPACITY***	
Hillcrest Baptist Medical Center				*138962907*
Related Category 3 Outcome Measure(s):	*IT-3.1*	138962907.3.4	*All Cause 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-1: Conduct specialty care gap assessment based on community need] Metric 1 P-1.1: Metric: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2) Baseline/Goal: None Data Source: P-1.1.b.: Needs Assessment Milestone 1 Estimated Incentive Payment*: $379,772* **Milestone 2** **CQI: P-21** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric	**Milestone 3** P-11: Launch/ expand a specialty care clinic (e.g., pain management clinic) Metric 1 P-11.1: Metric: Establish/ expand specialty care clinics Baseline/Goal: Unknown Data Source: P-11.1.c.: Documentation of new/ expanded specialty care clinic. Milestone 3 Estimated Incentive Payment: $*$437,016* **Milestone 4** **CQI: P-21** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric		**Milestone 5** I-23: Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increase clinic follow up and initial visits by 25%. Primarily focused on the 755 inpatient and outpatient indigent/Medicaid discharges from Limestone Co. in FY12. c. Total number of visits for reporting period d. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 5 Estimated Incentive Payment: $443,743 **Milestone 6** **CQI: P-21** Participate in face-to-face learning (i.e.	**Milestone 7** I-23: Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increase by 50% over baseline. Primarily focused on the 755 inpatient and outpatient indigent/Medicaid discharges from Limestone Co. in FY12. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 7 Estimated Incentive Payment: $*$368,972* **Milestone 8** **CQI: P-21** Participate in face-to-face learning (i.e. meetings or seminars) at least

138962907.1.1	***1.9.2 A-D***	***138962907.1.1***	***EXPAND SPECIALTY CARE CAPACITY***	
Hillcrest Baptist Medical Center				*138962907*
Related Category 3 Outcome Measure(s):	*IT-3.1*	138962907.3.4	*All Cause 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)**
P-21.1 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. Milestone 2 Estimated Incentive Payment *(maximum amount): $379,772*	**P-21.1** 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. Milestone 4 Estimated Incentive Payment *(maximum amount): $437,016*		meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric **P-21.1** 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. Milestone 6 Estimated Incentive Payment *(maximum amount):* $443,743	twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric **P-21.1** 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. Milestone 8 Estimated Incentive Payment *(maximum amount): $368,972*
Year 2 Estimated Milestone Bundle Amount: $759,544	Year 3 Estimated Milestone Bundle Amount: $874,033		Year 4 Estimated Milestone Bundle Amount: $887,486	Year 5 Estimated Milestone Bundle Amount: $737,944
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,259,006				

Summary Information
Performing Provider: Providence Health Center
Pass 1 Project
Project Unique ID #: 1118290102.1.1

- Provider: Providence Health Center is a 303-bed acute care hospital which includes a 48 bed Distinct Part Psychiatric Unit located in Waco, TX. Our primary market area is McLennan County servicing a population of approximately 233,000. Our secondary and tertiary markets include Falls, Coryell, Hamilton, Hill, Bosque and Limestone, Freestone and Bell counties.

- Intervention(s): Providence Healthcare Network will lead a regional DSRIP project to establish telemedicine capabilities across Region 16. Providence will provide value to the region by serving as the hub for Psychiatric Consults via a portal that is accessible by all hospitals in Region 16. Primarily the project will be implemented to offer behavioral telemedicine resources to all hospital providers in Region 16. Providence Healthcare Network will provide telemedicine units for each of the twelve hospitals in Region 16, with the initial intent to provide behavioral health screenings and treatment more timely, efficiently, and cost effectively. In addition, Providence will provide telemedicine services to McLennan County residents receiving services in our ED.

- Need for the project: It is estimated that one in four adults and one in ten children have behavioral health needs. Due to the shortage of mental health professionals and transportation hardships in Region 16, telemedicine capability undoubtedly provides tremendous benefit to our communities. This technology will be used to address immediate needs relative to behavioral health patients, and eventually be developed to expand services that patients would otherwise have to travel to Waco to receive.

- Medicaid and Uninsured Target population: It is anticipated that the primary population benefiting from this project will be Medicaid eligible and indigent patients. This population tends to have a greater need for behavioral health services than insured patients. Approximately 40% of McLennan County's population is eligible for Medicaid or Uninsured.

- Category 1 or 2 expected patient benefits: The project seeks to implement telemedicine capabilities in DY2, provide 1,000 psych consults in DY3 and additional growth of 5% in years DY4 and DY5.

- Category 3 outcomes: 111829102.3.1 Our goal is to improve overall patient satisfaction by 5% in DY4 from the baseline that will be established in DY3.

Category 1: Infrastructure Development

Providence Healthcare Network
111829102
(TPI) 1.7 Introduce, Expand or Enhance Telemedicine/Telehealth
11829102.1.1
Regional Health Promotion Programs

- **Project Description:**

Providence Healthcare Network offers to lead a regional DSRIP project to establish telemedicine capabilities across Region 16. Providence will provide value to the region by serving as the hub for Psychiatric Consults via a portal that is accessible by all hospitals in Region 16. Primarily the project will be implemented to offer behavioral telemedicine resources to all hospital providers in Region 16. Providence Healthcare Network will provide telemedicine units for each of the twelve hospitals in Region 16, with the initial intent to provide behavioral health screenings and treatment more timely, efficiently, and cost effectively. When potential psychiatric patients present in any emergency department in the region, telemedicine capability can be used to perform first QMHP screenings, followed by psychiatric physician screenings, if necessary, to determine appropriate treatment for the patient. In addition to the benefit of more timely and appropriate treatment for the patient, use of telemedicine for behavioral health patients will provide needed support to emergency physicians in each facility, ensure appropriate throughput of these patients, reduce the burden on the local psychiatric physicians and reduce law enforcement and other costs related to sometimes unnecessary transfers or forensic detail for psychiatric patients. It is anticipated that the primary population benefiting from this project will be Medicaid eligible or indigent patients.

Over the next five years, once the telemedicine units are in place, they can be used to provide other services throughout the region. It is anticipated that these units will be used to provide multi-site simultaneous education and support services, either on a routine or ad hoc basis, for patients suffering from chronic diseases such as diabetes, CHF, and COPD or for patients requiring other post-acute support services. Finally, the telemedicine units could also be used to provide specialist presence in the smaller communities in our region.

Challenges include educating physicians and nursing staff to utilize this technology appropriately and effectively. We anticipate to roll out the technology in waves to ensure all questions and concerns are addressed for a successful implementation.

Telemedicine capability undoubtedly provides tremendous benefit to our communities—for patients, the physician community, the hospitals and law enforcement. It can be used to address immediate needs relative to behavioral health patients, and it can be developed to expand services that patients would otherwise have to travel to Waco to receive. The Community Needs Assessment (CNA-006) identified opportunities for Region 16 that included coordination with Mental Health Providers to enhance access across all counties and development of models for use of telemedicine. Due to the shortage of mental health professionals and transportation hardships in Region 16, we believe this will fulfill a major community need as supported by the Community Needs Assessment.

- **Starting Point/Baseline:**

Telemedicine services are currently not offered in Region 16, so no baseline has been established. In DY3, a baseline will be established and additional volumes will increase each year in years DY 3 through DY 5. It is estimated that Providence will have provided 1,000 Psych Consults to patients in McLennan County as well as being the Regional hub for an additional 2,000 consults by the end of DY5. These numbers represent one on one Psych Consults with patients presenting to the ED and does not quantify the number of patients that will benefit from MHMR consults as that data is unavailable at this time. Providence Healthcare Network proposes the following timeline for implementation of telemedicine services. The timeline is informed by available HHSC DSRIP project guidance, but can be adjusted if implementation goes more quickly than anticipated and if sufficient project funding is available.

DY2 (10/1/12-9/30/13)	Implement telemedicine capability
DY3 (10/1/13-9/30/14)	Utilize telemedicine for behavioral health patients
DY4 (10/1/14-9/30/15)	Expand telemedicine to provide education and support for chronic disease patients
DY5 (10/1/15-9/30/16)	Expand telemedicine to provide specialist presence

- **Rationale:**

One of the greatest challenges facing the U.S. healthcare system is to provide quality care to the large segment of the population, which does not have access to specialty physicians because of factors such as geographic limitations or socioeconomic conditions. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers.

The use of telecommunications technologies and connectivity has impacted real-world patients, particularly for those in remote communities. This work has translated into observable outcomes such as:

- improved access to specialists
- increased patient satisfaction with care
- improved clinical outcomes
- reduction in emergency room utilization
- cost savings

Nowhere are these benefits more evident than in Texas. With a land mass area of 268,820 square miles and a growing population of 25.1 million, Texas is the second largest US state by area and population.1 Its population growth rose more than 18.8 percent between 2000 to 2009, reflecting an increase that is more than double the national growth in this period.2 This rapid growth is attributed to a diversity of sources such as natural increases from the total of all births minus all deaths and to a high rate of net immigration from other states and countries. Along with the increase in population, an ever-growing aging population (the state's older population, 65+, is expected to double that of the previous 8 years) has significantly affected the demand on the healthcare workforce as demands for quality care increased.

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

OD-6 Patient Satisfaction
111829102.3.1
IT-6.1 Percent improvement over baseline of patient satisfaction scores
Are getting timely care, appointments, and information?

- **Numerator**: Percent improvement in targeted patient satisfaction domain
- **Data Source**: Patient survey
- **Denominator**: Number of patients who were administered the survey
- **Rationale/Evidence**: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create

incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

- **Relationship to other Projects:**

  With the limited Mental Health Providers in RHP 16, this project enables collaboration throughout the region by providing access to physicians via telemedicine technology. The Heart of Texas MHMR projects' for RHP16 complement telemedicine by expanding access to rural communities where access to behavioral health services has been limited.

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

  The telemedicine program is a regional project and will be utilized in all counties who participate in the program. The Providence project includes our target population of McClennan County and those patients who hit our ED. Each participating provider will have their own unique target populations to include the patients served in their ED through telemedicine.

- **Plan for Learning Collaborative:**

  Providence will host a monthly meeting, via teleconference or webinar, to discuss the current status of this project and issues related to projects that affect local and regional populations. Learning collaborations offer the region an opportunity to learn from successes and failures and will be designed as follows:
  - *It should review data and respond to it every month.*
  - *It should invest more in learning than in teaching.* It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
  - *It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.*
  - *It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).*

- **Project Valuation:**

  This project will be regionally based and offered as a resource to all members of the targeted populations in each county. The project will be "branded" as a regional initiative using local providers to drive patients to the appropriate level of care.

Providence Healthcare Network (111829102)

1.7 Introduce, Expand or Enhance Telemedicine/Telehealth

Category 1 Identification Number: 111829102.1.1
Category 3 Outcome: OD-6
Category 3 Outcome Improvement Target: IT – 6.1

Milestone: P-4. Implement or expand telemedicine program for targeted health services based upon regional and community need.

- **Metric DY2**: P-4.1. Documentation of program materials including implementation plan, vendor agreements/contacts, staff training and HR documents
  - Submission of implementation documentation
  - Data Source: Program materials
  - Rationale/Evidence: It is important to expand telehealth to areas where greatest need and highest potential for impact is demonstrated in order to have optimal effect.
- **Metric DY3-5**: P-4.2. Documentation of the quantity of actual telehealth services delivered after implementation
  - Submit the number of telemedicine/telehealth sessions provided via video-conferencing for remote health care providers along with the educational materials from the session;
  - Data source: log of tele-services by type of health care professionals and type of service;
  - Rationale: ensure that actual implementation occurred

- **Improvement Milestones**:

Milestone: I-12. Increase number of telemedicine visits for each specialty identified as high need

- **Metric DY3-5**: I-12.1. Number of telemedicine visits
  - Numerator: Number of visits in which patients are seen using telemedicine services for each type of medical or surgical subspecialty provided by specified timeframe (e.g. one year) and geographic area in
  - RHP or for individual provider.
  - Denominator: Number of patients referred to medical specialties
  - Data Source: EHR or electronic referral processing system; encounter records from telemedicine program
  - Rationale: demonstrate increase in access due to teleservices

111829102.1.1	*RHP PP – 1.7.1*	*RHP PP – 1.7.1.A*	*INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH*
Providence Health Center			*111829102*
OD-6	*IT – 6.1*	*111829102.3.1*	*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-4. Implement or expand telemedicine program for targeted health services based upon regional and community need **Metric 1** P-4.1. Documentation of program materials including implementation plan, vendor agreements/contacts, staff training and HR documents Data Source: Program materials **Metric 1** P-4.2. Documentation of the quantity of actual telehealth services delivered after implementation **Data Source**: log of tele-services by type of health care professionals and type of service; Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,969,683	**Milestone 2** I-12 Increase number of telemedicine visits for each specialty identified as high need **Metric 1** I-12.1. Number of telemedicine visits Baseline/Goal: Set baseline **Data Source**: EHR or electronic referral processing system; encounter records from telemedicine program Milestone 2 Estimated Incentive Payment: $2,148,818	**Milestone 3** I-12 Increase number of telemedicine visits for each specialty identified as high need **Metric 1** I-12.1. Number of telemedicine visits Baseline/Goal: 5% growth over baseline **Data Source**: EHR or electronic referral processing system; encounter records from telemedicine program Milestone 3 Estimated Incentive Payment: $2,155,065	**Milestone 4** I-12 Increase number of telemedicine visits for each specialty identified as high need **Metric 1** I-12.1. Number of telemedicine visits Baseline/Goal: 5% growth over baseline **Data Source**: EHR or electronic referral processing system; encounter records from telemedicine program Milestone 4 Estimated Incentive Payment: $1,780,271
Year 2 Estimated Milestone Bundle Amount: $1,969,683	Year 3 Estimated Milestone Bundle Amount: $2,148,818	Year 4 Estimated Milestone Bundle Amount: $2,155,065	Year 5 Estimated Milestone Bundle Amount: $1,780,271

111829102.1.1	*RHP PP – 1.7.1*	*RHP PP – 1.7.1.A*	*INTRODUCE, EXPAND , OR ENHANCE TELEMEDICINE/TELEHEALTH*	
Providence Health Center				*111829102*
OD-6	*IT – 6.1*	*111829102.3.1*	*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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $8,053,837				

Category 2

Category 2: Program Innovation and Redesign
Project Option: 2.1.3 Implement medical homes in HPSA and other rural and impoverished areas
Coryell Memorial Healthcare System/134772611
Old: 134772611.2.1/ New: 134772611.2.5 Enhance/ Expand Medical Homes

Project Summary – Pass 3b

- Provider: Coryell Memorial Hospital/ Coryell Medical Clinic. Coryell Memorial Hospital is a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). Coryell Memorial Healthcare System (CMHS) operates two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. 24.7% of the population is considered uninsured (16,043). As of May 2012 (http://www.hhsc.state.tx.us/research/MedicaidEnrollment/me-results.asp), the number of residents in Coryell County with Medicaid was 6,078 of which 4,381 were children under the age of 19. The population of Coryell County in 2010 was 72,529 and has projected growth each year through 2020 and beyond.

- Interventions: Coryell Medical Clinic will implement a new Patient Centered Medical Home (PCMH) model for a select group of existing and new patients considered Indigent. This will include a transformation in the clinic to coordinate care for patients with chronic diseases.

- Need for Project: A PCMH project will enable the hospital and clinic to coordinate existing and new resources to provide care at the right time and in the right setting.

- Medicaid and Uninsured Target Population: CMHS will initially target citizens enrolled in the Indigent Healthcare program, currently 350. Those patients may eventually receive additional government assistance through Medicaid or become completely uninsured but will not be withdrawn from the program. Instead, the PCMH will be expanded to include additional Medicaid and Uninsured members of the community. Some of these patients who are enrolled may have visited CMHS in the past but only for urgent or emergent care situations.

- Category 1 or 2 expected patient benefits: CMHS will establish patient criteria and implement the medical home model by DY3. In DY4, 100 unique patients will be assigned to a PCMH and in DY5, 200 unique patients will be assigned to a medical home. Of these patients, 50% will receive communication regarding preventive health screenings in DY 4 and 75% will receive reminders in DY5.

- Category 3 outcomes: CMHS will reduce the number of emergency room visits that are the result of non-urgent care issues and lack of coordinated primary care.

Category 2: Program Innovation and Redesign
Project Option: 2.1.3 Implement medical homes in HPSA and other rural and impoverished areas
Coryell Memorial Healthcare System/134772611
Old: 134772611.2.1/ New: 134772611.2.5 Enhance/ Expand Medical Homes

Project Description

Coryell Memorial Healthcare System (CMHS) will implement a new Patient-Centered Medical Home (PCMH) model within the Coryell Medical Clinic in Gatesville, Texas. The model currently does not exist in Coryell County. The PCMH provides primary care "home base" for patients. Under this model, patients are assigned a healthcare 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. The project will specifically target patients whose health suffers as a result of uncoordinated care such as those who do not currently have a primary care physician, who are seen as needed and repeatedly in the emergency and specialty clinics and whose care is complex due to medical and/or psycho-social reasons. The target population consists of individuals enrolled in the Indigent Healthcare program and Medicaid including those who are high utilizers of the emergency room. The care team includes the physician, mid-level practitioner, pharmacist and social services. The PCMH model will be implemented in the HPSA which is located in a rural area using evidence-approached change concepts for practice transformation by the Commonwealth Fund's Safety Net Medical Home Initiative. CMHS will develop a systematic approach to identifying patients who would benefit from a PCMH, determine who will be initially selected and ensure they receive accurate and timely information concerning their first appointment and follow-up care. CMHS will establish patient criteria and implement the medical home model by DY3. In DY4, 100 unique patients will be assigned to a PCMH and in DY5, 200 unique patients will be assigned to a medical home. Of these patients, 50% will receive communication regarding preventive health screenings in DY 4 and 75% will receive reminders in DY5.

Goals:

- Patients assigned to a medical home will be able to self-manage chronic conditions
- Provide patients with easily accessible primary care services in their community
- Patients in the emergency room who need primary care appointment discharged with a scheduled appointment
- Decrease misuse of emergency room for primary and urgent care services.

Regional Goals:

The goals of RHP 16 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. RHP16 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. 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. 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 16, 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.

Challenges: Some patients do not identify with one provider or care team therefore their health care is not well coordinated. More significantly, CMHS does not yet have a systematic approach to identifying patients who need a medical home, triaging and prioritizing them, and insuring that they are both assigned to a medical home and have first appointment into that home. CMHS will need to train staff and providers on the PCMH model and define new roles and responsibilities to best utilize the skills and expertise of team members. CMHS will need to maximize existing resources and expand IT capability in order to capture and report on patient discharge information, emergency room data and referrals from other providers.

5 year expected outcome: Patients will recognize the value of care provided by a PCMH. Care coordination will be greatly enhanced by the level of service provided by the PCMH care team which will include professional support by a physician, mid-level practitioner, pharmacist and social services. A profile of patients who need a medical home will be developed. At least 50% of patients who are identified as candidates for a medical home will be assigned and an appointment will be scheduled within 90 days of referral.

Starting Point/ Baseline

CMHS will identify a target population of existing patients that will be assigned to the medical home, determine existing health status and areas of deficiencies and then determine how each patient will be managed using the protocols established by the PCMH team. Starting point will be the development of policies and procedures in order to implement the medical home model in DY3. Baseline for outcomes will be determined in DY3.

Rationale:

The PCMH will establish the foundation for improved case management, patient follow-up and better access to care.

Project Components:

The project core components will be fulfilled as follows:

a) Empanelment: Coryell Memorial will assess target population and identify patients who will be assigned to a medical home.
b) Restructure staffing into multidisciplinary care teams: Roles and tasks will be developed for the multi-disciplinary team that will manage a panel of patients.
c) Link patients to a provider and care team: Patients will be educated with regards to their medical home assignment in order to recognize their status and benefits of the program.
d) Assure that patients are able to see their provider or care team whenever possible: Clinic hours and call schedules will be developed for patients assigned to the medical home.
e) Promote and expand access to the medical home: 24/7 continuous access will be provided via phone, e-mail or in-person visit.

f) Continuous quality improvement activities include monthly project evaluations, identification of best practices and alternative processes to overcome challenges of extending project to larger populations.

Unique community need identification numbers the project addresses:

CNA-004 Potentially Preventable Hospitalizations
CNA-007 Inappropriate ER utilization
CNA-011 Projected Population Growth

More than 25% of the population of Coryell County is considered uninsured or underinsured. More often than not, these patients do not have a primary care physician nor do they access a primary care clinic for preventive or routine healthcare. By assigning these patients to a medical home, we can better coordinate activities related to their current condition to improve outcomes.

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

The PCMH is a unique project to Coryell County and much of Region 16, specifically as it related to the rural areas. CMHS will implement the PCMH model developed by the Commonwealth Fund's Safety Net Medical Home Initiative for rural and impoverished areas of Coryell County.

Process Milestones selected:

P-1. Implement the medical home model in primary care clinics

P-1.1. Increase the number of primary care clinics using medical home model

P-2. Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

P-2.1. Metric: Performing Provider policies on medical home

P-2.1.a. Data Source: Performing provider's "Policies and Procedures" documents

P-5. Milestone: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. 5.

P-5.1. Metric: Determine Panel size

P-5.1.a. Data Source: Panel size determination tool, patient registry, EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for proactive panel management

P-6. Milestone: Establish criteria for medical home assignment

P-6.1. Metric: Medical home assignment criteria

P-6.1.a. Data Source: Submission of medical home assignment criteria, such as patients with specified chronic conditions; patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high users of health care services; and patients with particular socio-economic, linguistic, and physical needs

P-14. Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

P-14.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by RHP.

P-14.1.a. Data Source: Documentation of semiannual meetings including meetings agendas, slides from presentations, and/or meeting notes.

Improvement Milestones selected:

I-12. Based on criteria, improve the number of eligible patients that are assigned to the medical homes.

I-12.1. Metric: Number of percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider.

I-12.1.c. Data Source: Practice management system, EHR, or other documentation as designated by Performing provider.

I-17. Medical home providers population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care.

I-17.1. Metric: Reminders for patient preventive services

I-17.1.c. Data Source: Registry, or other documentation as designated by Performing Provider.

Related Category 3 Outcome Measure(s)

Through the implementation of the medical home, patients will receive more coordinated and preventive care, resulting in reduced emergency room visits.

OD-9 Right Care, Right Setting

IT-9.2 ED appropriate utilization (stand-alone measure)

- Reduce all ED visits (including ACSC)

Reasons for selecting the outcomes measures:

Based on our ER utilization data, CMHS believes it can significantly impact the number of ER visits for non-emergent care.

Relationship to other Projects

The medical home model will be utilized in the expanded primary care clinic to provide better access to care (134772611.1.4). Expansion of Specialty Care (134772611.1.5) will also increase the ability of the medical home care team to provide an integrated multi-specialty approach to care.

Relationship to other Performing Providers' Projects in the RHP

There are no other PCMH projects in Region 16.

Plan for Learning Collaborative

Coryell Medical Clinic/ Project team will meet monthly to discuss the current status of projects related to expansion of specialty care. Learning collaborations offer the team an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
5. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
6. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).
7. It should use metrics to measure its success such as:
   - Rate of testing

- Rate of spread
- Time from idea to full implementation
- Commitment rate (rate at which 50% of organizations take action for any specific request)
- Number of questions asked per day

Project Valuation

CMHS will implement the PCMH model in its rural health clinics to serve the Indigent and Medicaid Population (6,500) as well as patients who are considered high utilizers of the emergency room. The PCMH will allow patients better access to care during normal business hours, evenings and weekends. Care coordination will be enhanced due to a redesign of staff responsibilities to meet the needs of the population enrolled in the PCMH. CMHS will establish patient criteria and implement the medical home model by DY3. In DY4, 100 unique patients will be assigned to a PCMH and in DY5, 200 unique patients will be assigned to a medical home. Of these patients, 50% will receive communication regarding preventive health screenings in DY 4 and 75% will receive reminders in DY5.

Project valuation is based upon the number of eligible Indigent and Medicaid recipients in Coryell County, the lack of available primary care and predominant chronic conditions in the community. According to ER utilization data at CMHS, more than 4,000 patient visits could have been redirected to a more appropriate level of care. The average ER visit costs $1,100 which would result in savings of over $4,000,000. This does not include the cost savings associated with better care coordination and case management that would result from the implementation of the PCMH.

Old: 134772611.2.1/ New: 134772611.2.5	2.1.3	2.1.3.A-F	Implement Medical Home in Rural Area	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	IT-9.2	Old:134772611.3.6/ New:134772611.3.18	ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff. Metric 1 [P-2.1]: Performing Provider policies on medical home Goal: Policies finalized Data Source: [P-2.1.a]: Performing provider's "Policies and Procedures" documents Milestone 1 Estimated Incentive Payment: $297,982	**Milestone 3** [P-5]: Milestone: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. Metric 1: [P-5.1]: Metric:		**Milestone 6** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1]: Metric: Number of percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider. Baseline: 0 Goal: 100 Data Source: [I-12.1.c]: Practice management system, EHR, or other documentation as designated by Performing provider. Milestone 6 Estimated Incentive Payment: $217,353 **Milestone 7** [I-17]: Medical	**Milestone 9** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1]: Metric: Number of percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider. Baseline: 100 Goal: 200 Data Source: [I-12.1.c]: Practice management system, EHR, or other documentation as designated by Performing provider. Milestone 9 Estimated Incentive Payment: $179,553 **Milestone 10** [I-17]: Medical

Old: 134772611.2.1/ New: 134772611.2.5	2.1.3	2.1.3.A-F	Implement Medical Home in Rural Area	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	IT-9.2	Old:134772611.3.6/ New:134772611.3.18	ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-6]: Milestone: Establish criteria for medical home assignment Metric 1 [P-6.1]: Medical home assignment criteria Goal: Criteria Established Data Source: [P-6.1.a]: Submission of medical home assignment criteria, such as patients with specified chronic conditions; patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high users of health care services; and patients with particular socio-economic, linguistic, and physical needs Milestone 2 Estimated Incentive Payment: $297,982	Determine Panel size Goal: Panel size finalized Data Source: [P-5.1.a]: Panel size determination tool, patient registry, EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for proactive panel management Milestone 3 Estimated Incentive Payment: $216,723 **Milestone 4** [P-1]: Implement the medical home model in primary care clinics Metric 1 [P-1.1]: Increase the number of primary care clinics using medical home model Baseline: 0 clinics Goal: 1 clinic Data Source: Clinic documentation		home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Metric 1 [I-17.1]: Reminders for patient preventive services Baseline:0 receive communication Goal: 50% of PCMH patients in registry that need preventive service receives communication (100% = 100) Data Source: [I-17.1.c]: Registry, or other documentation as designated by Performing Provider. Milestone 7 Estimated Incentive Payment: $217,353 **Milestone 8** [P-14]: Quality Improvement Milestone:	home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Metric 1 [I-17.1]: Reminders for patient preventive services Baseline: 50% receive communication Goal: 75% of PCMH patients in registry that need preventive service receives communication (100% = 200) Data Source: [I-17.1.c]: Registry, or other documentation as designated by Performing Provider. Milestone 10 Estimated Incentive Payment: $179,553 **Milestone 11** [P-14]: Quality Improvement Milestone:

Old: 134772611.2.1/ New: 134772611.2.5	2.1.3	2.1.3.A-F	Implement Medical Home in Rural Area	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	IT-9.2	Old:134772611.3.6/ New:134772611.3.18	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 4 Estimated Incentive Payment: $216,723 **Milestone 5** [P-14]: Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.		Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-14.1]: Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings scheduled Data Source: [P-14.1.a].	Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-14.1]: Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings scheduled Data Source: [P-14.1.a]

Old: 134772611.2.1/ New: 134772611.2.5	2.1.3	2.1.3.A-F	Implement Medical Home in Rural Area	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	IT-9.2	Old:134772611.3.6/ New:134772611.3.18	ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 1 [P-14.1]: Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings scheduled Data Source: [P-14.1.a]. Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $216,723		Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $217,353	Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 11 Estimated Incentive Payment: $179,553
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $595,964	Year 3 Estimated Milestone Bundle Amount: $650,169		Year 4 Estimated Milestone Bundle Amount: $652,059	Year 5 Estimated Milestone Bundle Amount: $538,659
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $2,436,851				

Category 2: Innovation and Redesign
Project Option: 2.6.3 Engage community health workers in an evidence-based program to increase health literacy
Coryell Memorial Healthcare System/134772611
Old: 134772611.2.2/ New: 134772611.2.6 Implement Evidence-based Health Promotion Program
Project Summary – Pass 3b

- Provider: Coryell Memorial Healthcare System (CMHS) is the performing provider for the regional project. Coryell Memorial Hospital is a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). Coryell Memorial Healthcare System (CMHS) operates two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. The total population of Medicaid, Indigent, and Uninsured in RHP 16 is over 85,000.
- Interventions: This project will implement a health literacy program utilizing trained community health workers in coordination with local healthcare providers to increase health literacy in the Medicaid, Uninsured, and Indigent Populations. This project will serve all 7 counties and include interaction with and support of healthcare providers in all counties in RHP 16. CMHS will delegate oversight of the health literacy program to Texas A&M Agri-Life Extension (TAMU) who will provide leadership to a RHP 16 Task Force for Health Literacy. TAMU is a state-wide system with more than 250 offices and 900 professional educators. Its mission is to improve the lives of all people through community-based education
- Need for Project: A coordinated, region-wide health literacy project utilizing community health workers does not exist in Central Texas. Minority men and women who are currently Medicaid, Indigent or Uninsured typically have lower health literacy scores.
- Medicaid and Uninsured Target Population: The target population will be low income minority families in RHP 16. In 2012, 30.7% of all RHP16 was considered Hispanic or African-American whereas these ethnic groups represented a much higher percentage of Medicaid recipients. Participants will be selected based on current health status and health literacy scores. Community Health Workers along with local healthcare providers will work directly with the target population (but will impact many more in the communities we serve) and the project is expected to reach 450 unique participants by DY5.
- Category 1 or 2 expected patient benefits: The number of participants served will increase each year with a baseline established in DY3 of 150 unique participants and increasing each year by 150 (150 unique participants in DY 4 and 150 unique participants in DY5).
- Category 3 Outcomes: Improve utilization rates of clinical preventive services for minority population: IT-11.3 30% of participants in DY3 will receive clinical preventive screenings for Diabetes Mellitus, High Blood Pressure and Lipid Disorders, 20% in DY4 and 40% in DY5.

Category 2: Innovation and Redesign
Project Option: 2.6.3 Engage community health workers in an evidence-based program to increase health literacy
Coryell Memorial Healthcare System/134772611
Old: 134772611.2.2/ New: 134772611.2.6 Implement Evidence-based Health Promotion Program

Project Description

Coryell Memorial Healthcare System (CMHS), in partnership with Texas A&M Agri-Life Extension Service (TAMU), will work together to administer a regional health promotion program utilizing community health workers designed to empower individuals and families and improve health literacy across the region. This project will benefit all counties in RHP 16. The target population will be low income minority families in RHP 16. In 2012, 30.7% of all RHP16 was considered Hispanic or African-American whereas these ethnic groups represented a much higher percentage of Medicaid recipients (more than 70%) statewide. In RHP 16, there are more than 57,000 people enrolled in Medicaid alone. Participants will be selected from this population based on current health status and health literacy scores. Those particularly at risk are racial and ethnic minorities, people with minimal education and considered "low income", non-English speaking individuals and families, and those with chronic health conditions (www.health.gov/communication/literacy/quickguide). The project will be designed to address people's ability to navigate the healthcare system, understand health insurance coverage, participate in self-care and decision making, understand chronic disease management, other health related topics and risks associated with lifestyle choices. The project will include the use of written materials using "plain language" and culturally appropriate communication that speaks to a diverse population. Services will be provided by Community Health Workers (CHW) trained by TAMU working together with local healthcare providers in the hospitals and clinics. CHWs create a bridge between providers of health care services and community and social services. CHWs will live in the communities they serve and recognize cultural barriers to understanding and navigating the healthcare system. The program will specifically address current health issues that exist within certain cultures (diabetes), health issues related to emergency room abuse, and overall health education within each community in group or home settings. The health literacy program will be "branded" as a regional effort on behalf of RHP 16 to provide the targeted population as well as the entire region with a resource for information, assistance and guidance towards a healthier future for themselves and their families. The number of participants served will increase each year with a baseline established in DY3 of 150 unique participants and increasing each year by 150 (150 unique participants in DY 4 and 150 unique participants in DY5).

Examples of evidence-based projects:

1) Identify minority participants with low health literacy within the Medicaid and Uninsured target population. According to the Agency for Healthcare Research and Quality (AHRQ), we can identify persons with limited health literacy by simply asking a few questions during a clinic visit, hospital admission, or by telephone. Individuals who ask the questions are bilingual and written questions are provided in English or Spanish.

2) Once these individuals have been identified, they will participate in several health literacy and self-management programs by telephone, in group settings and the home. Groups may be formed to address specific health related issues such as diabetes, asthma and heart disease. CHWs will work with local hospitals to identify low literacy patients so that they can better manage their healthcare once discharged through the use of health literacy training.

The health literacy program will utilize tools described in the Health Literate Care Model and AHRQ's Health Literacy Universal Precautions Toolkit. Outreach methods within the community and healthcare system will be critical to identify and recruit participants so that connections can be made for meaningful change. The program will provide coordinated outreach, intervention and follow-up with local healthcare providers to ensure participants receive the support they need.

Additionally, the CHWs will:

- Facilitate access to preventive care services
- Provide connection to community resources
- Develop relationships with families to ensure they develop the necessary skills to improve their health status and self-sufficiency
- Provide basic health education on a range of topics to include diabetes prevention and treatment, substance abuse and child development
- Ensure parents receive education concerning childhood immunizations and regular health care

Goals:

- RHP 16 will develop an evidence-based regional health literacy program designed to address issues related to low literacy which is responsible for poor health outcomes.
- CHWs will be utilized to deliver health education, provide health screenings, detection and improve basic health knowledge
- Quality will be improved by contributing to continuity of care and patient-provider communication

Relationship to Regional Goals:

A regional task force for RHP 16 will design a health literacy program to be implemented in DY3. The task force will include additional stakeholders in the region who can provide valuable input and feedback with regards to the targeted population. This is part of our strategy to be inclusive and transparent as we work to advance the goals of the Triple Aim: right care, right place, and right time. RHP16 has chosen to focus on strategies related to health literacy, including wellness and prevention. We anticipate that projects related to health promotion will reduce the burden on physicians and emergency departments and improve long term health outcomes across the region. RHP 16, 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.

5 Year Expected Outcome:
RHP 16 will achieve a regional identity as a collaboration between hospitals and other providers that promotes health literacy. Community Health Workers (CHW) and healthcare providers will coordinate activities that focus on appropriate communication methods to the target population. Utilizing the expertise of local providers and CHW, we can reach the target population by going to the "front lines" to address common health issues.

Challenges:
It can be difficult to understand the reasons behind choices people make regarding their health. RHP 16 will need to develop a method of keeping the population engaged in the program and understand what motivates and inspires others to make changes that will benefit their short and long term health status.

Starting Point/ Baseline
Currently, TAMU has agents and offices that serve all counties in Region 16. They will employ and train the community health workers who will provide services to the target population in RHP 16. The agents have a working relationship with county government, county services, local healthcare providers and social services. The programs will be unique to RHP 16 and "branded" as a regional initiative. They will work closely with local providers to identify the target population and ensure patients are enrolled and receiving services. This would include culturally sensitive delivery methods through written and oral communication. We will create a regional task force led by TAMU in DY2 to determine the priorities of the region as indicated in our Community Needs Assessment, identify participants, develop a strategic plan, and establish a schedule for ongoing communication and learning collaboratives for projects implemented in DY3 – DY5.

Rationale:
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 healthcare 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. We will oversee a program designed to

address health literacy in the region. It will be a collaborative effort between the physician community, community health workers, schools, businesses and other health care organizations. Information sharing, program support, program evaluation, and continuing education will be used to improve the existing health care delivery system.

Unique community need identification numbers the project addresses:

CNA: 001 Adult Diabetes
CNA: 002 Adult Obesity
CNA: 003 Low Income Obesity
CNA: 004 Preventable Hospitalizations

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

A regional health promotion/ health literacy program does not currently exist. As a collaborative effort between all RHP 16 hospitals, physicians and TAMU located in each county, transformation can occur by removing barriers related to competitive forces in order to bring continuity to the region and focus on the population as a whole.

Process Milestones selected:

- P-1. Milestone: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community
    - Metric: P-2.1. Document innovational strategy and plan
        - Data Source: Performing Provider evidence of innovational plan
- P-3. Milestone: Implement, document and test an evidence-based innovative project for targeted population
    - Metric: P-3.1. Document implementation strategy and testing outcomes.
        - Data Source: Documentation of implementation TBD by Performing Provider
- P-8. Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.
    - P-8.1. 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.

Improvement Milestones selected:

- 1-6. Milestone: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model.
    - Metric: 100 unique participants each year
        - Data Source: 1-6.1.c. Patient Records

Quality Improvement Milestone selected:
Related Category 3 Outcome Measure(s)
OD-11 Addressing Health Disparities in Minority Populations
IT-6.3 Improve utilization rates of clinical preventive services:
High Blood Pressure Screening
Lipid Disorders Screening
Type 2 Diabetes Milletus Screening.

Reasons for selecting the outcomes measures:
Using screening and testing programs recommended by the U.S. Preventive Services Task Force (USPSTF), CMHS hopes to prevent or reduce the risks associated with heart disease, diabetes, infectious diseases and other conditions that impact the health of adults, particularly those at greatest risk of acquiring long term complications due to inadequate primary care or inability to navigate the healthcare system.

Relationship to other Projects
Health promotions/health literacy programs support the efforts of the primary care clinic (134772611.1.4), expansion of specialty care (134772611.1.5), and patient centered medical home (134772611.2.5).

Relationship to other Performing Providers' Projects in the RHP
The health promotion program is a regional project and will be utilized in all counties who participate in the program.

Plan for Learning Collaborative
RHP 16 will meet monthly to discuss the current status of projects and issues related to projects that affect local and regional populations. Learning collaborations offer the region an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.

2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should support a small, lightweight web site to help site share ideas and simple data over time.
5. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
6. It should employ individuals (regional "innovator agents") to travel from site to site in the network to (a) rapidly answer practical questions about implementation and (b) harvest good ideas and practices that they systematically spread to others. The regional "innovator agents" should all attend the same initial training in improvement tools and skills organized by the State or RHP and should receive periodic continuing education on improvement.
7. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
8. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).
9. It should use metrics to measure its success such as:
    - Rate of testing
    - Rate of spread
    - Time from idea to full implementation
    - Commitment rate (rate at which 50% of organizations take action for any specific request)
    - Number of questions asked per day
    - Network affinity/reported affection for the network

Project Valuation

In 2012, 30.7% of all RHP16 was considered Hispanic or African-American whereas these ethnic groups represented a much higher percentage of Medicaid recipients (more than 70%) statewide. In RHP 16, there are more than 57,000 people enrolled in Medicaid alone. The target population will be those enrolled in Medicaid or considered indigent or uninsured. The number of minorities varies from county to county but each county will be given proportionate representation among those enrolled in the program. The number of participants enrolled will increase each year with a baseline established in DY3 of 150 unique participants and increasing each year by 150 (150 unique participants in DY 4 and 150 unique participants in DY5). Based on RHP 16 statistics, each county has a significant population of minorities that would potentially qualify for the program. The RHP 16 Regional Task Force will develop a method to reach members that would most benefit from a health literacy program. This project will be regionally based and offered as a resource to all members of the program in the targeted populations in each county. We also anticipate that the program will

reach far beyond the target population as it becomes recognized in the region as a source of support and information. Cost savings will be achieved by encouraging improved life-long health habits and lower risk factors as well as empowering individuals to take responsibility for their healthcare decisions. The incidence of Type 2 diabetes continues to grow at an alarming rate while many who are at risk or not yet diagnosed do not understand the condition itself, how to prevent diabetes, or simply that type 2 diabetes is a dangerous condition.

More than 75% of health care costs are a result of chronic conditions. This equates to almost $7,900 per person with a chronic disease (www.cdc.gov). The Trust for America's Health concluded that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within five years. This is a return of $5.60 for every $1. In Texas, the return is 4.7 to 1. (Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities [Internet]. Washington, D.C.: Trust for America's Health; 2008. Available from: http:// healthyamericans.org/reports/prevention08/). The World Health Organization has estimated that if the major risk factors for chronic disease were eliminated, at least 80 percent of all heart disease, stroke, and Type 2 diabetes would be prevented, and more than 40 percent of cancer cases would be prevented. Average hospital charges per day in Texas for Type 2 Diabetes in 2008 was $5,161. (Texas Chronic Disease Burder Report, April 2010). In 2010, local hospitals experienced more than 500 admissions for Type 2 Diabetes which resulted in costs of more than $2,500,000 per day.

With regards to CHWs involved in cancer outreach, it has been determined that the lifetime benefits of a CHW is $12,348 per individual served by a CHW, or $851,410 for every CHW that serves at least 69 individuals per year. (Wilder Research, June 2012). This return on investment is evident through the value of early screenings, additional taxes paid during extended life expectancy and savings from the use of urgent and emergency care. This would also be true of other chronic and life threatening illnesses that can be avoided or minimized through improved health literacy.

Old:134772611.2.2 / New: 134772611.2.6	2.6.3	N/A	Regional Health Promotion/Health Literacy Program	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	*IT-11.3*	*Old:134772611.3.7/ New: 134772611.3.19 New: 134772611.3.20 New: 134772611.3.21*	*Addressing Health Disparities in Minority Populations*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. Metric 1 Metric: [P-1.1]: Document innovational strategy and plan Goal: Strategic plan complete Data Source: [P-1.1.a]: Performing Provider evidence of innovational plan Milestone 1 Estimated	**Milestone 2** [P-3]: Implement, document and test an evidence-based innovative project for targeted population P-3.1 Metric: Document implementation strategy and testing outcomes. Goal: Project Implementation and Testing complete Data Source: Performing Provider documentation of implementation Milestone 2 Estimated Incentive Payment: $464,404 **Milestone 3** [P-8]: Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or		**Milestone 5** [1-6]: Number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Participant enrollment Baseline: 150 Goal: 150 additional unique participants - Medicaid and Uninsured Data Source [1-6.1.c]: Patient Records Milestone 4 Estimated Incentive Payment: $698,630 **Milestone 6** [P-8]: Quality Improvement Milestone: Participate in face-to-face	**Milestone 7** [1-6]: Number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Participant enrollment Baseline: 300 Goal: 150 additional unique participants - Medicaid and Uninsured Data Source [1-6.1.c]: Patient Records Milestone 6 Estimated Incentive Payment: $577,129.50 **Milestone 8** [P-8]: Quality Improvement Milestone:

Old:134772611.2.2 / New: 134772611.2.6	2.6.3	N/A	Regional Health Promotion/Health Literacy Program	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	*IT-11.3*	*Old:134772611.3.7/ New: 134772611.3.19 New: 134772611.3.20 New: 134772611.3.21*	*Addressing Health Disparities in Minority Populations*	
Year 2 (10/1/2012 – 9/30/2013)	**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: $1,277,066	seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.		learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Metric: Participate in semi-annual face-to-face meetings or seminars	Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Metric: Participate in semi-annual

Old:134772611.2.2 / New: 134772611.2.6	2.6.3	N/A	Regional Health Promotion/Health Literacy Program	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	*IT-11.3*	*Old:134772611.3.7/ New: 134772611.3.19 New: 134772611.3.20 New: 134772611.3.21*	*Addressing Health Disparities in Minority Populations*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Goal: Meetings/ Seminars complete Data Source: [P-8.1.a]. Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment: $464,403 Milestone 4 [1-6]: Number of patients in defined population receiving innovative intervention consistent with evidence-based model. <u>Metric 1</u> [I-6.1]: Participant enrollment Baseline: 0 Goal: 150 unique participants		organized by the RHP. Goal: Meetings/ Seminars complete Data Source: [P-3.1.a]: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $698,630	face-to-face meetings or seminars organized by the RHP. Goal: Meetings/ Seminars complete Data Source: [P-8.1.a] Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: $577,129.50

Old:134772611.2.2 / New: 134772611.2.6	**2.6.3**	**N/A**	**Regional Health Promotion/Health Literacy Program**	
Coryell Memorial Hospital				**134772611**
Related Category 3 Outcome Measure(s):	*IT-11.3*	*Old:134772611.3.7/ New: 134772611.3.19 New: 134772611.3.20 New: 134772611.3.21*	*Addressing Health Disparities in Minority Populations*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	- Medicaid and Uninsured Data Source [1-6.1.c]: Patient Records Milestone 4 Estimated Incentive Payment: $464,403			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,277,066	Year 3 Estimated Milestone Bundle Amount: $1,393,210		Year 4 Estimated Milestone Bundle Amount: $1,397,260	Year 5 Estimated Milestone Bundle Amount: $1,154,259
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $5,221,795				

Category 2: Innovation and Redesign
Project Option: 2.7.5 Implement Innovative Evidence-based Disease Prevention Program
Coryell Memorial Healthcare System/134772611
Old: 134772611.2.3/ New: 134772611.2.7 Reduce and Prevent Obesity in Children and Adolescents

Project Summary – Pass 3b

- Provider: Coryell Memorial Healthcare System (CMHS) is the performing provider for the regional project. This project will serve all 7 counties and include interaction with and support of healthcare providers in all counties in RHP 16. Coryell Memorial Hospital is a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). Coryell Memorial Healthcare System (CMHS) operates two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. The total population of Medicaid, CHIP and Uninsured in RHP 16 is over 85,000.
- Interventions: RHP 16 will develop a program using evidence based models to reduce and prevent childhood obesity and introduced in all counties in RHP 16. A select group of children and their families will be targeted during the initial phase of the program. The Pediatric Quality of Life Assessment tool will be administered to enrolled participants. CMHS will delegate oversight of the health literacy program to Texas A&M Agri-Life Extension. TAMU is a state-wide system with more than 250 offices and 900 professional educators. Its mission is to improve the lives of all people through community-based education. A RHP 16 Regional Task Force to address childhood obesity will be transparent and inclusive of all stakeholders.
- Need for Project: Due to the lack of available resources and the number of Medicaid and uninsured in RHP 16, many families do not have access to information or programs that will improve their quality of life. This project addresses childhood obesity in local communities and closer to home by introducing interventions in local schools, after school programs and clubs, and primary care clinics.
- Medicaid and Uninsured Target Population: The target population is children and adolescents who reside within the 7 counties in RHP 16. These children will be selected from the population who are currently enrolled in Medicaid or CHIP but the impact will be far greater in the community at-large. The total number of children in CHIP for RHP 16 is 7,604 and 38,000 in Medicaid.
- Category 1 or 2 expected patient benefits: The goal is to recruit 150 initial participants in the program in DY3 and reach 150 new unique participants in DY4 and another 150 in DY5 for a total of 450 participants.
- Category 3 outcomes: RHP 16 will improve quality of life scores by 1% over the baseline in DY4 and 3% in DY5 using the Pediatric Quality of Life assessment tool for enrolled participants.

Category 2: Innovation and Redesign

Project Option: 2.7.5 Implement Innovative Evidence-based Disease Prevention Program

Coryell Memorial Healthcare System/134772611

Old: 134772611.2.3/ New: 134772611.2.7 Reduce and Prevent Obesity in Children and Adolescents

Project Description

Coryell Memorial Healthcare System (CMHS) has partnered with Texas A&M Agri-Life Extension Services (TAMU) to implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents. TAMU will provide the leadership to establish a regional task force and develop and implement a regional disease prevention program targeting childhood and adolescent obesity designed to empower individuals and families to adopt healthy behaviors, improve health status and manage chronic healthcare conditions. According to the Texas Department of State Health Service's 2009 Health Facts, more than 58,000 Medicaid patients are served in RHP 16 and the majority are children under the age of 19. Several counties are considered "rural", and preventive health/disease prevention education is lacking or non-existent for this population. The disease prevention program will target Medicaid and CHIP enrollees and the indigent population in order to build healthier lives throughout the region. The disease prevention delivery model will include educational services and interventions provided by County Extension Agents of TAMU, community health representatives, and healthcare providers at clinics throughout the region. These individuals will work closely together to identify children who need additional health coaching and education. Instructional methodologies include educational series, one-on-one counseling, fact sheets, health screenings, school curriculum programs, youth educational programs and training for professionals. Each county within the region will determine the intensity of services applicable to their target population of Medicaid and Indigent children and adolescents based on list of approved programs developed by the RHP16 Task Force for Childhood Obesity. A selection of programs would include those that specifically target children in preschool and/or grade school and teen-agers as well as those programs that provide general support and education to more intense therapy. A regional database will be maintained to track the progress of children enrolled in weight management, nutrition or exercise programs to determine outcomes and improvement strategies. RHP16 will recruit 150 initial participants in the program in DY3 and reach 150 new unique participants in DY4 and another 150 in DY5 for a total of 450 participants.

Goals:

- Work collaboratively between community stakeholders such as hospitals, physicians, school based clinics and other healthcare providers to develop a region-wide disease prevention and treatment program targeting childhood and adolescent obesity.
- Make a significant impact on children's health through education and training not only for the children but for the entire family.

- Quality of life scores will improve for the target population

Relationship to Regional Goals:
A regional task force for RHP 16 will design a disease prevention program designed to address obesity in children and adolescents beginning in DY2. The task force will include additional stakeholders in the region who can provide valuable input and feedback with regards to the targeted population. This is part of our strategy to be inclusive and transparent as we work to advance the goals of the Triple Aim: right care, right place, and right time. RHP16 has chosen to focus on increasing strategies related to disease prevention, specifically the obesity epidemic. We anticipate that these evidence-based projects will reduce future healthcare costs related to obesity and improve health outcomes across the region. The selected DSRIP projects will begin to build the infrastructure needed for improved care coordination and chronic disease management. RHP 16, again, has identified a project that seeks to bend the cost curve by engaging the entire region in an organized and unified project which is foundational to the transformation of the healthcare system for patients and for providers.

Challenge: Although education and tools will be readily available to participants in the program, we cannot guarantee that the population will actively participate. It will be critical to include families in the program so that proper nutrition and exercise guidelines can be followed at home. The project will require additional staff and space which will take time to develop and acquire.

5-year expected outcomes: Disease prevention programs, specifically those addressing childhood obesity, will become common among youth in the region. They will be integrated in places where youth can be engaged such as schools, clubs, sports and academic centers. It will influence the establishment of obesity related health clubs and clinics that will promote disease prevention rather than disease treatment.

Starting Point/ Baseline
Currently, TAMU has agents and offices that serve all counties in Region 16. They currently do not have regional, collaborative obesity prevention program that targets children and adolescents as it relates to the objectives of the Medicaid waiver program. TAMU has a working relationship with county government, county services, 4-H clubs, and local school districts. The disease prevention programs specifically related to obesity will be new and “branded” as a RHP 16 initiative. The programs will target school aged children, including those in Head Start programs. We will create a regional task force led by TAMU in DY2 to identify the target population, finalize the strategic plan, and establish a schedule for ongoing communication and feedback as the program is introduced in DY3 – DY5.

Rationale:

More than 31% of the children in RHP 16 live below the poverty rate and due to the majority of counties being designated as HPSA and MUA/P, access is limited and disparities exist for many children in the region. Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. It can help manage and improve the health status of a defined population over the entire course of a disease.
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. The National Prevention Council strategy for Disease Prevention focuses on four areas: building healthy and safe community environments, expanding quality preventive services in clinical and community settings, helping people make healthy choices, and eliminating health disparities. To achieve these aims, the strategy identifies seven evidence-based recommendations that are likely to reduce the leading cause of preventable death and major illness, including healthy eating, active living, injury and violence-free living, and mental and emotional well-being.

Unique community need identification numbers the project addresses:

- CNA-001 – Diabetes rate
- CNA-003 – Childhood obesity
- CNA-005 – Shortage of primary care providers

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

Process Milestones selected:

P-1. Development of innovative evidence-based project for targeted population

P-1.1. Metric: Document innovational strategy and plan.

P-1.1.a. Data Source: Performing Provider evidence of innovational plan.

P-2. Implement evidence-based innovational project for targeted population.

P-2.1. Metric: Document Implementation strategy and testing outcomes.

P-2.1.a. Performing Provider contract or other documentation of implementation TBD by Performing Provider.

P-7. Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

P-7.1 Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

P-7.1.a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Improve Milestones selected:

I-5. 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

I-5.1.c. Data Source: Documentation of target population reached, as designated in the project plan.

Related Category 3 Outcome Measure(s)

OD-10 Quality of Life/ Functional Status

IT-10.1 Quality of Life

Reasons for selecting the outcomes measures:

QOL is considered an industry standard to measure symptoms and functional status. The survey will be administered prior to the start of the program which will enable RHP16 to establish a program tailored to the needs of the community.

Relationship to other Projects

Disease prevention programs can support the efforts of the expanded primary care clinic (134772611.1.4), expansion of specialists in the region (134772611.1.5), and patient-centered medical home model (134772611.2.5).

Relationship to other Performing Providers' Projects in the RHP

The disease prevention program is a regional project and will be utilized in all counties who participate in the program.

Plan for Learning Collaborative

RHP 16 will meet monthly to discuss the current status of projects and issues related to projects that affect local and regional populations. Learning collaborations offer the region an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should support a small, lightweight web site to help site share ideas and simple data over time.

5. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
6. It should employ individuals (regional “innovator agents”) to travel from site to site in the network to (a) rapidly answer practical questions about implementation and (b) harvest good ideas and practices that they systematically spread to others. The regional “innovator agents” should all attend the same initial training in improvement tools and skills organized by the State or RHP and should receive periodic continuing education on improvement.
7. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
8. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels (“raise the bar” on performance).
9. It should use metrics to measure its success such as:

- Rate of testing
- Rate of spread
- Time from idea to full implementation
- Commitment rate (rate at which 50% of organizations take action for any specific request)
- Number of questions asked per day
- Network affinity/reported affection for the network

Project Valuation

This project seeks to recruit 150 initial participants in the program in DY3 and reach 150 new unique participants in DY4 and another 150 in DY5 for a total of 450 participants. Participants will be children and adolescents in each county that would qualify for and benefit from a nutrition/ wellness program to reduce obesity. The initial target population would be those children enrolled in Medicaid and CHIP across RHP 16. At this time, more than 58,000 people in RHP 16 are considered Medicaid and the majority of those are children under the age of 19. According to the Texas Education Agency and School District Snapshots, several school districts in RHP 16 have a significant population of economically disadvantaged students. For example, the percentage of economically disadvantaged students in Falls County is 90%, 87% at Waco ISD/ McLennan County, and 48% in Coryell County. Those who are economically disadvantaged typically have limited access to healthy food, are not enrolled in after school programs that offer wellness and exercise programs and have limited ability to access preventive health services as some are considered homeless.

The current Medicaid population, low number of available physicians and predominant chronic conditions in Region 16 indicate RHP 16 would benefit from disease prevention programs that implement preventive and wellness initiatives to prevent future chronic illness and premature death. According to the Texas Department of State Health Services (DSHS) Obesity data sheet (2010), in 2009 more than 15% of Texas high-school students were reported to be overweight and more than 13% were considered obese. This percentage is even higher among low-income children, 2-5 years old. The overall prevalence of overweight and obesity in Texas

schoolchildren was 42% for fourth-graders, 39% for eighth-graders and 36% for eleventh-graders in 2004-2005. According to the Youth Risk Behavior Surveillance System (YRBSS) in 2009, 39.3% of Texas adolescents in grades 9-12 watch television more than 3 hours per day.

Obesity has lifelong health consequences and is one of the factors that contribute to the fact that our children today may actually face a shorter life span that their parents.[6] Costs to the child include health and medical costs. In 2005, obesity-associated hospital costs for children were $237.6 million per year[7]. There are also costs associated with absenteeism and low performance at school and at work. A study associated with middle school children in a Texas urban school district discovered that those classified as obese had lower scores in Math, Science, and the TAKS test.[8] Although these can also be associated with lower socioeconomic status and other disadvantages, it is understood that obesity among children, particularly adolescents, can lead to lower academic performance, lower self-esteem and eventually lower expectations and reduced productivity as an adult.

Based on these statistics, DSHS has indicated that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and eliminate tobacco usage, Texas could save $1 billion annually within five years through reductions in healthcare spending. This is a return of $4.70 for every $1 spent.

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[6] Koplan, J.P, Liverman, C.T, and Kraak, V.I. (Eds) (2005). Preventing Childhood Obesity: Health in the Balance. Institute of Medicine, The National Academies Press, p. 23.

[7] Transande, L. Liu, Y Fryer, G. and Weitzman, M. (July 2009). "Effects of Childhood Obesity on Hospital Care and Costs, 1999-2005." *Health Affairs* 28(4) w751-w760.

[8] Slate, J., Clark, D., and Viglietti, G.C. (2008) "Obesity Among Middle School Children: More cause for school leaders' concern?" National Council for Professors of Educational Administration, retrieved from http://cnx.org/content/m17414/1.2/ .

Old: 134772611.2.3/ New: 134772611.2.7	2.7.5	2.7.5	DISEASE PREVENTION – CHILDHOOD OBESITY	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*Old: 134772611.3.8/ New: 134772611.3.22*	*Quality of Life/Functional Status*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Development of innovative evidence-based project for targeted population Metric 1 [P-1.1]: Document innovational strategy and plan. Goal: Strategic Plan Draft Data Source: [P-1.1.a]: Performing Provider evidence of innovational plan. Milestone 1 Estimated Incentive Payment: $1,277,066	**Milestone 2** [P-1]: Development of innovative evidence-based project for targeted population Metric 1 [P-1.1]: Document innovational strategy and plan. Goal: Finalize Strategic Plan Data Source: [P-1.1.a]: Performing Provider evidence of innovational plan. Milestone 2 Estimated Incentive Payment: $464,403.33 **Milestone 3** [P-2]: Implement evidence-based innovational project for targeted population. Metric 1 [P-2.1]: Metric: Document Implementation strategy and testing outcomes Goal: Select 150 Participants for the program		**Milestone 5** [I-5]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Number of patients receiving intervention Baseline: 150 Goal: 150 new, unique individuals selected in target population (total 300) Data Source: [I-5.1.c]: Documentation of target population reached, as designated in the project plan. Milestone 5 Estimated Incentive Payment: $698,630 **Milestone 6** [P-7]: Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per	**Milestone 7** [I-5]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Number of patients receiving intervention Baseline: 300 Goal: 150 new, unique individuals selected in target population (total 450) Data Source: [I-5.1.c]: Documentation of target population reached, as designated in the project plan. Milestone 7 Estimated Incentive Payment: $577,129.50 **Milestone 8** [P-7]: Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or

Old: 134772611.2.3/ New: 134772611.2.7	2.7.5	2.7.5	DISEASE PREVENTION – CHILDHOOD OBESITY	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*Old: 134772611.3.8/ New: 134772611.3.22*	*Quality of Life/Functional Status*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: [P-2.1.a]: Performing Provider contract or other documentation of implementation TBD by Performing Provider. Milestone 3 Estimated Incentive Payment: $464,403.33 **Milestone 4** [P-7]. Quality Improvement Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for		year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1</u> [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Meeting/ seminars complete Data Source[P-7.1.a.] Documentation of semiannual meetings including meeting agenda,	seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1</u> [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Meeting/ seminars complete Data Source[P-7.1.a.] Documentation of semiannual meetings

Old: 134772611.2.3/ New: 134772611.2.7	2.7.5	2.7.5	DISEASE PREVENTION – CHILDHOOD OBESITY	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*Old: 134772611.3.8/ New: 134772611.3.22*	*Quality of Life/Functional Status*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1</u> [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Meeting/ seminars complete Data Source[P-7.1.a.] Documentation of semiannual meetings including meeting agenda, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $464,403.33		slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $698,630	including meeting agenda, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $577,129.50
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,277,066	Year 3 Estimated Milestone Bundle Amount: $1,393,210		Year 4 Estimated Milestone Bundle Amount: $1,397,260	Year 5 Estimated Milestone Bundle Amount: $1,154,259

Old: 134772611.2.3/ New: 134772611.2.7	2.7.5	2.7.5	DISEASE PREVENTION – CHILDHOOD OBESITY	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*Old: 134772611.3.8/ New: 134772611.3.22*	*Quality of Life/Functional Status*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $5,221,795				

Category 2: Program Innovation and Redesign
Project Option: 2.10.1 Implement a Palliative Care Program
Coryell Memorial Healthcare System/134772611
134772611.2.4 Palliative Care Program

Project Summary

- Provider: Provider: Coryell Memorial Hospital/ Coryell Medical Clinic. Coryell Memorial Hospital is a 25-bed critical access hospital in Gatesville, TX, Coryell County, and it is the only hospital in a county of 72,529 residents (as of 2010). Coryell Memorial Healthcare System (CMHS) operates two primary care clinics, one in Gatesville, TX, and another in Goldthwaite, TX (Mills County). CMHS also provides the community with an independent residential location known as The Oaks as well as skilled nursing services at The Meadows which includes a separate, private unit for Alzheimer's or similar memory loss conditions. 24.7% of the population is considered uninsured (16,043). As of May 2012 (http://www.hhsc.state.tx.us/research/MedicaidEnrollment/me-results.asp), the number of residents in Coryell County with Medicaid was 6,078 of which 4,381 were children under the age of 19. The population of Coryell County in 2010 was 72,529 and has projected growth each year through 2020.
- Interventions: Services provided in the Palliative Care Program will include outpatient office visits, inpatient consults, care planning including DNR preferences, referrals for post discharge support such as home health, and coordination of services with the patient's primary care provider and specialists. We will work with the Palliative Care team at Hillcrest Baptist Medical Center. They act as a central hub for Region 16 for all knowledge and resources related to Palliative Care. The Hillcrest team will provide training to our facility as well as access to their trained staff. The highly trained and specialized providers can help to train and guide our primary care providers to offer the best care for our patients.

- Need for Project: Coryell County has the second highest population in RHP 16 and lacks access to specialists in Palliative Care. Considering the fact that many residents of Coryell County live more than 50 miles from an urban area, it is unlikely that all patients who currently qualify for a palliative care program receive the care they need closer to their home by local caregivers. A palliative care plan across the region should be seamless between facilities but is currently fragmented and inconsistent. In 2009, Coryell County had 390 deaths from all causes including 85 for heart disease, 99 for cancer, 28 for Chronic Lower Respiratory Disease and 17 deaths related to diabetes. Although the inpatient and ER costs associated with their illnesses are unknown, we do know that cost savings could have been achieved had they been enrolled in a palliative care program.
- Medicaid and Uninsured Target Population: Our target population will be patients identified as candidates for a palliative care program who are currently Medicaid, Uninsured or Indigent which represents 30% of the population of Coryell County.

Furthermore, more than 50% of our patients in long term care are dual eligible Medicare/ Medicaid. To determine potential patients that could receive a referral to the palliative service we assumed a 5% rate of total acute care inpatient volume. The capture rate was calculated based on the number of patients that would actually end up using services from the total referred. This capture rate identifies that the number of participants eligible for palliative care could range from an average of 25 - 45 patients per year.

- Category 1 or 2 expected patient benefits: CMHS will minimize transfers to ICUs, stays in the hospital, and patients discharged to the home without follow-up care while maximizing patient transitions to home care, hospice and SNF. By DY4, we expect the transition rate to be 50% for patients enrolled in a palliative care program from acute hospital care into home care, hospice, or a SNF and increase this rate to 75% by DY5.
- Category 3 outcomes:

  IT-13.1 Our goal is to increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD % over baseline by DY4 and DY5.

  IT-13.2 Our goal is to increase the percentage of hospice or palliative care patients with chart documentation of preferences for life sustaining treatments by TBD % over baseline by DY4 and DY5.

  IT-13.5 Our goal is to increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD % over baseline by DY4 and DY5.

Pass 2
Category 2: Program Innovation and Redesign
Project Option: 2.10.1 Implement a Palliative Care Program
Coryell Memorial Healthcare System/134772611
134772611.2.4 Palliative Care Program

Project Description

The Palliative Care project will focus on the delivery of services to patients of Coryell Memorial Healthcare System (CMHS) to provide appropriate and quality end-of-life care. Coryell County has a higher mortality rate for "Deaths from All Causes", specifically cancer and heart disease, than the State of Texas and a growing population of patients with chronic disease and co-morbidities. Our target population will be patients identified as candidates for a palliative care program who are currently Medicaid, Uninsured or Indigent which represents 30% of the population of Coryell County. Furthermore, more than 50% of our patients in long term care are dual eligible Medicare/ Medicaid. Patients currently in the hospital or recently discharged to the home and residents of our skilled nursing and long term care facilities will also be eligible. Addressing care needs and end-of-life decisions is a priority for CMHS to continue supporting the best possible quality of life for the patient and the family throughout the lifespan regardless of prognosis. The principles of implementing a palliative care program will focus on care coordination and evidence-based practice and decision making to ensure that patients receive dignified and culturally appropriate end-of-life care, provided in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

Services provided in the Palliative Care Program will include outpatient office visits, inpatient consults, care planning including DNR preferences, referrals for post discharge support such as home health, and coordination of services with the patient's primary care provider and specialists. We will work with the Palliative Care team at Hillcrest Baptist Medical Center (HBMC). They act as a central hub for Region 16 for all knowledge and resources related to Palliative Care. The Hillcrest team will provide training to our facility as well as access to their trained staff. The highly trained and specialized providers at HBMC can help to train and guide our primary care providers, social services staff and home health providers to offer the best care for our patients. CMHS will provide palliative care options for patients not only admitted to CMHS but those that are transferred to our own SNF and assisted living facilities (in addition to acute care beds, CMHS has an additional 120 beds for skilled nursing, long and short term care and assisted living).

Goals:

- Implement care coordination in the hospital and local community
- Patients will receive dignified and culturally appropriate end-of-life care that prioritizes pain control, social and spiritual care and patient/family preferences
- Improved patient satisfaction

Relationship to Regional Goals:
The relationship between palliative care and the regional goals include the impact on reducing potentially preventable hospitalizations by ensuring that patients are receiving the right care, in the right place, and at the right time. Palliative care offers a focus on quality of life and the holistic view of the patient in an attempt to reduce unnecessary hospitalization and unnecessary use of emergency departments. This project is a regional collaboration between regional community hospitals and HBMC which will further advance our efforts to utilize existing resources in the most efficient and cost effective manner.

5yr Expected Outcomes:
The five year goal for CMHS is to develop a palliative care program with trained providers in protocols and evidence-based practices to treat patients during end-of-life care. This will also include the appropriate transition of patients to the most beneficial setting such as home care, hospice, or skilled nursing facility and the improvement in the patient and family experience.

Challenges:
Patient education and provider training will be critical to the success of the program. IT support for a seamless transfer of information between facilities will be critical. Assistance in addressing the challenges we face in program implementation will be provided through a regional partner, HBMC. This partnership will allow for collaboration on the project and aid in additional resources to fully implement and carry out the palliative care program.

Starting Point/Baseline
A palliative care program does not formally exist at this time. Baseline data will be established in DY3.

Rationale
According to the RHP Planning Protocol for the use of palliative care programs, "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 dementia. Further, some experts have suggested that palliative and hospice care could be more widely embraced for many dying patients…It seems clear that improving care coordination near the end-of-life can improve care for patients with chronic conditions."

Using a model from the Center to Advance Palliative Care, we established reasonable estimates of the impact a Palliative Care Program could serve. To determine potential patients that could receive a referral to the palliative service, we assumed a 5% rate of total acute care inpatient volume. According to the estimation model from the Center to Advance Palliative Care, results that

exceed projected volumes may be the consequence of 1) hospital demographics and practice style 2) current performance in case management in the hospital, and the opportunities for improvement 3) success of the program's marketing and outreach activities, and 4) breadth of services offered by the program, including outpatient follow-up. Based upon age demographics and rate of chronic disease we feel this to be a viable service opportunity to offer to our community.

CMHS currently offers hospice options through contracts with external hospice organizations. The hospice provider would work together with the Palliative Care program in order to provide appropriate transitions between the various levels of care. While hospice care is important for patients in their final stages of life, palliative care offers a much wider range of patients the same type of benefits and treatment goals but with much earlier and longer-term intervention periods. Within palliative care, patients received 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.

Required core project components will be fulfilled as follows:

- a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
- b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility
- c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
- 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 population.

The project timeline will follow the HBMC model for accomplishment of core components: (a) In DY2 of the waiver a business plan will be developed and submitted. (b) In DYs 4 and 5, the number of transitions accomplished through the palliative care program will be measured and reported. (c) In DY 4 the patient/family experience survey will be implemented with improved scores in DY5. (d) Quality methodology will be performed based on internal program characteristics and will also be met through collaboration with regional partners in conference calls to discuss best practices, areas of opportunity, care hand-off challenges, available resources, and optimal education/outreach efforts.

Unique community need identification numbers the project addresses:
CNA-004 – Potentially Preventable Hospitalizations
CNA-007 – Inappropriate utilization of Emergency Room

CNA-009 – CMS 30-day Readmission Measures for Chronic Disease

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
A palliative care program does not currently exist in Coryell County.

Related Category 3 Outcome Measure(s)
OD-13 Palliative Care
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
IT-13.2 Treatment Preferences (NQF-1641) (Non-standalone measure)
IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. As a companion project, these outcome measures are also supportive data for HBMC to validate the resources they are providing for the regional partners.

Relationship to other Projects
The Palliative Care Program will correlate with other projects, most specifically the Medical Home project. Palliative care will serve as a compliment to what is being accomplished with the Medical Home project and will allow for a practical avenue in transitioning patients to the correct setting. Palliative care will be an important piece of offering care throughout the lifespan and disease state of our patients.

Relationship to Other Performing Providers' Projects in the RHP
HBMC and several other rural community hospitals will implement similar projects for their specific patient populations. HBMC will develop the model and provide education and training for local healthcare providers and other palliative care team members. These facilities and providers will share in a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative

CMHS will meet monthly with PHN to discuss the current status of projects related to the implementation of a regional Palliative Care Program. Learning collaborations offer the team an opportunity to learn from successes and failures and will be designed as follows:

1. It should review data and respond to it every month.
2. It should set one or two quantifiable, project-level goals, with a deadline, preferably defined in terms of outcomes, related to the project's area of work. Participants should actively manage toward this goal over the course of the work.
3. It should invest more in learning than in teaching. It is more effective to get out into the field and support learning and exchange at the front lines where care is delivered.
4. It should set up simple, interim measurement systems, based on self-reported data and sampling, that can be shared at the local level and are sufficient for the purposes of improvement.
5. It should employ individuals (regional "innovator agents") to travel from site to site in the network to (a) rapidly answer practical questions about implementation and (b) harvest good ideas and practices that they systematically spread to others. The regional "innovator agents" should all attend the same initial training in improvement tools and skills organized by the State or RHP and should receive periodic continuing education on improvement.
6. It should set up face-to-face learning (meetings or seminars) at least a couple of times a year.
7. It should mandate some improvements (simple things that everyone can do to "raise the floor" on performance) and it should unleash vanguard sites to pursue previously unseen levels ("raise the bar" on performance).
8. It should use metrics to measure its success such as:

- Rate of testing
- Rate of spread
- Time from idea to full implementation
- Commitment rate (rate at which 50% of organizations take action for any specific request)
- Number of questions asked per day
- Network affinity/reported affection for the network

Project Valuation

Our target population will be patients identified as candidates for a palliative care program who are currently Medicaid, Uninsured or Indigent which represents 30% of the population of Coryell County (or 22,000). CMHS will target patients currently in the hospital or recently discharged to the home and residents of our skilled nursing and long term care facilities (more than 50% are dual eligible Medicare/ Medicaid). To determine potential patients that could receive a referral to the palliative service we assumed a 5% rate of total acute care inpatient volume. The capture rate was calculated based on the number of patients that would actually end up using services from the total referred. This capture rate identifies that the number of participants eligible for palliative care could range from an average of 25 - 45 patients per year. CMHS is considered a critical access hospital but is also connected to a skilled

nursing facility and assisted living facility for more than 120 residents. These residents along with patients in the hospital and Coryell County community members receiving care through our home health care agency will be eligible to receive palliative care treatment options using the expertise of our professional staff. The professional staff will receive training and ongoing education from professionals at Hillcrest Baptist Medical Center in Waco who is leading this regional project. The performing providers will also need to develop an efficient and seamless transfer of information process between facilities to ensure continuity of care which may require additional IT resources.

This project has been valued at $3,754,651. According to the National Palliative Care Research Center in 2011, in the U.S., states with more than 80% of hospitals reporting a palliative care program received a grade of "A". More than half of the states had a grade of "B". Texas achieved a grade of "C".[9] This project would further promote the triple aim of the waiver program. Project valuation accounts for the following factors: 1) The project achieves the waiver goals by assuring patients receive high-quality and patient-centered care in the most cost effective ways. This program will bolster the healthcare infrastructure to reduce costs and better serve Medicaid and uninsured residents by avoiding unnecessary treatments and expenses during stages of the disease process where these treatments do not improve outcomes or quality of life for the patient; 2) Palliative Care has been proven to lower costs and shorten length of stay, reduce readmissions through the ED and reduce low-margin admissions (long stays for exacerbations of chronic illness). 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 length-of-stay or lower costs per day once the patient has been referred to palliative care[10]; 3) This addresses a community need by providing an appropriate transition outlet for patients that do not qualify for hospice care; 4) The project will require a considerable amount of training, program development, and time for implementation. The valuation for this project specifically focuses on the potential for better patient care that will ultimately improve patient satisfaction and lower costs associated with end-of-life care.

[9] Center to Advance Palliative Care, http://www.capc.org/reportcard/findings

[10] Center to Advance Palliative Care http://www.capc.org/building-a-hospital-based-palliative-careprogram/financing/costsavings/index_html/view?searchterm=quality%20and%20cot%20savings

134772611.2.4	**2.10.1**	**2.10.1 A** **2.10.1 B** **2.10.1 C** **2.10.1 D**	**PALLIATIVE CARE PROGRAM**
Coryell Memorial Hospital			*134772611*
Related Category 3 Outcome Measure(s):	*134772611.3.10* *134772611.3.11* *134772611.3.12*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*

Year 2 (10/1/2012 – 9/30/2013)	**Year 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 Baseline/Goal: Develop baseline data information. Re-evaluate referral opportunities and sources. Data Source: Business case write-up; documentation of planning activities Milestone 1 Estimated Incentive Payment : $875,059	**Milestone 2** [P-3]: Implement palliative care education and training programs for providers (physicians, RNs, Pas, NPs, etc.) that incorporates management of non-cancer patients. Metric 1 [P-3.1]: Palliative care training and education for other providers. Baseline/Goal: Educate frontline providers in the palliative care program. Data Source: Database that tracks type and number of training and education sessions by health professional category (physicians, RNs, Pas, NPs,	**Milestone 5** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice, or SNF Denominator: Total number of palliative care discharges. Goal: 50% of patients in a palliative care program transitioned to home care, hospice, or SNF Data Source: EHR, data	**Milestone 8** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice, or SNF Denominator: Total number of palliative care discharges. Goal: 75% of patients in a palliative care program transitioned to home care, hospice, or SNF Data Source: EHR, data

134772611.2.4	**2.10.1**	**2.10.1 A** **2.10.1 B** **2.10.1 C** **2.10.1 D**	**PALLIATIVE CARE PROGRAM**
Coryell Memorial Hospital			*134772611*
Related Category 3 Outcome Measure(s):	*134772611.3.10* *134772611.3.11* *134772611.3.12*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	etc). Milestone 2 Estimated Incentive Payment: $335,653.66 **Milestone 3** [P-5]: Implement a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Goal: Palliative care program operational and care team in place. Data Source: Palliative care program Milestone 3 Estimated	warehouse, palliative care database Milestone 5 Estimated Incentive Payment: $340,819 **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 Goal: Establish survey data,	warehouse, palliative care database Milestone 8 Estimated Incentive Payment: $283,391.34 **Milestone 9** [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

134772611.2.4	**2.10.1**	**2.10.1 A** **2.10.1 B** **2.10.1 C** **2.10.1 D**	**PALLIATIVE CARE PROGRAM**
Coryell Memorial Hospital			*134772611*
Related Category 3 Outcome Measure(s):	*134772611.3.10* *134772611.3.11* *134772611.3.12*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*

Year 2 (10/1/2012 – 9/30/2013)	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: $335,653.66 **Milestone 4** [P-11]: Participate in face-to-face learning (meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should	mechanism of distribution, focus on solid response rate for generalizable data; Increase scores by 2% from beginning of DY4 to end of DY4. Data Source: Patient/family experience survey Milestone 6 Estimated Incentive Payment: $340,819 **Milestone 7** [P-11]: Participate in face-to-face learning (meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning	Goal: Establish survey data, mechanism of distribution, focus on solid response rate for generalizable data; Increase scores by 4% from beginning of DY4 to end of DY4. Data Source: Patient/family experience survey Milestone 9 Estimated Incentive Payment: $283,391.33 **Milestone 10** [P-11]: Participate in face-to-face learning (meetings or seminars) at least twice per

134772611.2.4	**2.10.1**	**2.10.1 A** **2.10.1 B** **2.10.1 C** **2.10.1 D**	**PALLIATIVE CARE PROGRAM**
Coryell Memorial Hospital			*134772611*
Related Category 3 Outcome Measure(s):	*134772611.3.10* *134772611.3.11* *134772611.3.12*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in 2 meetings each year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $335,653.66	around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in 2 meetings each year	year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars

134772611.2.4	**2.10.1**	**2.10.1 A** **2.10.1 B** **2.10.1 C** **2.10.1 D**	**PALLIATIVE CARE PROGRAM**	
Coryell Memorial Hospital				*134772611*
Related Category 3 Outcome Measure(s):	*134772611.3.10* *134772611.3.11* *134772611.3.12*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*	
Year 2 (10/1/2012 – 9/30/2013)	**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 semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: $340,819	organized by the RHP. Goal: Participate in 2 meetings each year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 10 Estimated Incentive Payment: $283,391.33
Year 2 Estimated Milestone Bundle Amount: $875,059	Year 3 Estimated Milestone Bundle Amount: $1,006,961		Year 4 Estimated Milestone Bundle Amount: $1,022,457	Year 5 Estimated Milestone Bundle Amount: $850,174
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $3,754,651				

Summary Information:

Pass 3B Project: 121792903.2.6

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): This project will introduce a chronic disease management program for the benefit of congestive heart failure patients. The program will assist in the redesign of the outpatient delivery system to coordinate care for chronic disease patients with congestive heart failure.
- Need for the project: Our community need for targeting congestive heart failure (CHF) is evident as CHF ranks among our top readmission diagnoses as well as our second highest potentially preventable hospitalization with charges over the 2005-2010 time period at $1,020,095 according the DSHS Potentially Preventable Hospitalizations for Hamilton County. Recent inpatient volume over the first half of 2012 (January-June), for patients with a primary or secondary diagnosis of CHF, totals 1,106 patient days among 236 patients. This statistic makes heart failure patients 36% of our overall inpatient census from the same timeframe.
- Medicaid and Uninsured Target population: 31.2% of our patient population is uninsured and 20% are covered by Medicaid. We have identified our CHF population as a group of patients that have high utilization rates within our system at 36% for acute care hospitalizations.
- Category 1 or 2 expected patient benefits: The heart failure program will provide continuity of care for patients across the disease continuum. The projected annual number of inpatient education sessions based on current volume of hospitalized patients is 380. The projected number of total referrals for the outpatient service is 200 annually. By DY5 we expect to develop and implement the outpatient heart failure program to increase the number of heart failure patients that receive care under the Chronic Care Model by 25% and see the reduction in our CHF hospital readmission rate below 20%.
- Category 3 outcomes:
    - IT-3.2 Our goal is to reduce the CHF 30 day readmission rate by 3% below baseline by DY4 and 5% below baseline by DY5.
    - IT-2.1 Our goal is to reduce the CHF admission rate by TBD % below baseline by DY4 and DY5.

Pass 3B
Category 2: Program Innovation and Redesign

Hamilton General Hospital
TPI 121792903
Project Identifier:
New: 121792903.2.6
Old: 121792903.2.1
Project Title 2.2 ***Chronic Disease Management for Heart Failure Program***
Project Option 2.2.2 *Apply evidence-based care management model to patients identified as having high-risk health care needs*

Project Description

The purpose for the establishment of a heart failure program is to promote patient centered care in our patient's hometown environment with a focus on meeting the needs of both patients and families. We have identified a need to improve upon the delivery of care to heart failure patients through the establishment of an outpatient heart failure program to monitor patients, provide individualized multidisciplinary disease management plans, education, and ensure evidence-based medication regimens and appropriate device therapies are initiated. This program will assist in the redesign of the outpatient delivery system to coordinate care for chronic disease patients with congestive heart failure.

The heart failure program will receive referrals from both the clinic and hospital setting. Patients will be scheduled for outpatient visits in the heart failure program for continued follow-up and assessment. Through thorough assessment by licensed professionals, heart failure symptoms will be recognized and treated in a timely manner to prevent unnecessary use of acute care services in the ED or inpatient hospitalization.

Our community need for targeting congestive heart failure (CHF) is evident as CHF ranks among our top readmission diagnoses as well as our second highest potentially preventable hospitalization with charges over the 2005-2010 time period at $1,020,095 according the DSHS Potentially Preventable Hospitalizations for Hamilton County. Recent inpatient volume over the first half of 2012 (January-June), for patients with a primary or secondary diagnosis of CHF, totals 1,106 patient days among 236 patients. This statistic makes heart failure patients 36% of our overall inpatient census from the same timeframe. Furthermore, these patients are also at a high risk for readmission thereby supporting the need for a population specific program utilizing evidence-based protocols for disease management. The Community Needs Assessment, specifically CNA-009, further supports the need for this program based on data available through CMS and the Department of State Health Services.

Goals: The goal of the Heart Failure Program is to offer comprehensive outpatient disease management for patients with heart failure, cardiomyopathy, chronic ischemic or non-

ischemic heart disease and adult congenital heart disease. The program will focus on the care of heart failure patients in order to excel in CMS core measures, lower inpatient congestive heart failure readmission rates and efficiently reduce cost. Most importantly, we can offer accessible care within our community. Through compliance with recommended treatment guidelines, patient education, close patient follow-up and continuity of care, the services provided will produce the following results:

1) Improve quality of life and functional status of the patient
2) Prolong heart failure survival and improve CHF mortality
3) Decrease length-of-stay for heart failure patients
4) Decrease inpatient hospitalizations and
5) Decrease heart failure related healthcare costs.

Challenges: The primary challenge in the establishment of the outpatient heart failure program is the culture change within our health care system to move into a care model that provides care from the outpatient setting instead of in acute care. Moving into an outpatient driven system will require physician buy-in and education for the services that can be provided through the outpatient heart failure program. Specialized staff training will also be necessary to make sure staff is equipped for a new role in caring for heart failure patients. We anticipate addressing these challenges in the program development phase and to particularly address physician buy-in with their involvement in the program development including standardized protocols, order sets, and policies that will be followed in the provision of care for their patients. As with any service, there may be barriers for patients regarding social issues and transportation that can be limiting factors for patients keeping scheduled appointments. These issues may require providing patients with additional resources for local transportation availability, financial assistance, and medication assistance. We have a Social Worker available as a support resource to assist patients in overcoming these barriers and accessing needed services. Patient education on the need for frequent monitoring in the heart failure disease process will also be considered. Patients will need to understand the benefit of the heart failure program and the service provided in order to establish patient capture from the referrals generated. Patients can be educated through their physicians, clinic and hospital nurses, heart failure nurses, and community outreach to market the program.

Number of People Served: The heart failure nurses will provide hospital inpatient education to patients admitted with or being treated for heart failure. This will initiate the first phase of the hospital setting referrals. When the heart failure nurse meets with a hospital inpatient, the goal is to schedule the outpatient follow-up visit, ideally within 2-3 days of discharge, to provide a thorough assessment and to make sure discharge instructions and medications are understood by the patient and/or caregiver. Bringing the heart failure nurse into the hospital setting allows for a better transition of care for the patient and establishes a beneficial relationship between the patient and their care provider. The projected annual number of inpatient education sessions based on current volume of hospitalized patients is 380. This includes patients that may benefit from inpatient teaching or follow-up phone calls from the heart failure nurse but may not be able to attend outpatient appointments. Referrals into the heart failure program will also be received from the clinic setting for heart failure

patients needing more frequent follow-up for monitoring and education. The projected number of total referrals for the outpatient service is 200 annually.

Expected 5-Year Outcome: The heart failure program will provide continuity of care for patients across the disease continuum. The program will have incremental goals to improve upon throughout the waiver period. After the baseline is established in DY2 for the number of patients enrolled in the program, we expect to increase the number enrolled over baseline by 10% in DY3, 15% in DY 4 and 25% by DY5. We will also be looking at the number of patient interactions that occur in the program. We will establish a baseline number in DY3 for the number of patient interactions. In DY4 we will increase the number of patient interactions by 10% over baseline and by 15% over baseline in DY5. The ultimate goal of the program is to see a reduction of our CHF hospital readmission rate to below 20% at the end of the five year period.

Starting Point/Baseline

This is a new project with a baseline for the number of patients enrolled in the program to be determined during DY 2. Patients will be enrolled in the Heart Failure Program through physician referral for the service. Referrals will be generated upon discharge for inpatients treated during their hospitalization at Hamilton General Hospital for CHF and will also be received from Primary Care Providers and Cardiology specialists in the outpatient setting. We will also establish a baseline in DY3 for the number of interaction types between the patients and the healthcare team.

Rationale

Currently, the nearest heart failure clinic for our patients is located 70 miles away. With our aging population more than double the state rate at 25.1% for persons over aged 65 compared to 10% for the State it is very important to offer local services that meet the needs of our demographic service area. Transportation becomes more difficult for the elderly who often feel uncomfortable driving long distances and who do not have readily available support resources to attend every appointment with them. Chronic conditions, such as heart failure, pose an even larger problem because continuous active follow-up in the outpatient setting is needed. Patients will limit or miss appointments due to the travel burden. While patients have increasing difficulty with long travel times and navigating urban areas as they age, they can remain functional much longer when able to use services close to home. Not only can we clinically ensure the best outcomes with active follow-up but patients can maintain independence which is very important as we work within the chronic care models to improve disease self-management behaviors and empower patients.

With a large elderly population we have a greater incidence of congestive heart failure. According to a published fact sheet from the National Heart, Lung, and Blood Institute (NHLB), CHF is the most common diagnosis in hospital patients age 65 years and order. Also in that age group, one fifth of all hospitalizations have a primary or secondary diagnosis of heart failure. The project goal for category 2.2 is focused on the assessment of the patient's risk of developing complications, identifying symptoms early, and implementing intervention to

prevent utilization of acute or emergency services. The nature of our heart failure clinic design matches each element of the 2.2 project goal.

Related Category 3 Outcome Measure

OD-2 Potentially Preventable Admissions (PPAs)

- IT-2.1 Congestive Heart Failure Admission rate (CHF) 238- PQI #8 *(Standalone measure)*

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

- IT-3.2 Congestive Heart Failure 30 day readmission rate (*Standalone measure*)

Rationale

The CHF 30-day readmission rate and the CHF Admission rate are a priority of this project due to the inpatient volume within our facility as evidenced by only 6 months of data reflecting 236 inpatient hospitalizations with primary or secondary diagnosis of CHF. Readmissions in our facility also account for almost 30% of admissions. The large volume of congestive heart failure patients coupled with readmissions makes this outcome important within our facility and also a priority to avoid financial penalty from the Hospital Readmissions Reduction Program. Across RHP 16, the Potentially Preventable Hospitalizations Report from 2005-2010 published by DSHS reflects a regional trend for CHF to be the number one ranking diagnosis for total hospital charges expended. This data recognizes that low-income populations are contributing to the large volume of congestive heart failure hospitalizations and readmissions both at Hamilton General Hospital and throughout RHP 16. Measuring hospital admissions and 30-day readmissions for CHF is an outcome measure that will hold accountability to our project for effective implementation. This outpatient program for heart failure patients will decrease cost burden from admissions and readmissions and direct patients to the appropriate setting for disease management. Providing patients with access to the most appropriate disease management program will improve health in low income populations through timely assessment, recognition, and treatment of critical symptomatology.

Relationship to other Projects

The Heart Failure Program works to achieve Hamilton's goal for more outpatient, patient-centered healthcare options provided in a local and more low cost setting for care delivery. The Heart Failure Program will work in conjunction with other Hamilton projects such as Expansion of Primary Care (121792903.1.3), Chronic Care Management (121792903.2.7), and Care Transitions (121792903.2.8). The Heart Failure Program will receive referrals from both the primary care setting and from chronic care management case managers. The Heart Failure Program will also serve as a means to improve care transitions as patients move from an acute hospitalization to outpatient care. The Heart Failure Program nurses will be able to serve as liaisons between primary care providers and patients to provide streamlined care.

Relationship to Other Performing Providers' Projects in the RHP

RHP 16 providers will offer several projects related to Chronic Care Disease management. Collaboration with other performing providers will allow Hamilton General Hospital to

effectively manage this project and develop the project over the next few years by sharing best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative

Opportunities exist for collaboration among other performing providers in RHP 16 sharing a similar project for chronic care management. Regional data is similar to our local data particularly in comparison to the potentially preventable hospitalizations. A learning collaborative could benefit our region through the sharing of experiences and information related to accomplishing outcomes in the reduction of PPAs and PPRs.

Project Valuation

This project has been valued at $5,277,853. The actual value of this program to our community is intangible as it provides additional access to specialized care in a local setting, ensures appropriate monitoring and follow-up from hospitalizations to prevent unnecessary readmissions, and it will ultimately improve the quality of life and functional status for heart failure patients and their families. Evidence-based disease management, decreased length of stay, and decreased healthcare costs will impact patients, families, our community, and our hospital. Cost avoidance from decreased readmission rates through the implementation of the heart failure clinic is projected at $182,000 per year. This value does not encompass the improvement in clinical outcomes from the implementation and use of established practice guidelines, improved care coordination, active follow-up to ensure the best outcome, and patients better trained about their condition and self-management.

Valuation of project 2.2.2 considers the cost of program implementation including supplies and staff training, cost avoidance from hospitalizations and readmissions, and improved clinical outcomes. From review of our internal statistical data, our current average hospital charge for a congestive heart failure admission is slightly over $14,000. Valuation considered the hospital charges of $1,020,095 for CHF Potentially Preventable Hospitalizations for Hamilton County (DSHS 2005-2010), inpatient volume of CHF patients, current readmission rates, and the community need for access to care. Currently, patients needing a CHF clinic have a 70 mile drive to the nearest point of service. This leads to significant underutilization of the service due to financial, physical, and transportation barriers.

The heart failure program will provide continuity of care for patients across the disease continuum. The projected annual number of inpatient education sessions based on current volume of hospitalized patients is 380. The projected number of total referrals for the outpatient service is 200 annually. By DY5 we expect to develop and implement the outpatient heart failure program to increase the number of heart failure patients that receive care under the Chronic Care Model by 25% and see the reduction in our CHF hospital readmission rate below 20%.

NEW: 121792903.2.6 ***OLD: 121792903.2.1***	***2.2.2***	***2.2.2***	***CHRONIC DISEASE MANAGEMENT FOR HEART FAILURE PROGRAM***
Hamilton General Hospital			*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.2* *IT-2.1*	*New: 121792903.3.16* *Old: 121792903.3.2* *New: 121792903.3.15* *Old: 121792903.3.3*	*Congestive Heart Failure 30 day readmission rate* *Congestive Heart Failure Admission Rate (CHF)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 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. Milestone: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 P-2.1. Metric: Increase percent of staff a. Numerator: Number of relevant staff trained in the Chronic Care Model ("relevant" as defined per the Performing Provider) b. Denominator: Total number of relevant staff Baseline/Goal: Train active staff in the CHF program delivering patient care. Data Source: HR, training program materials Milestone 1 Estimated Incentive Payment: $608,942 **Milestone 2** P-3. Milestone: Develop a comprehensive care	**Milestone 3** P-10. Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric 3 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 (please specify type of visit) Baseline/Goal: Establish baseline for number of interaction types Data source: EHR, billing records Milestone 3 Estimate Incentive Payment: $470,561.33 **Milestone 4** P-3. Milestone: Develop a comprehensive care management program	**Milestone 6** P-12. Milestone: Develop and implement plan for standing orders (i.e., lab orders for chronic conditions) Metric 1 P-12.1. Metric: Documentation of plan for standing orders Goal: Completed standing orders for routine monitoring of heart failure lab values. Data Source: Computerized system to manage standing orders. Milestone 6 Estimated Incentive Payment: $475,427 **Milestone 7** P-10. Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric 3 P-10.1 Metric: Increase	**Milestone 9** I-17. Milestone: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 I-17.1. Metric: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC a. Name the chronic disease or MCC included [I-1.2]: Goal: Increase the number of heart failure patients that receive care under the Chronic Care Model by 25% over baseline. Data Source: Registry Milestone 9 Estimated Incentive Payment: $611,002 **Milestone 10** I-X. Milestone: Number of patient touches in the program Metric 1 I-X.1. Metric: Total number of in-person and virtual

NEW: 121792903.2.6 ***OLD: 121792903.2.1***	***2.2.2***	***2.2.2***	***CHRONIC DISEASE MANAGEMENT FOR HEART FAILURE PROGRAM***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.2* *IT-2.1*	*New: 121792903.3.16* *Old: 121792903.3.2* *New: 121792903.3.15* *Old: 121792903.3.3*	*Congestive Heart Failure 30 day readmission rate* *Congestive Heart Failure Admission Rate (CHF)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
management program Metric 1 P-3.1. Metric: 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: Utilize evidence-based sources in program develop including Chronic Care Model for care delivery, Establish baseline for number of patients enrolled in the program Data Source: Program materials Milestone 2 Estimated Incentive Payment: $608,942	Metric 4 P-3.2. Metric: Increase the number of patients enrolled in a care management program over baseline. a. Numerator: Number of patients enrolled in a care management program over baseline Baseline/Goal: Increase the number of patients enrolled in the heart failure management program by 10% over baseline. Data Source: Program enrollment records Estimated Incentive Payment: $470,561.33 **Milestone 5** P-9. Milestone: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 P-9.1. Metric: Increase the number of patients identified		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 (please specify type of visit) Goal: Increase number of interactions by 10% over baseline Data source: EHR, billing records Milestone 7 Estimate Incentive Payment: $475,427 **Milestone 8** I-17. Milestone: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 I-17.1. Metric: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC a. Name the chronic disease or MCC included [I-1.2]:	(including e-mail and phone) visits (absolute value) a. Numerator: Number of patient touches recorded in the registry Goal: Increase the number of patient interactions in the heart failure program by 15% over baseline. Data Source: Program records Milestone 10 Estimated Incentive Payment: $611,002

NEW: 121792903.2.6 ***OLD: 121792903.2.1***	***2.2.2***	***2.2.2***	***CHRONIC DISEASE MANAGEMENT FOR HEART FAILURE PROGRAM***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.2* *IT-2.1*	*New: 121792903.3.16* *Old: 121792903.3.2* *New: 121792903.3.15* *Old: 121792903.3.3*	*Congestive Heart Failure 30 day readmission rate* *Congestive Heart Failure Admission Rate (CHF)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	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 b. Denominator: Number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal: Determine % of patients with echocardiogram data available. Data Source: EHR, patient registry Milestone 5 Estimated Incentive Payment: $470,561.33		Goal: Increase the number of heart failure patients that receive care under the Chronic Care Model by 15% over baseline Data Source: Registry Milestone 8 Estimated Incentive Payment: $475,427	
Year 2 Estimated Milestone Bundle Amount: $1,217,884	Year 3 Estimated Milestone Bundle Amount: $1,411,684		Year 4 Estimated Milestone Bundle Amount: $1,426,281	Year 5 Estimated Milestone Bundle Amount: $1,222,004

NEW: 121792903.2.6 ***OLD: 121792903.2.1***	***2.2.2***	***2.2.2***	***CHRONIC DISEASE MANAGEMENT FOR HEART FAILURE PROGRAM***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.2* *IT-2.1*	*New: 121792903.3.16* *Old: 121792903.3.2* *New: 121792903.3.15* *Old: 121792903.3.3*	*Congestive Heart Failure 30 day readmission rate* *Congestive Heart Failure Admission Rate (CHF)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**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: $5,277,853				

Summary Information:

Pass 3B Project: 121792903.2.7

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): This project will introduce a chronic disease management program to address major chronic health issues such as diabetes, respiratory disease, and obesity. Case Managers will be assigned to apply the Chronic Care Management model to patients identified as having high-risk health care needs to prevent unnecessary utilization of the acute care setting.
- Need for the project: Across RHP 16, COPD and diabetes were chronic conditions contributing to potentially preventable hospitalizations. Among the three targeted diagnoses for this project of pneumonia, COPD, and diabetes there were total hospital charges in RHP 16 of $241,769,000 according to the data published by Texas Department of State Health Services. From October 1, 2011-September 30, 2012 we had 469 inpatient or observation admits with a primary diagnosis of COPD, Diabetes or Flu/Pneumonia. This data strongly supports the existing need for Hamilton County as a part of RHP 16 to implement a chronic care management model with interventions to achieve timely and effective chronic disease management to reduce the healthcare cost burden and improve clinical outcomes.
- Medicaid and Uninsured Target population: 31.2% of our patient population is uninsured and 20% are covered by Medicaid. This is over half of our patient population.
- Category 1 or 2 expected patient benefits: The Chronic Care Management program will provide continuity of care for patients across the disease continuum. From October 1, 2011-September 30, 2012 we had 469 inpatient or observation admits with a primary diagnosis of COPD, Diabetes or Flu/Pneumonia. The program will have incremental goals to improve upon throughout the waiver period. After the baseline is established in DY3 for the number of patients enrolled in the program, we expect to increase the number enrolled over baseline by 15% in DY 4 and 25% by DY5. By DY 5 we expect to measure, report, and improve the coordination of care in the outpatient setting of our patients for whom optimal and coordinated ambulatory care can prevent or reduce hospital admissions for ~~heart failure,~~ pneumonia, chronic obstructive pulmonary disease, and diabetes.
- Category 3 outcomes:
  - IT-2.5 Our goal is to reduce the COPD admission rate by TBD % below baseline by DY4 and DY5.
  - IT-2.9 Our goal is to reduce the uncontrolled diabetes admission rate by TBD % below baseline by DY4 and DY5.
  - IT-2.10 Our goal is to reduce the flu and pneumonia admission rate by TBD % below baseline by DY4 and DY5.

Pass 3B
Category 2: Program Innovation and Redesign

Hamilton General Hospital
TPI 121792903
Project Identifier:
New: 121792903.2.7
Old: 121792903.2.2

Project Title 2.2 ***Chronic Care Management (CCM)***

Project Option 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Required core project components:
a) Design and implement care teams that are tailored to the patient's healthcare needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system
b) Ensure that patients can access their care teams in person or by phone or email
c) 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
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.

Project Description

Reducing the long term cost associated with the care of chronically ill individuals is primarily linked to the available care and functionality in chronic disease management. For residents in RHP 16, the burden of chronic disease is compounded with limited means of transportation, long drives to specialty care for rural residents, limited support resources, and lack of care coordination to address the full scope of a chronic illness. Our project is a chronic disease management initiative using a population-based approach to create practical, supportive, evidence-based interaction between patients and providers to improve the management of chronic conditions and identify symptoms earlier. We want to do this project due to our community need for management of chronic

conditions. From October 1, 2011-September 30, 2012 we had 469 inpatient or observation admits with a primary diagnosis of COPD, Diabetes or Flu/Pneumonia, the three diagnoses this project will be focused on. Locally 25.1% of our population is 65 years and over compared to the state rate of 10.5%. With more than double the elderly population as compared to the state we serve a high-risk group with increased likelihood for chronic disease and co-morbidity.

This Chronic Care Management service will focus on providing chronic disease patients with a knowledgeable point of reference and contact person for them with a case management registered nurse. The patient's assigned case manager will be able to coordinate care, assess needs and physical condition, serve as a liaison with the patient's physician, provide education on the disease process as needed, and expedite clinic visits with a provider to promptly address any acute issues before they warrant utilization of emergency or hospital services. The idea will be to form a "hub" for the patient with their case manager so that care can be streamlined. Chronic disease patients have multiple needs often requiring care from a primary care provider, specialists, lab monitoring, and other outpatient services such as cardiopulmonary rehabilitation or diabetes education as examples. Patients would be able to readily access their assigned case manager to ask questions and to gain assistance coordinating appointments or medical treatments. The case manager would follow chronic disease patients regularly and evaluate compliance with recommended treatments and appointments to avoid preventable complications. The case manager would also help identify barriers to patients receiving care or in performing self-care behaviors and would work to resolve those issues or seek out other resources as needed.

Cited in the Community Needs Assessment as opportunities for RHP 16 is the need for joint efforts within and across communities to address major chronic health issues such as diabetes, respiratory disease, and obesity. Elements of the project include the identification of chronic health conditions and co-occurring chronic health conditions that merit intervention through either a risk based assessment for the development of complications or the utilization of acute or emergency services. The targeted chronic conditions of community-acquired pneumonia, chronic obstructive pulmonary disease and diabetes will be followed by case managers providing care outside of the clinic setting via phone, email, and in person visits. The case managers will apply the CCM model to patients identified as having high-risk health care needs to prevent unnecessary utilization of the acute setting.

Goals: This project will be accomplished by case managers that identify patients using a risk adjustment tool and through assessment of acute care utilization. Patients meeting the screening criteria and with a diagnosis of pneumonia, COPD, or diabetes will be passively enrolled in the chronic care model. Case managers will follow enrolled patients with disease specific protocols, will make follow-up visits and/or phone calls, and monitor utilization of services and redirect to outpatient service as needed.

Challenges: Data shows that more than 145 million people, or almost half of all Americans, live with a chronic condition. The 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. (Rationale 2.2) Data reported by the Texas Department of State Health Services from 2005-2010 regarding hospital charges for potentially preventable hospitalizations can be used to identify the high cost diagnoses across RHP 16. The conditions are considered potentially preventable because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. Across RHP 16 bacterial pneumonia is a condition with one of the greatest hospital charges. Hamilton County reflects the same regional trend, our reason for initiating the project, with total hospital charges during the 2005-2010 period for bacterial pneumonia of $1,214,714. Additionally, across RHP 16, COPD and diabetes were chronic conditions contributing to potentially preventable hospitalizations. Among the three ~~four~~ targeted diagnoses for this project (pneumonia, COPD, and diabetes) there were potentially preventable total hospital charges in RHP 16 of $241,769,000 according to the data published by Texas Department of State Health Services. This data strongly supports the existing need for Hamilton County as a part of RHP 16 to implement a chronic care management model with interventions to achieve timely and effective chronic disease management to reduce the healthcare cost burden and improve clinical outcomes.

Expected 5-Year Outcome: The program will have incremental goals to improve upon throughout the waiver period. After the baseline is established in DY3 for the number of patients enrolled in the program, we expect to increase the number enrolled over baseline by 15% in DY 4 and 25% by DY5. By DY 5 we expect to measure, report, and improve the coordination of care in the outpatient setting of our patients for whom optimal and coordinated ambulatory care can prevent or reduce hospital admissions for pneumonia, chronic obstructive pulmonary disease, and diabetes. The Category 3 outcome measure targeted through the CCM project is Potentially Preventable Hospitalizations for these chronic disease patients.

Starting Point/Baseline

As a new initiative there are no patients currently served under this model. We will develop and implement this project in DY2 with baseline data collection in DY3. The starting point for this project will be with a lead case manager.

Rationale

Project option 2.2.1 was selected for the Chronic Care Management plan as a way to provide the most impact on potentially preventable hospitalizations. This project is a new initiative for our health system. The chosen project option includes 5 core components which will all be included in the project.

Core components:
(a) Patient Care teams will be designed and implemented that include case managers providing care outside of the clinic setting via phone, email, and in-person visits. The case managers will coordinate care for these patients, assisting in directing patients to the appropriate service and will monitor healthcare utilization by the targeted chronic disease patients.

(b) Patients will have access to case managers and other members of the care team through in- person, phone, and email contact.

(c) One of the focuses within the design of the project will be increasing patient engagement which will be facilitated through the case managers leading the care team. Patients will be referred into education programs, self-management support and connected to appropriate community resources. Patient-provider communication techniques will be emphasized along with ease of access and identifying barriers to communication.

(d) Programs will be made available specific to disease self-management for the three targeted diagnoses of pneumonia, chronic obstructive pulmonary disease, and diabetes.

(e) Quality improvement activities will be conducted to evaluate project impact and identify opportunities for program expansion.

The primary outcome of this project relates to the CNA-004 for reducing potentially preventable hospitalizations. The category 3 outcome of the project will be the reduction in PPAs. Also cited in the Community Needs Assessment for RHP 16 is CNA-001 which identifies the adult diabetes rate with diabetes being one of the chronic diseases targeted by the project.

The driving data point for the initiation of the CCM project at Hamilton General Hospital is the DSHS data for Hamilton County from the period of 2005-2010 indicating our top Potentially Preventable Hospitalizations for bacterial pneumonia with hospital charges of $1,214,714. This data coupled with internal data review of our top primary and secondary diagnoses for our inpatient hospitalizations demonstrated that the greatest volume for both admissions and readmissions are patients with the three diagnoses targeted by this project. The local community need based on our current service volume data and the needs across RHP 16 as cited in the Community Needs Assessment justifies the selection of this project as an area with needed improvement to reduce the cost burden of preventable hospitalization on Medicaid and other public payers and to improve the quality and coordination of care provided to low-income patient populations. The design of the CCM project will specifically be able to address barriers with the low-

income populations through the provision of better care coordination, better communication with providers, and connection with community resources which will work together to empower patients in disease self-management.

Related Category 3 Outcome Measure

OD-2 Potentially Preventable Admissions
IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5 *(Standalone measure)*
IT-2.9 Uncontrolled Diabetes Admissions Rate- PQI 14245 *(Standalone measure)*
IT-2.10 Flu and pneumonia Admission Rate *(Standalone measure)*

Potentially Preventable Admissions are the goal to be achieved through the CCM Project. Because the project plan will be to target the three diagnoses of PN, COPD, and diabetes based on supporting data we feel that measuring the outcomes for all three diagnoses will be the most effective way to demonstrate improvement within these high risk populations. Each of the chronic diseases targeted by the project is congruent with the Transformation Waiver goals.

Relationship to other Projects

Chronic Care Management Project will enable the success of other projects initiated in the RHP plan. For our district, the CCM Project is a piece that will work with the other RHP plan projects of Primary Care Expansion (121792903.1.3), Heart Failure Program (121792903.2.6), and Care Transitions (121792903.2.8). The role that CCM will play amongst these other projects is a re-structuring of the outpatient delivery system. Through the development of the care teams, patients will be guided to the correct utilization of services. The case managers leading the care teams will help to ensure that appropriate referrals are being made for the patients and that they have access to the appropriate resources. This may include scheduling appointments with primary care for evaluation, obtaining a physician referral and helping a patient schedule with the Heart Failure program for chronic disease management, or by receiving a referral to be a part of the CCM Project from the inpatient Care Transitions team that identify a patient need beyond the scope of the Care Transition and discharge process. The CCM Project is meant to be a long-standing program to continue tracking, monitoring, and serving as a point of contact for high risk patients long after an acute care episode. Each project works together to compliment the continuum of care and achieve the Transformation Waiver goals.

Relationship to Other Performing Providers' Projects in the RHP

RHP 16 providers will offer several projects related to Chronic Care Disease management. Collaboration with other performing providers will allow Hamilton General Hospital to effectively manage this project and develop the project over the next few years by sharing best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative

Opportunities exist for collaboration among other performing providers in RHP 16 sharing a similar project for chronic care management. Regional data is similar to our local data particularly in comparison to the potentially preventable hospitalizations. A learning collaborative could benefit our region through the sharing of experiences and information related to accomplishing outcomes in the reduction of PPAs.

Project Valuation

This project has been valued at $5,917,597. The value of this project for our community includes decreasing inappropriate use of high cost services and facilities, reducing potentially preventable admissions, and re-directing patients to receive appropriate care in the appropriate setting which in turn will decrease overall healthcare costs. The intangible value of this project is the empowerment patients in our community will gain through the ability to self-manage their disease process. With an estimated population in Hamilton County of 8,625 our insurance payer sources include a larger uninsured population than the rest of our region at 31.2%. We also have total Medicaid enrollment of 1,060, Medicare enrollment for the elderly of 1,451, and disabled Medicare of 143. The combination of our Medicaid/Medicare and uninsured population is well over half our total population.

From October 1, 2011-September 30, 2012 we had 469 inpatient or observation admits with a primary diagnosis of COPD, Diabetes or Flu/Pneumonia. The program will have incremental goals to improve upon throughout the waiver period. After the baseline is established in DY3 for the number of patients enrolled in the program, we expect to increase the number enrolled over baseline by 15% in DY 4 and 25% by DY5.

From the DSHS Potentially Preventable Hospitalizations from 2005-2010 we had 63 admissions for bacterial pneumonia alone. From review of our internal statistical data, our current average hospital charge for bacterial pneumonia around $17,500. In assuming a modest result from the implementation of Chronic Care Management, with a reduction in potentially preventable admissions by 10 per year, the cost savings could reach $175,000 annually with the potential by DY5 to save $560,000-$700,000 for public payers. These figures reflect modest valuation based on our top potentially preventable admission diagnoses whereas our project will encompass a larger targeted service population.

NEW: 121792903.2.7 ***OLD: 121792903.2.2***	***2.2.1***	***2.2.1.A*** ***2.2.1.B*** ***2.2.1.C*** ***2.2.1.D*** ***2.2.1.E***	***CHRONIC CARE MANAGEMENT (CCM)***
HAMILTON GENERAL HOSPITAL			*121792903*
Related Category 3 Outcome Measure(s):	*IT-2.5* *IT-2.9* *IT-2.10*	*New: 121792903.3.17* *Old: 121792903.3.4* *New: 121792903.3.18* *Old: 121792903.3.5* *New: 121792903.3.19* *Old: 121792903.3.6*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate* *Uncontrolled Diabetes Admissions Rate* *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-3. Milestone: Develop a comprehensive care management program Metric 1 P-3.1. Metric: Documentation of Care management program Goal: Utilize chronic care models in developing the care management program. Data Source: Program materials Milestone 1 Estimated Incentive Payment: $1,365,506	**Milestone 2** P-2. Milestone: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 P-2.1. Metric: Increase percent of staff a. Numerator: Number of relevant staff trained in the Chronic Care Model ("relevant" as defined per the Performing Provider) b. Denominator: Total number of relevant staff Goal: Train case managers in the CCM project and train staff to serve as "points of contact" in the inpatient setting and the outpatient setting that can work with the CCM Case Manager to	**Milestone 4** P-10. Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric 1 P-10.1. 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 (please specify type of visit) Goal: Develop systematic process for utilizing various interaction types such as scheduled time for telephone visits.	**Milestone 6** I-17. Milestone: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 I-17.1. Metric: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC a. Name the chronic disease or MCC included Baseline/Goal: Apply the Chronic Care Model to chronic obstructive pulmonary disease, bacterial pneumonia, and diabetes patients. Increase number of patients under the Chronic Care Model by 25% over baseline. Data Source: Registry

NEW: 121792903.2.7 ***OLD: 121792903.2.2***	***2.2.1***	***2.2.1.A*** ***2.2.1.B*** ***2.2.1.C*** ***2.2.1.D*** ***2.2.1.E***	***CHRONIC CARE MANAGEMENT (CCM)***	
HAMILTON GENERAL HOSPITAL				*121792903*
Related Category 3 Outcome Measure(s):	*IT-2.5* *IT-2.9* *IT-2.10*	*New: 121792903.3.17* *Old: 121792903.3.4* *New: 121792903.3.18* *Old: 121792903.3.5* *New: 121792903.3.19* *Old: 121792903.3.6*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate* *Uncontrolled Diabetes Admissions Rate* *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)**
	ensure utilization of services is appropriate and establish understanding of the CCM program system-wide. Data Source: HR, training program materials Milestone 2 Estimated Incentive Payment: $791,402.50 **Milestone 3** P-3. Milestone: Develop a comprehensive care management program Metric 1 P-3.2. Metric: Increase the number of patients enrolled in a care management program over baseline. a. Number of patients enrolled in a care management program Goal: Establish baseline for the		Data Source: EHR, billing records Milestone 4 Estimated Incentive Payment: $799,580.50 **Milestone 5** I-17. Milestone: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 I-17.1. Metric: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC a. Name the chronic disease or MCC included Goal: Apply the Chronic Care Model to chronic obstructive pulmonary disease, bacterial pneumonia, and diabetes patients. Increase number of	Milestone 6 Estimated Incentive Payment: $1,370,125

NEW: 121792903.2.7 ***OLD: 121792903.2.2***	***2.2.1***	***2.2.1.A*** ***2.2.1.B*** ***2.2.1.C*** ***2.2.1.D*** ***2.2.1.E***	***CHRONIC CARE MANAGEMENT (CCM)***	
HAMILTON GENERAL HOSPITAL				*121792903*
Related Category 3 Outcome Measure(s):	*IT-2.5* *IT-2.9* *IT-2.10*	*New: 121792903.3.17* *Old: 121792903.3.4* *New: 121792903.3.18* *Old: 121792903.3.5* *New: 121792903.3.19* *Old: 121792903.3.6*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate* *Uncontrolled Diabetes Admissions Rate* *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)**
	number of patients enrolled. Data Source: Program enrollment records Milestone 3 Estimated Incentive Payment: $791,402.50		patients under the Chronic Care Model by 15% over baseline. Data Source: Registry Milestone 5 Estimated Incentive Payment: $799,588.50	
Year 2 Estimated Milestone Bundle Amount: $1,365,506	Year 3 Estimated Milestone Bundle Amount: $1,582,805		Year 4 Estimated Milestone Bundle Amount: $1,599,161	Year 5 Estimated Milestone Bundle Amount: $1,370,125
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,917,597				

Summary Information:
Pass 3B Project: 121792903.2.8

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): The Care Transition Program will be a combination of a new initiative and the inclusion of core project component elements that build on practices currently in place within our health system. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care, for example, from hospital to home or nursing home, or from facility to home and community based services have been shown to be prone to errors. Safe, effective and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities.
- Need for the project: Readmissions serve as 30% of our annual inpatient hospitalizations. This emphasizes the need and reach of this project in targeting potentially preventable readmissions through care transition initiatives and through the remodeling of the hospital discharge process.
- Medicaid and Uninsured Target population: 31.2% of our patient population is uninsured and 20% are covered by Medicaid. This is over half of our patient population. The plan is to develop a program that reaches our full inpatient population which is around 2,000 discharges per year.
- Category 1 or 2 expected patient benefits: The scope of this project impacts our total acute care population transitioning to home or other care settings post-acute care stay. The program will initially focus on patients that are discharged home. From October 2011-September 2012 we had 919 patients discharged to home from our inpatient unit. Based on our current inpatient volume, current number of readmissions and our projected goal by DY 5 to reduce readmissions, a roughly estimated reduction in readmissions could be approximately 180 per year by DY 5 when the project is fully implemented. Cost avoidance from 180 hospitalizations is significant for impacting Medicaid cost and reducing the burden from the uninsured population as well. The Care Transitions program is expected to increase the number of patients in our population receiving care under the care transitions plan protocol and to reduce the monthly average of patients with a readmission within 30 days. The projected target is a result of a 20% reduction of 30 day readmissions by year DY 5.
- Category 3 outcomes: IT-3.1 Our goal is to reduce the all cause 30 day readmission rate by 3% below baseline by DY4 and 5% below baseline by DY5.

Pass 3B
Category 2: Program Innovation and Redesign

Hamilton General Hospital
TPI 121792903
Project identifier:
New: 121792903.2.8
Old: 121792903.2.3

Project Title 2.12 ***Care Transition Program***

Project Option 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence based care delivery model to improve care transitions

Required core project components:
a) Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.).
b) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews.
c) Integrate information systems so that continuity of care for patients is enabled
d) Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
e) Implement discharge planning program and post discharge support program
f) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
g) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Project Description

The Care Transition Program will be a combination of a new initiative and the inclusion of core project component elements that build on practices currently in place within our health system. The development of an organized, fully established, multi-component program centered on care transitions will be a new aspect that focuses on the prevention of readmissions through the coordination of care from inpatient to outpatient, post-acute care, and home care settings.

The Care Transition Program developed and implemented will include use of best practice models, identification system for patients being discharged that are potentially at risk for needing acute care services within 30-60 days, standardized clinical protocols and a care delivery model that will integrate information systems so that continuity of care for our patients is enabled. The program will also include the redesign of our discharge planning program and post discharge support program and well as a more robust quality improvement methodology to evaluate program impacts, limitations, and opportunities.

More specifically, the best practice model for Project RED will be used as well as risk standardized screening of patients and chart review tools for readmission analysis. The Re-Engineered Hospital Discharge (Project RED) intervention initiative redesigns the workflow process and improves patient safety by using a nurse discharge advocate who follows 11 discrete, mutually reinforcing action steps shown to improve the discharge process and decrease hospital readmissions. Patients who have a clear understanding of their after-hospital care instructions, including how to take their medicines and when to make follow-up appointments, are 30 percent less likely to be readmitted or visit the emergency department than patients who lack this information, according to a study published in the Annals of Internal Medicine (February 3, 2009).

Goals: Best practice implementation of Project RED will help with the following:

- Improve patient outcomes.
- Improve 30 day readmission rate
- Improve cost/revenue management.
- Improve HCAHPS scores.
- Prepare for changes to CMS reimbursement penalties for high readmission rates.
- Improve nurse/provider time utilization.
- Enhance portability of PHI across the continuum of care.
- Improve relationship with PCPs.

Challenges: The current business case for allocating resources will be needed to be successful in Project RED. The hospital will meet challenges with last minute tests and consolations so not to delay the final discharge plan. Medication reconciliation must start on the day of admission. We will need to find financial incentives to sustain discharge programs and personalize discharge papers instead of the current standardized forms. Patients will need to have a PCP with limited or no insurance coverage being a need to overcome. We need a plan to pay for medications when the patient cannot pay for the medications or co-pays and make sure that discharge teaching begins on admission. As demonstrated by evidence-based studies, teaching is less effective if you wait until the patient is discharged and they are anxious to leave the facility.

Expected 5-Year Outcome: The scope of this project impacts our total acute care population transitioning to home or other care settings post-acute care stay. BY DY5 we expect to reduce the monthly average of patients with a readmission within 30 days by 20% over baseline and increase adherence with care transition protocol by 20% over baseline. Based on our current inpatient volume, current number of readmissions and our projected goal by DY 5 to reduce readmissions, a roughly estimated reduction in readmissions could be approximately 180 per year by DY 5 when the project is fully implemented. Cost avoidance from 180 hospitalizations is significant for impacting Medicaid cost and reducing the burden from the uninsured population as well.

Starting Point/Baseline

We currently do not have a full Care Transition Program in place. The plan is to develop a program that reaches our full inpatient population which is around 2,000 discharges per year. The program will initially focus on patients that are discharged home. From October 2011-September 2012 we had 919 patients discharged to home from our inpatient unit. Current readmission rates will also be used as a baseline for the program. Currently we have an estimated 30% of annual admissions resulting from readmissions. Baseline data collection will continue in DY2 to establish solid groundwork and continue identifying needs to be covered with the Care Transitions Program. Process measurements and outcomes will be collected at the beginning of the project so the data can help establish realistic goals and identify cause and effect of processes. The projected target is a result of a 20% reduction of 30 day readmissions by year DY 5. The continued development of integration between our inpatient and outpatient electronic health records within our health system and the process flow/transfer of data will also be addressed within the scope of the Care Transition project.

Rationale

Hamilton Healthcare System will implement improvements in care transitions and coordination of care from inpatient to outpatient, post- acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care, for example, from hospital to home or nursing home, or from facility to home and community based services have been shown to be prone to errors. Safe, effective and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. Readmissions serve as 30% of our annual inpatient hospitalizations. This emphasizes the need and reach of this project in targeting potentially preventable readmissions through care transition initiatives and through the remodeling of the hospital discharge process. The primary outcome of this project relates to the CNA-004 for reducing potentially preventable hospitalizations and CNA-009 for reducing 30-day readmissions.

Patients will receive education throughout the hospital stay with easy flow of information from the patient's doctor to the hospital team and back to the doctor including a written discharge plan. The discharge plan for the patient will include making appointments for follow-up care and testing as well as confirming the medication plan and making sure the patient understands changes in the routine and side effects to watch for. We will ask patients to explain in their own words the details of the discharge plan, through teach-back methodology, and will telephone the patient 2-3 days after discharge to identify and resolve any problems.

Process measurements and outcomes will be collected at the beginning of the project so the data can help establish realistic goals and identify cause and effect of processes. Patients then should have the knowledge and skills to care for themselves at home. The projected target is a result of a 20% reduction of 30 day readmissions by year DY 5.

All core project components will be included in the project. The identified need of this project was recognized through evaluation of readmission reports including the PEPPER and the Hospital Readmissions Reduction Program reports from CMS. Locally, we have an excess readmission ratio from the baseline data period for the Readmissions Reduction Program. The Standardized Readmission Ratio (SRR) is the measure that will be used to determine the payment adjustment for the program. Our goal is to perform better than the average hospital that admitted similar patients and reduce our baseline SSR to less than 1.0000. While the SRR currently targets the diagnoses of AMI, HF, and PN our goal is to implement the Care Transition Program to impact Hospital-Wide All-Cause Readmission.

Related Category 3 Outcome Measure

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

IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)*

a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

b. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older

c. Data Source: EHR, Claims

d. Rationale/Evidence: This measure estimates the hospital-level, risk standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty

cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. The measure was developed for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. The following was used: the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data. (RHP Planning Protocol)

Reasoning for the selection of this outcome measure is to work toward the goals of CMS within the Readmissions Reduction Program, to prepare for future expansion with the readmission program and to reduce the cost burden for preventable hospital readmissions. Our evaluation of our facility scores on the SRR and internal EHR reports supports the need for a Care Transition project to target excess readmissions. We estimate from internal data that nearly 30% of our annual inpatient hospitalizations are due to readmission. This is a priority for our organization. Across RHP 16 the Community Needs Assessment identifies many opportunities that will tie into the transition of care such as expansion of primary and specialty care, coordination with Mental Health Providers, efforts within and across communities to address major health issues, and models for telehealth. These opportunities outlined in the Community Needs Assessment will impact the successes of the Care Transitions program by providing outlets for patients to be directed for better coordinated and more efficient outpatient care.

Relationship to other Projects

Care transitions will work concomitantly with other Hamilton projects. Care transitions will help guide hospitalized patients in the right direction during the post-acute phase of illness. This may include ensuring that a referral is placed to the Heart Failure Program (121792903.2.6) for outpatient follow-up or that the primary care appointment is timely due to the Expansion of Primary Care project (121792903.1.3). Case managers in the inpatient side working with Care Transitions may help identify and contact the outpatient case manager that may be following chronic disease patients through the Chronic Care Management project (121792903.2.7). The goal of the Hamilton projects is to provide better access to quality care and reduce the need for inpatient stays.

Relationship to Other Performing Providers' Projects in the RHP Use the RHP 16 listing

RHP 16 providers will offer several projects that will support the Care Transitions project at Hamilton General Hospital.
Collaboration with other performing providers will allow Hamilton General Hospital to effectively manage this project and develop the project over the next few years by sharing best practices, new ideas, and solutions across the RHP.

Project Valuation

This project has been valued at $5,757,661. There are currently 1060 Medicaid recipients and 1451 Elderly Medicare and 143 Medicare disabled recipients in Hamilton County. Hamilton County is 31.2% uninsured this is higher than any other county in our region (Region 16 Community Needs Assessment). We also have a high rate of Potentially Preventable Hospitalizations for CHF & Bacterial Pneumonia (RHP 16 Potentially Preventable Hospitalization DSHS). We need to develop standardized clinical protocols, consolidate references in the community and utilize them to lead the patient to proper aftercare follow-up with their PCP and with educating the patient and family of early warning signs. We will focus on improving the quality of care for Medicare beneficiaries as they transition between providers. Participants will form relationships with community organizations and health care providers and coordinate activities to ensure community-wide adoption of best practices.

The scope of this project impacts our total acute care population transitioning to home or other care settings post-acute care stay. The program will initially focus on patients that are discharged home. From October 2011-September 2012 we had 919 patients discharged to home from our inpatient unit. Based on our current inpatient volume, current number of readmissions and our projected goal by DY 5 to reduce readmissions, a roughly estimated reduction in readmissions could be approximately 180 per year by DY 5 when the project is fully implemented. Cost avoidance from 180 hospitalizations is significant for impacting Medicaid cost and reducing the burden from the uninsured population as well. The Care Transitions program is expected to increase the number of patients in our population receiving care under the care transitions plan protocol and to reduce the monthly average of patients with a readmission within 30 days. The projected target is a result of a 20% reduction of 30 day readmissions by year DY 5.

NEW: 121792903.2.8 ***OLD: 121792903.2.3***	***2.12.1***	***2.12.1.A*** ***2.12.1.B*** ***2.12.1.C*** ***2.12.1.D*** ***2.12.1.E*** ***2.12.1.F*** ***2.12.1.G***	***CARE TRANSITIONS PROGRAM***
Hamilton General Hospital			*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*New: 121792903.3.20* *Old: 121792903.3.7*	*All cause 30 day readmission rate-NQF 1789 (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: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions Metric 1 P-1.1. Metric: Care transitions protocols Goal: Implement Project RED with hospital inpatients. Data Source: Submission of protocols, Care transitions program materials Milestone 1 Estimated Incentive	**Milestone 4** P-4. Milestone: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge Metric 1 P-4.1. Metric: Care transitions assessment a. Submission of care transitions assessment and resource planning documents Goal: Develop resources for staff to determine appropriate post-discharge support and generate appropriate referrals to CBO. Data Source: Care transitions assessment and resource planning documents	**Milestone 8** P-7. Milestone: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 P-7.1. Metric: Documentation of the staffing plan. Goal: Research and develop appropriate staffing plan for addressing patient case load. Data Source: Staffing and implementation plan. Milestone 8 Estimated Incentive Payment: $518,646.66 **Milestone 9** I-10. Milestone: Identify the top chronic	**Milestone 11** I-10. Milestone: Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions Metric 1 I-10.1. Metric: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. a. List by frequency of most prevalent chronic conditions,

NEW: 121792903.2.8 ***OLD: 121792903.2.3***	***2.12.1***	***2.12.1.A*** ***2.12.1.B*** ***2.12.1.C*** ***2.12.1.D*** ***2.12.1.E*** ***2.12.1.F*** ***2.12.1.G***	***CARE TRANSITIONS PROGRAM***
Hamilton General Hospital			*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*New: 121792903.3.20* *Old: 121792903.3.7*	*All cause 30 day readmission rate-NQF 1789 (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: $442,868.33 **Milestone 2** P-2. Milestone: Implement standardized care transition processes Metric 1 P-2.1. Metric: Care transitions policies and procedures Goal: Policies and procedures to be developed. Data Source: Policies and procedures of care transitions program materials Milestone 2 Estimated Incentive Payment: $442,868.33 **Milestone 3** P-3. Milestone: Establish a process for hospital-based case managers to	Milestone 4 Estimated Incentive Payment: $385,005.50 **Milestone 5** P-5. Milestone: Using a validated risk assessment tool, create a patient identification system. Metric 1 P-5.1. Metric: Patient stratification system Baseline/Goal: Develop risk assessment tool using evidence-based resources. Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization of report findings. Milestone 5 Estimated Incentive	conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions Metric 1 I-10.1. Metric: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. a. List by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest	patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates. Goal: Reduce the monthly average of patients with a readmission within 30 days for our top chronic conditions by 20% over baseline. Data Source: Registry or EHR report/analysis Milestone 11 Estimated Incentive Payment: $666,547 **Milestone 12** I-14. Milestone: Implement standard care transition processes in specified patient populations. Metric 1 I-14.1. Metric: Measure

NEW: 121792903.2.8 ***OLD: 121792903.2.3***	***2.12.1***	***2.12.1.A*** ***2.12.1.B*** ***2.12.1.C*** ***2.12.1.D*** ***2.12.1.E*** ***2.12.1.F*** ***2.12.1.G***	***CARE TRANSITIONS PROGRAM***
Hamilton General Hospital			*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*New: 121792903.3.20* *Old: 121792903.3.7*	*All cause 30 day readmission rate-NQF 1789 (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)**
follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge Metric 1 P-3.1. Metric: Care transitions protocols Goal: Develop specific criteria for chronic disease patient groups to be evaluated post-hospital stay during follow-up phone call. Example: disease specific templates.	Payment: $385,005.50 **Milestone 6** I-10. Milestone: Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions Metric 1 I-10.1. Metric: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. a. List by frequency of most	readmission rates. Goal: Reduce the monthly average of patients with a readmission within 30 days for our top chronic conditions by 10% over baseline. Data Source: Registry or EHR report/analysis Milestone 9 Estimated Incentive Payment: $518,646.66 **Milestone 10** I-14. Milestone: Implement standard care transition processes in specified patient populations. Metric 1 I-14.1. Metric: Measure adherence to processes. a. Numerator: Number of patients in defined population receiving	adherence to processes. a. Numerator: Number of patients in defined population receiving care according to standard protocol. b. Denominator: Number of population patients discharged. Goal: Increase adherence with care transition protocol by 20% over baseline. Data Source: Hospital administrative data and the patient medical record. Milestone 12 Estimated Incentive Payment: $666,547

NEW: 121792903.2.8 ***OLD: 121792903.2.3***	***2.12.1***	***2.12.1.A*** ***2.12.1.B*** ***2.12.1.C*** ***2.12.1.D*** ***2.12.1.E*** ***2.12.1.F*** ***2.12.1.G***	***CARE TRANSITIONS PROGRAM***
Hamilton General Hospital			*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*New: 121792903.3.20* *Old: 121792903.3.7*	*All cause 30 day readmission rate-NQF 1789 (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)
Data Source: Care transitions program materials Milestone 3 Estimated Incentive Payment: $442,868.33	prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates. Goal: Establish readmission rates specific for chronic conditions. Baseline: Average number of patients with a readmission within 30 days for our top chronic conditions Data Source: Registry or EHR report/analysis Milestone 6 Estimated Incentive Payment: $385,005.50 **Milestone 7** I-14. Milestone: Implement standard care transition processes in specified	care according to standard protocol. b. Denominator: Number of population patients discharged. Goal: Increase adherence with care transition protocol by 10% over baseline. Data Source: Hospital administrative data and the patient medical record. Milestone 10 Estimated Incentive Payment: $518,646.66	

NEW: 121792903.2.8 ***OLD: 121792903.2.3***	***2.12.1***	***2.12.1.A*** ***2.12.1.B*** ***2.12.1.C*** ***2.12.1.D*** ***2.12.1.E*** ***2.12.1.F*** ***2.12.1.G***	***CARE TRANSITIONS PROGRAM***	
Hamilton General Hospital				*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*New: 121792903.3.20* *Old: 121792903.3.7*	*All cause 30 day readmission rate-NQF 1789 (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)**
	patient populations. Metric 1 I-14.1. Metric: Measure adherence to processes. a. Numerator: Number of patients in defined population receiving care according to standard protocol. b. Denominator: Number of population patients discharged. Goal: Define protocol for standard care transition. Baseline: All inpatient discharges with % adherence to standard protocol. Data Source: Hospital administrative data and the patient medical record. Milestone 7 Estimated Incentive Payment: $385,005.50			

NEW: 121792903.2.8 ***OLD: 121792903.2.3***	***2.12.1***	***2.12.1.A*** ***2.12.1.B*** ***2.12.1.C*** ***2.12.1.D*** ***2.12.1.E*** ***2.12.1.F*** ***2.12.1.G***	***CARE TRANSITIONS PROGRAM***
Hamilton General Hospital			*121792903*
Related Category 3 Outcome Measure(s):	*IT-3.1*	*New: 121792903.3.20* *Old: 121792903.3.7*	*All cause 30 day readmission rate-NQF 1789 (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)**
Year 2 Estimated Milestone Bundle Amount: $1,328,605	Year 3 Estimated Milestone Bundle Amount: $1,540,022	Year 4 Estimated Milestone Bundle Amount: $1,555,940	Year 5 Estimated Milestone Bundle Amount: $1,333,094
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,757,661			

Summary Information:

Pass 3B Project: 121792903.2.9

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): Services provided in the Palliative Care Program will include outpatient office visits, inpatient consults, care planning including DNR preferences, referrals for post discharge support such as home health, and coordination of services with the patient's primary care provider and specialists. We will work with the Palliative Care team at Hillcrest Baptist Medical Center. They act as a central hub for Region 16 for all knowledge and resources related to Palliative Care. The Hillcrest team will provide training to our facility as well as access to their trained staff. The highly trained and specialized providers can help to train and guide our primary care providers to offer the best care for our patients.
- Need for the project: With an elderly population in Hamilton County more than double the state rate at 25.1% for those over 65, and a growing population of patients with chronic disease and co-morbidities, the need for addressing care needs and end-of-life decisions is a priority for our health system to continue supporting the best possible quality of life for the patient and the family throughout the lifespan regardless of prognosis.
- Medicaid and Uninsured Target population: 31.2% of our patient population is uninsured and 20% are covered by Medicaid. This is over half of our patient population.
- Category 1 or 2 expected patient benefits: To determine potential patients that could receive a referral to the palliative service we assumed a 5% rate of total acute care inpatient volume. The capture rate was calculated based on a 20-50% assumption for the number of patients that would actually end up using services from the total referred. This capture rate identifies that the program volume for palliative care could range from an average of 18-45 patients per year. The goal of palliative care is to minimize transfers to ICUs, stays in the hospital, and discharge home with no services; while maximizing patient transitions to home care, hospice and SNF. By DY4 we expect to transition rate to be 50% for our palliative care patients from acute hospital care into home care, hospice, or a SNF and increase this rate to 75% by DY5.
- Category 3 outcomes:
    - IT-13.1 Our goal is to increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD % over baseline by DY4 and DY5.
    - IT-13.2 Our goal is to increase the percentage of hospice or palliative care patients with chart documentation of preferences for life sustaining treatments by TBD % over baseline by DY4 and DY5.

- IT-13.5 Our goal is to increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD % over baseline by DY4 and DY5.

Pass 3B
Category 2: Program Innovation and Redesign

Hamilton General Hospital
TPI 121792903
Unique RHP Project Identification Number:
New: 121792903.2.9
Old: 121792903.2.4

Project Title 2.10 **Palliative Care Program Companion Project**

Project Option 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

Required core project components:
a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility
c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
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 population.

Project Description

The Palliative Care project will deliver a service to patients of Hamilton General Hospital to provide appropriate and quality end-of-life care. With an elderly population in Hamilton County more than double the state rate at 25.1% for those over 65, and a growing population of patients with chronic disease and co-morbidities, the need for addressing care needs and end-of-life decisions is a priority for our health system to continue supporting the best possible quality of life for the patient and the family throughout the lifespan regardless of prognosis. The principles of implementing a palliative care program will focus on care coordination and evidence-based practice and decision making to ensure that patients receive dignified and culturally appropriate end-of-life care, provided in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

The relationship between palliative care and the regional goals include the impact on reducing potentially preventable hospitalizations by ensuring that patients are receiving the right care, in the right place, and at the right time. Palliative care offers a focus on quality of life and the holistic view of the patient in an attempt to reduce unnecessary hospitalization of patients based on inappropriate or overly aggressive care. Utilization of the Emergency Department can also be common due to chronic conditions. The ED is often over-utilized for conditions where treatment in the emergent or acute setting does not offer additional benefit in attaining the patient's quality of life goals.

Services provided in the Palliative Care Program will include outpatient office visits, inpatient consults, care planning including DNR preferences, referrals for post discharge support such as home health, and coordination of services with the patient's primary care provider and specialists.

We will work with the Palliative Care team at Hillcrest Baptist Medical Center. They act as a central hub for Region 16 for all knowledge and resources related to Palliative Care. The Hillcrest team will provide training to our facility as well as access to their trained staff. The highly trained and specialized providers can help to train and guide our primary care providers to offer the best care for our patients.

Goals: The primary goal for delivering the Palliative Care Program is to offer needed care to our end-of-life patients with chronic diseases in an appropriate cost effective manner while utilizing the right setting of care and improving. Through collaboration with our regional partner we will be able to accomplish the intended goals of the project relative to our local need for the patient population, the regional goals previously identified, regional collaboration through partnership with Hillcrest Baptist Medical Center, and the waiver goals of Category 3 outcome measures.

Challenges: The challenge will be developing the program, as we currently do not have this service in place, and educating our care providers. The transition of care for palliative care patients will also be a point of attention to ensure continuity of care and coordination with appropriate services. Palliative care and planning considers the wishes of the patient and plans to focus on quality of life rather than curative medicine. Lack of planning is more prevalent in the indigent and underserved population. Assistance in addressing the challenges we face in program implementation will be provided through a regional partner, Hillcrest Baptist Medical Center. This partnership will allow for collaboration on the project and aid in additional services to fully implement and carry out the palliative care program.

Expected 5-year Outcome: The five year goal for Hamilton General Hospital is to develop a palliative care program with trained providers in protocols, appropriate algorithms, and evidence-based practice to treat patients during end-of-life care. This will also include increasing the transition of patients to the appropriate setting such as home care, hospice, or skilled nursing facility and the improvement in the patient and family experience. The project timeline will follow the Hillcrest Baptist Medical Center project (138962907.2.1) for accomplishment of core components:

(a) In DY2 of the waiver a business plan will be developed and submitted.

(b) In DY3 a formal baseline will be established for the number of patients served and the percent of transitions accomplished

(c) In DYs 4 and 5, the number of transitions accomplished through the palliative care program will be measured and reported. The patient/family experience survey will be implemented with improved scores by the end of DY4 and DY5.

(d) Quality methodology will be performed based on internal program characteristics and will also be met through collaboration with regional partners in conference calls to discuss best practices, areas of opportunity, care hand-off challenges, available support, and optimal education/outreach efforts.

Starting Point/Baseline

A palliative care program does not formally exist at this time. Baseline data will be established in DY3. Using a model from the Center to Advance Palliative Care, we established reasonable estimates of the impact a Palliative Care Program could serve. To determine potential patients that could receive a referral to the palliative service we assumed a 5% rate of total acute care inpatient volume. Utilizing admission trends over the last three fiscal years at Hamilton General Hospital, this would result in potential referral volume from 78-100 patients per year. The capture rate was calculated based on a 20-50% assumption for the number of patients that would actually end up using services from the total referred. This capture rate identifies that the program volume for palliative care could range from an average of 18-45 patients per year. According to the estimation model from the Center to Advance Palliative Care, results that exceed projected volumes may be the consequence of 1) hospital demographics and practice style 2) current performance in case management in the hospital, and the opportunities for improvement 3) success of the program's marketing and outreach activities, and 4) breadth of services offered by the program, including outpatient follow-up.

Rationale

As a rural facility, the opportunity to provide "hometown healthcare" and bring a service or specialty to the local population we serve is an important feature in the mission for our organization. Patients and families feel comfortable being cared for in a local setting and by people they know and love. An especially trying time for patients and families is coping with end-of-life decisions and the care and treatment options available. As the elderly population continues to grow there is a larger need for more support options in this aspect of care. Being able to provide the right avenue of care delivery in the right setting is important for our health system financially and in regard to patient comfort and preferences.

According to the RHP Planning Protocol for the use of palliative care programs, "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 dementia. Further, some experts have suggested that palliative and hospice care could be more widely embraced for many dying patients…It seems clear that improving care coordination near the end-of-life can improve care for patients with chronic conditions."

Often the most persuasive argument for hospital support is demonstrated cost savings resulting from formal palliative care services. Palliative Care has been proven to lower costs and shorten length of stay, thereby helping to improve throughput and increase capacity for admissions, reduce readmission to ED, reduce low-margin admissions (long stays for exacerbations of chronic illness), emergency department interventions, and timely discussions about ICU therapies. While the program can generate revenue derived from delivery of palliative care, its typically will be modest compared to the larger number of dollars saved through shorter length-of-stay 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-careprogram/financing/costsavings/index_html/view?searchterm=quality%20and%20cot%20savings).

Based upon age demographics and rate of chronic disease we feel this to be a viable service opportunity to offer to our community. Another resource by the Center to Advance Palliative Care is a completed study on variability in access to palliative care by state. Texas offers one of the lower rates of palliative care programs compared to the rest of the nation. 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.

Hamilton General Hospital currently offers inpatient hospice options through contract relationships with four hospice providers. The inpatient hospice options would work together with the Palliative Care program in order to provide appropriate transitions between the various levels of care. While hospice care is important for patients in their final stages of life, palliative care offers a much wider range of patients the same type of benefits and treatment goals but with much earlier and longer-term intervention periods. Within palliative care, patients received 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.

All required core project components for project option 2.10.1 will be implemented within the Palliative Care Program. Core components: (a) A business case will be developed for the palliative care program and planning activities necessary as a precursor to program implementation will be performed. (b) Palliative care patients will be transitioned from acute hospital care into home care, hospice, or a skilled nursing facility. Improvement milestone I-9 and metric I-9.1 will be reported. The goal is to minimize transfers to ICUs, stays in the hospital, and discharge home with no services while maximizing patient transitions to home care, hospice and SNF. (c) A patient/family experience survey will be administered regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care. The goal will be to improve scores over time as the Palliative Care Program becomes fully developed with all aspects launched. (d) Quality improvement methodology will be employed to identify project impacts, “lessons learned,” and opportunities for the program.

Related Category 3 Outcome Measure(s)

OD-13 Palliative Care
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
IT-13.2 Treatment Preferences (NQF-1641) (Non-standalone measure)
IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program. As a companion project, these outcome measures are also supportive data for Hillcrest Baptist Medical Center to validate the services they are providing for the regional partners.

Relationship to other Projects

The Palliative Care Program will correlate with other projects, most specifically the Care Transitions project (121792903.2.8). Palliative care will serve as a compliment to what is being accomplished with the Care Transitions project and will allow for a practical avenue in transitioning patients to the correct setting. Projects of relationship will also include the Chronic Care Management (CCM) (121792903.2.7) and Congestive Heart Failure Program (121792903.2.6). These projects with work with the chronic management of conditions, CCM through the use of additional case management support in the outpatient setting for assisting in guiding patients with chronic illnesses to the right point of care and ensuring they are receiving needed services. The Heart Failure Program is disease specific but will be able to serve as a referral source from the outpatient setting to the Palliative Care Program for eligible patients when they reach a palliative need in their disease process such as is the case with end-stage congestive heart failure. Palliative care will be an important piece of offering care throughout the lifespan and disease state of our patients.

Relationship to Other Performing Providers' Projects in the RHP

The Hamilton General Hospital Palliative Care Project will be related to projects of other performing providers in the region. Hillcrest Baptist Medical Center and Coryell Memorial Hospital plan implementation of similar projects. These facilities will share in a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative

RHP 16 will meet quarterly to discuss the current state of the region's projects, issues related to those projects, and the populations served by the region. RHP 16 will also meet to discuss opportunities to learn from successes and failures during the implementation of the projects.

Project Valuation

This project has been valued at $1,862.097. Project valuation accounts for the following factors:

1) The project achieves the waiver goals by assuring patients receive high-quality and patient-centered care in the most cost effective ways. This program will bolster the healthcare infrastructure to reduce costs and better serve Medicaid and uninsured residents by avoiding

unnecessary treatments and expenses during stages of the disease process where these treatments do not improve outcomes or quality of life for the patient.

2) This addresses a community need by providing a service and an appropriate transition outlet for patients with end-stage disease that do not qualify for hospice care. CNA-007 and CNA-010 will both be impacted through the reduction of inappropriate emergency room utilization due to patients not having an appropriate transition to the right level of care and through the measurement of patient/family experience, respectively.

3) The scope of this project will be small in comparison to Hamilton General Hospital's other projects but will be able to provide additional savings from avoiding/preventing unnecessary ER visits and readmissions as well as reducing length of stay. Outreach will be performed in the targeted population and local providers will be trained in practice of palliative care.

4) Project investment will require a considerable amount of training, program development, and time for implementation as this will be a new area of service for the facility. The valuation for this project specifically focuses on the potential of better care transition management to improve patient outcomes and challenges in implementing this project in the hospital setting.

To determine potential patients that could receive a referral to the palliative service we assumed a 5% rate of total acute care inpatient volume. The capture rate was calculated based on a 20-50% assumption for the number of patients that would actually end up using services from the total referred. This capture rate identifies that the program volume for palliative care could range from an average of 18-45 patients per year. The goal of palliative care is to minimize transfers to ICUs, stays in the hospital, and discharge home with no services; while maximizing patient transitions to home care, hospice and SNF. By DY4 we expect to transition rate to be 50% for our palliative care patients from acute hospital care into home care, hospice, or a SNF and increase this rate to 75% by DY5.

NEW: 121792903.2.9 ***OLD: 121792903.2.4***	***2.10.1***	***2.10 A*** ***2.10 B*** ***2.10 C*** ***2.10 D***	***PALLIATIVE CARE PROGRAM***	
Hamilton General Hospital				*TPI- 121792903*
Related Category 3 Outcome Measure(s):	*IT-13.1* *IT-13.2* *IT-13.5*	*New: 121792903.3.21* *Old: 121792903.3.9* *New: 121792903.3.22* *Old: 121792903.3.10* *New: 121792903.3.23* *Old: 121792903.3.11*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 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 Baseline/Goal: Develop baseline data information. Potential for 78-100 referrals annually. Re-evaluate referral opportunities and sources. Data Source: Submission of business case write-up; documentation of planning activities Milestone 1 Estimated Incentive Payment : $409,082	**Milestone 2** [P-2]: Educate primary care specialties (e.g. family medicine, internal medicine, pediatrics, geriatrics and other IM subspecialties) in providing palliative care including non-cancer training. Metric 1 [P-2.1]: Primary care specialties training and education in palliative care. Baseline/Goal: Educate our family practice physicians in providing palliative care. Data Source: Database that tracks type and number of training and education sessions by health professional category. Milestone 2 Estimated Incentive		**Milestone 5** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice, or SNF Denominator: Total number of palliative care discharges. Goal: 50% of palliative care discharges to home care, hospice, or SNF Data Source: EHR, data warehouse, palliative care database	**Milestone 7** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished Numerator: Number of palliative care discharges to home care, hospice, or SNF Denominator: Total number of palliative care discharges. Goal: 75% of palliative care discharges to home care, hospice, or SNF Data Source: EHR, data warehouse, palliative care database

NEW: 121792903.2.9 ***OLD: 121792903.2.4***	***2.10.1***	***2.10 A*** ***2.10 B*** ***2.10 C*** ***2.10 D***	***PALLIATIVE CARE PROGRAM***	
Hamilton General Hospital				*TPI- 121792903*
Related Category 3 Outcome Measure(s):	*IT-13.1* *IT-13.2* *IT-13.5*	*New: 121792903.3.21* *Old: 121792903.3.9* *New: 121792903.3.22* *Old: 121792903.3.10* *New: 121792903.3.23* *Old: 121792903.3.11*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*	
Year 2 (10/1/2012 – 9/30/2013)	**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: $166,722 **Milestone 3** [P-3]: Implement palliative care education and training programs for providers (physicians, RNs, Pas, NPs, etc.) that incorporates management of non-cancer patients. Metric 1 [P-3.1]: Palliative care training and education for other providers. Baseline/Goal: Educate frontline providers in the palliative care program. Data Source: Database that tracks type and number of training and education sessions by health professional category (physicians, RNs, Pas, NPs, etc).		Milestone 5 Estimated Incentive Payment: $255,813 **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 Goal: Establish survey data, mechanism of distribution, focus on solid response rate for generalizable data; Increase	Milestone 7 Estimated Incentive Payment: $220,611.50 **Milestone 8** [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 Goal: Increase scores by 5% over DY4 Data Source: Patient/family experience survey

NEW: 121792903.2.9 ***OLD: 121792903.2.4***	***2.10.1***	***2.10 A*** ***2.10 B*** ***2.10 C*** ***2.10 D***	***PALLIATIVE CARE PROGRAM***	
Hamilton General Hospital				*TPI- 121792903*
Related Category 3 Outcome Measure(s):	*IT-13.1* *IT-13.2* *IT-13.5*	*New: 121792903.3.21* *Old: 121792903.3.9* *New: 121792903.3.22* *Old: 121792903.3.10* *New: 121792903.3.23* *Old: 121792903.3.11*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 Estimated Incentive Payment: $166,722 **Milestone 4** [P-5]: Implement a palliative care program <u>Metric 1</u> [P-5.1]: Implement comprehensive palliative care program Goal: Palliative care program operational and care team in place; Establish baseline for number of patients served and the % of transitions completed. Data Source: Palliative care program Milestone 4 Estimated Incentive Payment: $166,722		scores by 3% from beginning of DY4 to end of DY4. Data Source: Patient/family experience survey Milestone 6 Estimated Incentive Payment: $255,813	Milestone 8 Estimated Incentive Payment: $220,611.50

NEW: 121792903.2.9 ***OLD: 121792903.2.4***	***2.10.1***	***2.10 A*** ***2.10 B*** ***2.10 C*** ***2.10 D***	***PALLIATIVE CARE PROGRAM***	
Hamilton General Hospital				*TPI- 121792903*
Related Category 3 Outcome Measure(s):	*IT-13.1* *IT-13.2* *IT-13.5*	*New: 121792903.3.21* *Old: 121792903.3.9* *New: 121792903.3.22* *Old: 121792903.3.10* *New: 121792903.3.23* *Old: 121792903.3.11*	*Pain assessment* *Treatment preferences* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss*	
Year 2 (10/1/2012 – 9/30/2013)	**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: $409,082	Year 3 Estimated Milestone Bundle Amount: $500,166		Year 4 Estimated Milestone Bundle Amount: $511,626	Year 5 Estimated Milestone Bundle Amount: $441,223
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,862,097				

Summary Information:
Pass 3B Project: 121792903.2.10

- Provider: Hamilton General Hospital is a 42-bed hospital in Hamilton County, Texas serving an 835 square mile area and a county population of approximately 8,600. Our service area has a population of over 32,000 people in Hamilton County and the surrounding areas. Hamilton General Hospital is a part of the Hamilton Healthcare System that also operates three rural health clinics (2 located in RHP 16 and 1 located in RHP 8), an ambulance service, a behavioral health clinic and a wellness center that provides rehabilitation and preventative services.
- Intervention(s): Hamilton General Hospital and Providence Healthcare Network will partner to provide formal diabetic education that is accessible throughout Region 16 and will establish new support resources for medical management through the addition of practitioners specialized in endocrinology.
- Need for the project: Diabetic Self-Management Education (DSME) is not a covered service by traditional Medicaid and is typically not something the uninsured will pay for out of pocket. These populations of high risk patients with chronic disease are not able to obtain this service and receive the same care that patients with Medicare and Insurance have access to. This project will allow the opportunity to provide much needed education and care within the Medicaid and uninsured population as well as work to standardize diabetes care for all patients across the region.
- Medicaid and Uninsured Target population: The target population for this project is patients with adult diabetes that are either Medicaid or uninsured. According to CDC data for county-level estimates of diagnosed diabetes the 2009 percentage of adults with diabetes averaged 10.5 across the seven counties in our region. The number in this population totaled 28,103. The program will focus on providing services to the adult Medicaid and uninsured population since they are not currently provided access to these services through an insurance source. Adult Medicaid and the uninsured account for 46% of the region's adult population, which means approximately 46% of the total adult diabetes population of 28,103 would be categorized as Medicaid or uninsured, or 12,927 people.
- Category 1 or 2 expected patient benefits: Since DSME is not a service that is funded by traditional Medicaid, it is difficult to utilize prior referral data to estimate the number of referrals expected to be received into the program once it is implemented. As stated above, the estimated population of patients with Medicaid or uninsured with adult diabetes is 12,927 for Region 16. Previous year historical data from Hamilton and Providence accounted for a total of 438 referrals into their diabetes programs. A formal baseline for number of patients enrolled throughout Region 16 will be established in DY3. By DY4 we expect to increase the number of patients enrolled in the program by 25% over baseline and by 50% over baseline in DY5.
- Category 3 outcomes: IT-10.1 Our goal is to reduce the percentage of patients with HbA1c>9.0% by TBD % below baseline by DY4 and DY5.

Pass 3B
Category 2: Program Innovation and Redesign

Hamilton General Hospital
TPI 121792903
Unique Category 2 Project Identifier:
New: 121792903.2.10
Old: 121792903.2.5

Project Title 2.2 ***Diabetes Management Regional Project***

Project Option 2.2.2 Apply evidence-based care management model to patients identified as having high-risk health care needs.

Project Description

The Diabetes Management Project will develop and implement a regional chronic disease management program that is 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 the patients' risk of developing complications, comorbidities or utilizing acute or emergency services.

Hamilton General Hospital and Providence Healthcare Network currently have American Association of Diabetes Educators (AADE) certified Diabetes Self Management Education (DSME) programs that are offered to our respective patient populations on a limited basis.

Hamilton General Hospital and Providence Healthcare Network will partner to provide formal diabetic education that is accessible throughout Region 16. Project development includes hiring additional staff to provide the services on a consistent, regional basis. Providence currently employees two diabetic educators. The program will hire an Endocrinologist, two Dietitians with Certified Diabetes Education designation (with one having bilingual capability), two Care Managers, a program coordinator and two support staff. The program staff will establish diabetes education programs in the additional 5 counties in Region 16 (Bosque, Coryell, Falls, Hill and Limestone).

The project will provide the following services for all 7 counties in Region 16:

- Diabetic Self-Management Education (DSME) classes offered in each county
- Access to a dietitian with CDE designation

- An Endocrinologist
- Established protocols for diabetes care developed with regional input
- Ongoing education for primary care providers including semi-annual CMEs focused on diabetes care for providers in the entire Region 16 area

Quality improvement activities will be conducted to evaluate project impact and identify opportunities for program expansion. Continuous quality improvement will provide data monitoring throughout the project that can be used for continued program development. The current model being used for rapid-cycle improvement in the Hamilton Diabetes Education program is the Plan-Do-Study-Act (PDSA) cycle. This allows changes to be made and tested over shorter periods of time than other standard models and the continual implementation of improvements enables better service to patients, faster goal achievement, and an overall improvement in quality. Previous CQI data from Hamilton and Providence DSME programs will be used to guide the CQI processes for the comprehensive regional project.

Challenges: Currently, Diabetic Self-Management Education (DSME) is not covered by Medicaid. These populations of high risk patients with chronic disease are not able to obtain this service and receive the same care that patients with Medicare and Insurance have access to. This project will allow the opportunity to provide much needed education and care within the Medicaid and unfunded population as well as work to standardize diabetes care for all patients across the region. Other challenges faced include the initiation of generating referrals into the Diabetes Management program. Data supports the community needs and the potential patient volume. Outreach to care providers across the region will be necessary to build the target patient base. Relationships will need to be developed within communities through the region for the most pragmatic approach in delivering care at accessible locations.

Targeted Patient Population: The target population for this project is patients with adult diabetes that are either Medicaid or uninsured. According to CDC data for county-level estimates of diagnosed diabetes the 2009 percentage of adults with diabetes averaged 10.5 across the seven counties in our region. The number in this population totaled 28,103. The program will focus on providing services to the adult Medicaid and uninsured population since they are not currently provided access to these services through an insurance source. Adult Medicaid and the uninsured account for 46% of the region's adult population, which means approximately 46% of the total adult diabetes population of 28,103 would be categorized as Medicaid or uninsured, or 12,927 people.

Goals: The primary goal is to impact clinical improvements related to diabetes such as lowering A1C values, reducing blood pressure, and increasing the number of diabetic patients receiving retinal eye exams, foot exams, and nephropathy screening throughout Region 16. The project plans will accomplish the clinical impact through the addition of practitioners trained in diabetes management such as endocrinology and potentially mid-level providers for medical management of the diabetes disease process,

certified diabetic educators for providing diabetic self-management education, and registered dietitians for providing medical nutrition therapy.

Expected 5-Year Outcome: Over the next five years the expected outcome is to standardize and expand diabetes care across the region and to break the current barrier to the Medicaid and uninsured population through the care team in the Diabetes Management project. This will include outreach and information delivery to all providers of diabetes management. The development of standardized diabetes care will include the important components of education and access to specialized medical care. Applying a standard care management model to diabetic patients will reduce and prevent acute complications and the risk of long-term complications.

Starting Point/Baseline

A regionally focused diabetes management program is currently not offered in Region 16, so no formal baseline has been established. Since DSME is not a service that is funded by traditional Medicaid, it is difficult to utilize prior referral data to estimate the number of referrals expected to be received into the program once it is implemented. As stated above, the estimated population of patients with Medicaid or uninsured with adult diabetes is 12,927 for Region 16. Previous year historical data from Hamilton and Providence accounted for a total of 438 referrals into their diabetes programs. In DY3, a baseline will be established and additional volumes will increase each year in DY4 and DY5. The proposed timeline for implementation of a regional diabetes management program is as follows. The timeline was developed in accordance with available HHSC DSRIP project guidance, but can be adjusted if implementation goes more quickly than anticipated and if sufficient project funding is available.

DY2 (10/1/12-9/30/13)	Onboard staff and start physician recruitment; Develop and rollout program to Region 16 sites
DY3 (10/1/13-9/30/14)	Establish formal baseline; Onboard additional staff; Expand population served
DY4 (10/1/14-9/30/15)	Onboard Endocrinologist; Increase number of patients enrolled in program by 25% over baseline
DY5 (10/1/15-9/30/16)	Increase the number of patients enrolled in program by 50% over baseline

Rationale

The Community Needs Assessment, CNA-001, identified opportunities for Region 16 to address an adult diabetes population rate of 9.9%. Opportunities cited in the CNA as a need in RHP 16 is the need for a joint effort within and across communities to address major health issues such as diabetes. This includes education for all age levels and coordination with physicians and other providers, including use of protocols across the region. We believe this program will fulfill a major community need as supported by the Community Needs Assessment. This program is unique from other projects in both the practical application of the project and the intended outcome. This project is designed to clinically improve glycemic control and self-management for diabetic patients.

These clinical improvements will lead to a decrease in complications from diabetes. Based on DSHS data for Potentially Preventable Hospitalizations from 2005-2010, across Region 16, the combined hospital charges from diabetes short and long term complications accounted for $59,525,859.

Expanding chronic care management models promotes effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings. 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:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- 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.

According to the position statement released by the American Diabetes Association, diabetes mellitus is a chronic illness that requires continuing medical care and ongoing patient self-management education and support. Diabetes care is complex and requires that many issues beyond glycemic control, be addressed. There exists a large body of evidence to support a range of interventions to improve diabetes outcomes. One of these interventions includes diabetes self-management education (DSME). "DSME is an essential element of diabetes care, and national standards for DSME are based on evidence for its benefits. Education helps people with diabetes initiate effective self-management and cope with diabetes when they are first diagnosed. Ongoing DSME and diabetes self-management support (DSMS) also help people with diabetes maintain effective self-management throughout a lifetime of diabetes as they face new challenges and as treatment advances become available. DSME helps patients optimize metabolic control, prevent and manage complications, and maximize quality of life in a cost-effective manner." (Diabetes Care, volume 35, supplement 1, January 2012)

Current best practice approaches for DSME are skills-based and designed to help the person with diabetes make informed self-management choices. Care centers on the patient to ensure that collaboration with health care professionals accounts for patient preferences, needs, and values to guide decision making.

Multiple studies support that associated outcomes from DSME include improved diabetes knowledge and self-care behavior, improved clinical outcomes such as lower A1C, lower self-reported weight, improved quality of life, and lower costs. DSME follows

national standards to guide the quality for programs. Important to the 1115 Waiver goals is the fact that evidence from the Urban Diabetes Study in 2008 demonstrated that diabetes education is associated with increased use of primary and preventive services and lower use of acute, inpatient hospital services.

The Community Needs Assessment identifies the adult obesity rate at 9.9% for RHP16 in CNA-002 and the low income preschool obesity rate at 13.8% in CNA-003. Obesity is a risk factor in diabetes. The standards of medical care in diabetes note that overweight adults with a BMI > 25kg/m2 with only one additional risk factor should be tested for diabetes. In children, two risk factors and a BMI >85th percentile for age and sex, weight for height >85th percentile, or weight >120% of ideal for height should be tested for diabetes. Based on findings from the CNA in RHP 16 related to adult and childhood obesity, the significance of Type 2 diabetes and patients at risk for developing Type 2 diabetes is supported. Focusing on the target population will allow for the most regional improvement.

The methodology used to create the county-level estimates was through data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), and data from the U.S. Census Bureau's Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. Survey respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Three years of data were used to improve the precision of the year-specific county level. www.cdc.gov/diabetes/atlas/countydata/atlas.html

Through the Diabetes Management Project, an expected result will be that enrolled patients will be more likely to adhere to best practice treatment recommendations which in turn will reduce claim costs and demonstrate positive health benefits for the diabetic population in RHP 16. Additionally, the regional emphasis will target a larger patient volume for further effect as evidenced by the need through the CNA and CDC county-level data.

Related Category 3 Outcome Measure

OD-1- Primary Care and Chronic Disease Management

IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

Improvement target 1.10 was chosen to measure the percentage of patients considered to have poor glycemic control with a HbA1c >9.0%. The implementation of the Diabetes Management project is meant to provide clinically significant results to impact diabetes outcomes. Demonstrating controlled A1c values is a strong clinical indicator of improvement from the project and evidence that the risk of complication has decreased.

Relationship to other Projects

Diabetes Management will work alongside other project offerings to provide medical management and education for self-management in the targeted diabetic population. Other relational projects include the Chronic Care Management Project, Care

Transitions, and Expansion of Primary Care. The Chronic Care Management Project and the Care Transitions project will both contain components that will help navigate patients into the correct outpatient service. Case managers working in and with the Chronic Care Management and Care Transitions projects may serve as liaisons and referral sources into the Diabetic Management program. The Diabetic Management program however, will be a clinically based program to treat the disease process. Case Managers in the Chronic Care Management and Care Transitions projects may help identify patients from the inpatient and outpatient setting that could benefit from the Diabetic Management program. The Expansion of Primary Care will allow for greater access to providers to address problems as they arise on an outpatient basis to curtail preventable emergency visits and inpatient hospitalizations. The additional outpatient service with the ability to target a large volume of chronic disease patients will play a role in the re-structuring of the outpatient delivery system. Through the development of the Diabetes Management program patients will have increased access to utilize an appropriate level of care. The Diabetes Management staff will help to ensure that appropriate referrals are being made for the patients and that they have access to the appropriate services. This may include scheduling appointments with primary care for evaluation, obtaining a physician referral and helping a patient schedule lab work, eye exams, or foot exams. Each project works together to compliment the continuum of care and achieve the Transformation Waiver goals while providing clinically significant patient outcomes.

The aim from Diabetes Management is very clinical so that as we increase access to clinical care, add diabetes specialties such as Endocrinology and diabetic education, the outcome achieved is a reduction in A1c value. The A1c value will serve as a clinical indicator of improvement and is strongly evidenced based through such studies as the Diabetes Control and Complications Trial of 1993 that determined better glycemic control led to better outcomes and fewer complications from diabetes

Relationship to Other Performing Providers' Projects in the RHP

Across RHP 16, performing providers are demonstrating various efforts on expanding chronic care management models. The Diabetes Management project will be carried out in a regional effort through a partnership between Hamilton General Hospital and Providence Healthcare Network. Hamilton and Providence will collaborate for the development and implementation of Diabetes Management and through this joint effort will be able to provide the regional emphasis needed to impact diabetes care.

Plan for Learning Collaborative

Opportunities exist for collaboration among other performing providers in RHP 16. A learning collaborative could benefit our region through the sharing of experiences and information related to accomplishing outcomes in diabetes care. Hamilton and Providence will be working in collaboration to promote continuous learning and exchange between providers to determine collectively how to "raise the bar" in diabetes care. Semi-annual provider education will be hosted at Providence.

Project Valuation

This project has been valued at $8,379,436. The value of this project for our community and region includes decreasing inappropriate use of high cost services and facilities, reducing potentially preventable admissions, and re-directing patients to receive appropriate care in the appropriate setting which in turn will decrease overall healthcare costs. The intangible value of this project is the empowerment patients in our communities will gain through the ability to self-manage their disease process.

Since DSME is not a service that is funded by traditional Medicaid, it is difficult to utilize prior referral data to estimate the number of referrals expected to be received into the program once it is implemented. As stated above, the estimated population of patients with Medicaid or uninsured with adult diabetes is 12,927 for Region 16. Previous year historical data from Hamilton and Providence accounted for a total of 438 referrals into their diabetes programs. A formal baseline for number of patients enrolled throughout Region 16 will be established in DY3. By DY4 we expect to increase the number of patients enrolled in the program by 25% over baseline and by 50% over baseline in DY5.

Better diabetes care is needed as evident from the DSHS Potentially Preventable Hospitalizations from 2005-2010. In McClennan County there was $37,306,882 in hospital charges for diabetes short-term and long-term complications. This equates to $213 in hospital charges per adult according to the 2010 population. While improved diabetes care is a desired outcome of the Diabetes Management project, with better care, a reduction in potentially preventable admissions will result in tremendous cost savings over a 5 year period.

NEW: 121792903.2.10 ***OLD: 121792903.2.5***	***2.2.2***	***2.2.2***	***DIABETES MANAGEMENT***	
HAMILTON GENERAL HOSPITAL				*121792903*
Related Category 3 Outcome Measure(s):	*IT-1.10*	*New: 121792903.3.24* *Old: 121792903.3.12*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**	
Milestone 1 P-3. Milestone: Develop a regional comprehensive care management program Metric 1 P-3.1. Metric: Documentation of Care management program Goal: Utilize current DSME model from Hamilton and Providence to develop a regional diabetes management program. Data Source: Program materials Milestone 1 Estimated Incentive Payment: $920,434.50 **Milestone 2** P-2. Milestone: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 P-2.1. Metric: Increase percent of staff a. Numerator: Number of relevant staff trained in the Chronic Care Model ("relevant" as defined per the Performing Provider)	**Milestone 3** P-11. Milestone: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 P-11.1. Metric: Increase the number of patients enrolled in a self-management program. a. Number of patients enrolled in a care management program Baseline: Establish baseline data for DY4 & DY5 goals Goal: Outreach across region for program enrollment. Data Source: Program enrollment records Milestone 3 Estimated Incentive Payment: $750,249.67 **Milestone 4** P-13. Milestone: Develop and implement program for diabetes care managers to support primary care clinics. Metric 1 P-13.1. Metric: Diabetes care manager support for primary care clinics. Goal: Develop relationships with primary care clinics and establish support methodology.	**Milestone 6** P-16. Milestone: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-16.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Identify and agree upon improvements that will "raise the floor" for performance. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $1,151,158 **Milestone 7** I-18 Milestone: Improve the percentage of patients with self-management goals Metric 1 I-18.1. Metric: Patients with self-management goals a. Numerator: Number of	**Milestone 8** P-16. Milestone: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-16.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Identify and agree upon improvements that will "raise the floor" for performance. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $992,751 **Milestone 9** I-18 Milestone: Improve the percentage of patients with self-management goals Metric 1 I-18.1. Metric: Patients with self-management goals a. Numerator: Number of

NEW: 121792903.2.10 ***OLD: 121792903.2.5***	***2.2.2***	***2.2.2***	***DIABETES MANAGEMENT***	
HAMILTON GENERAL HOSPITAL				*121792903*
Related Category 3 Outcome Measure(s):	*IT-1.10*	*New: 121792903.3.24* *Old: 121792903.3.12*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
b. Denominator: Total number of relevant staff Goal: Train staff in the Diabetes Management project that will be delivering care to patients. Data Source: HR, training program materials Milestone 2 Estimated Incentive Payment: $920,434.50	Data Source: Evidence of diabetes management care coordination clinic plan Milestone 4 Estimated Incentive Payment: $750,249.67 **Milestone 5** P-16. Milestone: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. <u>Metric 1</u> P-16.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Identify and agree upon improvements that will "raise the floor" for performance. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $750,249.67		patients with the specified chronic condition/MCC in the registry with at least one recorded self-management goal b. Denominator: Total number of patients with the specified chronic condition/MCC in the registry Goal: Enroll patients into diabetic self-management education, Increase enrollment by 25% over baseline Data Source: Program data/registry Milestone 7 Estimated Incentive Payment: $1,151,158	patients with the specified chronic condition/MCC in the registry with at least one recorded self-management goal b. Denominator: Total number of patients with the specified chronic condition/MCC in the registry Baseline/Goal: Enroll patients into diabetic self-management education, Increase enrollment by 50% over baseline Data Source: Program data/registry Milestone 9 Estimated Incentive Payment: $992,751

NEW: 121792903.2.10 ***OLD: 121792903.2.5***	***2.2.2***	***2.2.2***	***DIABETES MANAGEMENT***	
HAMILTON GENERAL HOSPITAL				*121792903*
Related Category 3 Outcome Measure(s):	*IT-1.10*	*New: 121792903.3.24* *Old: 121792903.3.12*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $1,840,869	Year 3 Estimated Milestone Bundle Amount: $2,250,749		Year 4 Estimated Milestone Bundle Amount: $2,302,316	Year 5 Estimated Milestone Bundle Amount: $1,985,502
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $8,379,436				

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.2.1

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will provide integrated physical and behavioral health care services. The local FQHC will co-locate at the community center and serve individuals in a collaborative model with center's psychiatrists. It is anticipated that an additional 900 individuals will be served in the project, with 250 being served in YR 3, 300 in YR 4 and 350 in YR 5.

- Need for the project: Currently many of the individuals served by the community center do not communicate their physical health needs well and do not always follow through with recommended courses of treatment. This integrated approach will identify health issues and provide wellness initiatives to improve health outcomes and quality of life.

- Medicaid and Uninsured Target population: Currently 55% of HOTRMHMR Center consumers have Medicaid. The remaining portion is either on Medicare, Third Party Insurance or is uninsured.

- Category 1 or 2 expected patient benefits: It is expected that by providing early screening and diagnosis of physical health issues and then treating individuals in a holistic manner, that these individuals will have fewer untreated chronic conditions, less costly health care treatment, have a better quality of life and live longer.

- Category 3 outcomes: IT -1.7; A reduction in the number of individuals previously diagnosed with hypertension whose blood pressure is within acceptable limits.

C.

D.

E.

F. Category 2: Program Innovation and Redesign

Identifying Project and Provider Information: Project Options 2.15.1; Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. Integrated Health Clinic. 084859002.2.1 - HOTRMHMR/084859002

Project Description: Establish a clinic for integrated health care for consumers accessing local behavioral health care services at HOTRMHMR and physical health care at the local FQHC - The Family Health Center. The clinic which would be located at the HOTRMHMR Center would include minor medical care, nutrition services, smoking cessation, diet, exercise and management of chronic medical conditions. The individuals would be served by a physician, nurse, patient navigator, a wellness coordinator and billing clerk. The clinic would also serve as a back door for consumers stepping down from HOTRMHMR services. This type of clinic would allow for better coordination of care between the HOTRMHMR Center and the Family Health Center and would eliminate the waiting list for services and more appropriately define behavioral health services offered by both entities. Goals of the project would include:

1. To create a clinic that integrates behavioral health care with physical health care for consumers of the HOTRMHMR Center.
2. To provide early screening and diagnosis of physical health issues that left untreated could lead to chronic medical conditions, costlier treatment, poor quality of life and earlier death.
3. To provide structured support for consumers to live healthier lifestyles by promoting participation in wellness activities such as smoking cessation, weight loss, exercise, and management of chronic health conditions.

It is anticipated that the clinic would increase the number of consumers served and eliminate the waiting list for HOTRMHMR services. Additionally, the Center anticipates early detection of symptoms and conditions that left untreated could lead to significant chronic medical conditions and documented promotion of wellness and health behaviors, and decrease the risk of more costly health related conditions. This project fits into the regional goal of serving more consumers in a manner that reduces their risk for additional more costly services in the future. Specifically, the project will see a significant improvement in the management of hypertension in individuals engaged in the project.

Starting Point / Baseline: The HOTRMHMR Center does not currently provide integrated physical and behavioral health care services.

Rationale: National data shows individuals experiencing a SMI die 25 years earlier than their peers. In Texas that rate is 29 years earlier. Additionally, individuals with SMI have a 68% chance of having at least one chronic health related issue especially infectious disorders, pulmonary and cardiovascular diseases and diabetes (CAN-001 & CAN -002). These individuals also make up 30+ % of the potentially preventable hospitalizations in Texas (CAN-004). The inability to clearly articulate their health concerns and the problems understanding and following through with treatment recommendations based on their cognitive deficits leads to much poorer outcomes for this population. An integrated approach to working with this population has proven to be a successful way of improving both behavioral and physical health issues. Early identification and wellness initiatives have also been found to significantly reduce the risk of chronic health issues and early mortality. Utilizing Maeng, 2012; assessment of cost savings in a collaborative care model, the cumulative cost savings of 7.1% puts the return on investment at 1.7 dollars saved per dollar spent. Project Options 2.15.1; Design, implement, and evaluate projects that provide integrated primary and behavioral health care services which would include all required core components. Core components: a). The co-located site will be at the HOTRMHMR Main Center located at 110 S. 12th Street. The partner will be the Family Health Center. This is the local FQHC. Approximately 70% of HOTRMHMR Center consumers qualify for services at the FHC. We will employ a fully integrated system sharing information, accessing medical records, regular clinic staffing, etc. b). Development of provider agreements have begun and will address co-scheduling and information sharing for all enrolled patients. c). Protocols and processes will be developed prior to implementation for all issues such as information sharing, release of records, clinical staffing and referrals. d). One physician, one RN and one billing clerk will be hired by the Family Health center (FHC) for this project. Additionally a patient navigator and wellness coordinator will be hired by the HOTRMHMR Center for patient coordination. e). All staff involved in the project including clinical staff at the HOTRMHMR Center will be trained on the procedures for the project. Regular meetings will be held to address issues, staff cases and work of CQI efforts. Shared treatment planning will implemented for project participants. f). Currently, both facilities have independent electronic medical records. The HOTRMHMR Center is in the process of implementing a new system. Attempts will be made to connect certain aspects of the electronic medical records of both and other manual processes of information sharing will occur where electronic transfer is not possible. g). Legal agreements will be addressed where needed to met the statuary requirements of both organizations. h). Utility and building services will be provided by the HOTRMHMR Center. i). The HOTRMHMR Center will develop and implement data collection processes to ensure adequate tracking of utilization and outcome measurements for the project. j). Will implement a CQI process utilizing the rapid cycle improvement model. Process milestones P-3, P-6 and P-7 would be implemented. Other process milestones would not be used based on pre-identified community needs or programmatic design. Improvement milestones I-8 would be selected for use.

Related Category 3 Outcome Measure: The Category 3 outcome measure is OD-1 – Primary Care and Chronic Disease Management. Utilizing specific health metrics to show overall project effectiveness gives concrete data to verify progress and ties into the regional goal of better health outcomes.

Relationship to Other Projects: The project ties in with HOTRMHMR Center project 084859002.2.4 and project 084859002.2.6. These projects also work with special populations with at risk medical conditions, but that require different interventions to be successful in reaching substantial changes in behaviors. Category 4 is not applicable.

Relationship with Other Performing Providers' Projects in the RHP: This project ties into most of the other RHP projects as it specifically deals with positive health outcomes. This project is unique as it works with a special population that has demonstrated issues with poor health outcomes.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to integrated health care services. In Texas several agencies already have a collaborative related to this issue and other new projects would meet with those Centers to review progress and address problems and needs of specific targeted areas.

Project Valuation: The project was valued utilizing Maeng's assessment of cost savings in a collaborative care model combined with data on health related issues within the SMI population to determine the size and scope of the project. It was determined that identifying those at the greatest risk and then tailoring an integrated health service delivery system to meet their needs would be the most effective way of combating the issue.

084859002.2.1	***2.15.1; A-J***		***INTEGRATED HEALTH CLINIC***
Heart of Texas Region MHMR Center		***084859002***	
Related Category 3 Outcome Measure(s):	***IT-1.7***	*084859002.3.2*	**Primary care and Chronic Disease management**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013– 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P-3 **Metric 1** – P-3.1 **Baseline/Goal:** P-3.1 Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. Number and types of referrals that are made between providers at the location.	**Milestone 4** – P-7 **Metric 4** – P-7.1 **Baseline/Goal:** P-7 Evaluate and continuously improve services. P-7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycle. **Data Source:** Document CQI.	**Milestone 6** – P-7 **Metric 6** – P-7.1 **Baseline/Goal:** P-7 Evaluate and continuously improve services. P-7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycle. **Data Source:** Document CQI.	**Milestone 8** – P-7 **Metric 8** – P-7.1 **Baseline/Goal:** P-7 Evaluate and continuously improve services. P-7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycle. . **Data Source:** Document CQI.

084859002.2.1	***2.15.1; A-J***		***INTEGRATED HEALTH CLINIC***
Heart of Texas Region MHMR Center		***084859002***	
Related Category 3 Outcome Measure(s):	***IT-1.7***	*084859002.3.2*	**Primary care and Chronic Disease management**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013– 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Surveys of providers to determine the degree and quality of information sharing. Review of referral data and survey results. **Milestone 1 Estimated Incentive Payment:** $ 92,192 **Milestone 2** – P-6 **Metric 2**– P-6.2 **Goal:** P-6 Develop integrated behavioral health and primary care services within co-located sites. P-6.2 Number of providers who achieved Level 5 interaction. **Data Source:** Documentation of establishing integrated clinic at level 5 of interaction. **Milestone 2 payment:** $92,192 **Milestone 3** – P-7 **Metric 3** – P-7.1 **Goal:** P-7 – Evaluate and continuously improve integration of primary and behavioral health services.	**Milestone 4 Payment:** $311,147 **Milestone 5 – I-8** **Metric 5**– I-8.1 **Baseline/Goal:** I-8 Integrated Services. I-8-1 Enroll and serve an additional two hundred and fifty individuals (250) in this project. 100% of these individuals will receive both physical and behavioral healthcare at this location. **Data Source:** Center IT system. **Milestone 2 Estimated Incentive Payment:** $ 311,147	**Milestone 1 Payment:** $373,376.50 **Milestone 7 – I-8** **Metric 7**– I-8.1 **Baseline/Goal:** I-8 Integrated Services. I-8-1 Enroll and serve an additional three hundred individuals (300) in this project. 100% of these individuals will receive both physical and behavioral healthcare at this location. **Data Source:** Center IT system. **Milestone 2 Estimated Incentive Payment:** $ 373,376.50	**Milestone 8 Payment:** $415,000 **Milestone 9 – I-8** **Metric 9** – I-8.1 **Baseline/Goal:** I-8 Integrated Services. I-8-1 Enroll and serve an additional three hundred and fifty individuals (350) in this project. 100% of these individuals will receive both physical and behavioral healthcare at this location. **Data Source:** Center IT system. **Milestone 9 Estimated Incentive Payment:** $ 415,000

084859002.2.1	***2.15.1; A-J***		***INTEGRATED HEALTH CLINIC***
Heart of Texas Region MHMR Center		***084859002***	
Related Category 3 Outcome Measure(s):	***IT-1.7***	*084859002.3.2*	**Primary care and Chronic Disease management**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013– 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-7.1Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Data Source**: Documentation of CQI. **Milestone 3 Payment:** $92,192			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 276,575	Year 4 Estimated Milestone Bundle Amount: $622,294	Year 4 Estimated Milestone Bundle Amount: $ 746,753	Year 5 Estimated Milestone Bundle Amount: $ 830,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 2,475,622			

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.2.2

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will establish a FACT (Forensic Assertive Community Treatment) team that will work with individuals who interface with the legal system and /or individuals who have had multiple arrests and /or emergency department contacts. It is anticipated that 115 individuals will be served in the project, with10 being served in YR 2, 30 in YR 3, 35 in YR 4, and 40 in YR 5.

- Need for the project: Currently there are a significant number of individuals who are non-compliant with tradition behavioral health interventions who utilize a significant amount of community resources. These individuals need the combination of an intensive treatment program combined with a legal and judicial oversight that allows for leverage in engaging these individuals into treatment services.

- Medicaid and Uninsured Target population: Only a small percentage of these individuals (Approximately 25%) have Medicaid benefits. The remaining portion are uninsured.

- Category 1 or 2 expected patient benefits: It is expected that by providing intensive treatment services to this population that there would be a significant reduction in the utilization of more costly community resources such as ED visits, inpatient care, law enforcement interventions and incarcerations; and that more positive outcomes would be achieved.

- Category 3 outcomes: IT -10.2; Improved Quality of life/Functional status based on improvements from baseline data.

Identifying Project and Provider Information: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. FACT Team. 084859002.2.2 - HOTRMHMR/084859002

Project Description: Establish an intensive FACT (Forensic Assertive Community Treatment) Team that would work with individuals who interface with the legal system and who have had multiple arrests and/or emergency department contacts. These

individuals would be selected for the program based on repeatedly engaging in behaviors that cause law enforcement and emergency department interventions. These individuals are treatment resistant and need the leverage provided by a Mental Health / Veteran Court in order to comply with treatment services. Interventions would include intensive case management, medication management, psychosocial rehabilitation, substance abuse counseling and legal services. The goal of the project would be to reduce the number of individuals who repeatedly are arrested, incarcerated and who utilize a significant amount of community resources such as emergency department's visits, law enforcement contacts and inpatient psychiatric hospital beds. The project would seek a reduction of arrests and emergency room / inpatient care for participating individuals. The project would establish baseline data for each participant. We would then compare the pre-admission data with post-participation data to determine measurable progress in reducing preventable incarcerations / admissions. The reduction in the number of these individuals who access more costly community interventions ties in with the region's goals of serving individuals in the right setting with the appropriate types of interventions that would positively impact the individual's recovery rather than treat the symptoms. By the end of this project we anticipate a significant reduction in the number of community interventions needed to support these individuals in the community.

Starting Point / Baseline: The HOTRMHMR Center has extensive experience in providing Assertive Community Treatment (ACT) Team services as well as jail diversion initiatives. The Center also has a specialized criminal justice program called TCOOMMI that works to reduce recidivism by working as a team with probation and parole officers. The programs currently in place are effective, but do not meet the specific needs of the population identified. There is currently no Mental Health / VA Court and no designated FACT team in our community.

Rationale: The HOTRMHMR Center has monitored the jail bookings to cross reference individuals who have had a behavioral health history. In the past four years we have seen a reduction from 412 per month to 107 per month. This has been accomplished by providing alternative treatment and assessment options for law enforcement who encounter individuals who may be experiencing a behavioral health crisis. In examining the data, there is a subset of individuals who continue to be booked into jail for a variety of reasons. These individuals are treatment resistant and without the leverage offered by a Mental Health / Veteran Court are likely to continue to be high utilizers of services (CAN- 006 & CNA-007). A review of psychiatric inpatient and Crisis Care Center triage data conclude the same issue is prevalent. Forensic ACT Teams and Mental Health / Veteran Courts throughout the country have proven results in impacting this particular issue. Project Options will be 2.13.1; Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting, and will include core components. Core Components: a). the HOTRMHMR Center will assess the size, characteristics and needs of the target population. Currently the identified population is individuals with SMI that are treatment resistant and require specialized mental health treatment along with legal intervention of a Mental Health / Vet Court. b). A review of the literature has been completed and the identified approach appears to be a best practice to impacting the multitude of issues such as criminal justice involvement, homelessness, substance abuse, inappropriate inpatient and Emergency Department (ED) use. c). The HOTRMHMR in collaboration with its community partners will develop a project evaluation plan that utilizes metrics to determine outcomes. d). The project will design models that include the full-range of community supports as well as residential options. e). The project will assess the impact of intervention utilizing standardized

quantitative measures and qualitative analysis relevant to the target population. Process milestones will include P-2, P-3 and P-4. Other Process milestones are excluded based on milestones already being achieved or project design. Improvement milestones I-1 will be implemented. Other improvement milestones are either not relevant to the population or are included as a Category 3 outcome measure.

Related Category 3 Outcome Measure: The Category 3 outcome measure is OD-10 – Quality of Life/Functional Status. The measurement of functioning directly relates to all areas of concern such as admission / readmissions to the criminal justice system, inpatient hospital utilization, ED contacts, and other health related provider healthcare services. The project ties into the regional goal of providing the appropriate services to individuals in special categories that are historically high utilizers of other health care services.

Relationship to Other Projects: The project ties in with HOTRMHMR Center project 084859002.2.4 and project 084859002.2.6. These projects also work with special populations with at risk conditions, but that require different interventions to be successful in reaching substantial changes in behaviors. Category 4 is not applicable.

Relationship with Other Performing Providers' Projects in the RHP: This project ties into the RHP regional project dealing with emergency department screenings and the use of telehealth equipment to improve mental health screenings.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to mental health screenings and diversions from state and local inpatient settings and emergency departments. In Texas the forensic population is quickly eroding at the capacity for community centers to access civil commitments for inpatient care. This creates significant delays in getting individuals out of emergency departments and into appropriate inpatient settings. A collaborative approach to addressing this issue is needed to reduce the impact felt by local hospitals and law enforcement entities.

Project Valuation: Utilizing cost analysis methodology (CAM) data from the HOTRMHMR Center and including additional costs for Court related expenses the average cost to serve each individual in an FACT model with Court support would be $14,425 per participant. Based on data provided from the Bluebonnet MHMR Center Jail Diversion Project the potential cost to the community for this type of individual is $37,500 per year.

084859002.2.2	*2.13*	*2.13.1 A,C,D,& E*	*FACT TEAM*
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.2***	***084859002.3.3***	**Quality of Life/Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 – P-2 **Metric 1 –** P-2.1 **Baseline/Goal:** P-2 Design community-based specialized interventions for target population of treatment resistant individuals who repeatedly access community resources. P-2.1 Project plans which are based on evidence / experience and which address the project goals **Data Source:** Project plan is evidence based **Milestone 1 Estimated Incentive Payment –** $93,991 **Milestone 2 –** P-3 **Metric 2 –** P-3.1	**Milestone 4 – P-3** **Metric 4** P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve thirty (30) individuals in the project. **Data Source:** HOTRMHMR Clinical records. **Milestone 1 Estimated Incentive Payment:** $ 126,887 **Milestone** 5 - P-4 **Metric 5 –** P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation	***Milestone 7 – P-3*** ***Metric 7*** *P-3.1* ***Baseline/Goal:*** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve thirty-five (35) individuals in the project. **Data Source:** HOTRMHMR Clinical records. ***Milestone 7 Estimated Incentive Payment:*** *$ $148,065* **Milestone** 8- P-4 **Metric 8 –** P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and	**Milestone 10– P-3** **Metric 10** P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve forty (40) individuals in the project. **Data Source:** HOTRMHMR Clinical records. **Milestone 10 Estimated Incentive Payment:** $ 160,000 **Milestone** 11 - P-4 **Metric 11 –** P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation

084859002.2.2	2.13	2.13.1 A,C,D,& E	FACT TEAM
Heart of Texas Region MHMR Center			084859002
Related Category 3 Outcome Measure(s): OD-10	**IT-10.2**	**084859002.3.3**	**Quality of Life/Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Baseline/Goal: P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve ten (10) individuals in the project. **Data Source:** HOTRMHMR Clinical records. **Milestone 2 Payment:** $93,991 **Milestone 3** –P-4 **Metric 3** – P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 3 Payment:** $93,991	demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 5 Estimated Incentive Payment:** $ 126,887 **Milestone 6** – I-1 **Metric 6**– I-1.1 **Baseline/Goal:** I-1 Criminal Justice admissions / readmissions. I-1.1 Ten (10) percent reduction in criminal justice admissions / readmissions. **Data Source:** Arrests and / or revocations. **Milestone 6 Payment:** $126,887	implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 8 Estimated Incentive Payment:** $ *148,065* **Milestone** *9– I-1* **Metric 9** – *I-1.1* **Baseline/Goal:** I-1 Criminal Justice admissions / readmissions. I-1.1 Fifteen (15) percent reduction in criminal justice admissions / readmissions. **Data Source:** Arrests and / or revocations. **Milestone 9 Payment:** *$148,065*	demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 11 Estimated Incentive Payment:** $ 160,000 **Milestone 12** – I-1 **Metric 12** – I-1.1 **Baseline/Goal:** I-1 Criminal Justice admissions / readmissions. I-1.1 Twenty (20) percent reduction in criminal justice admissions / readmissions. **Data Source:** Arrests and / or revocations. **Milestone 12 Payment:** $160,000

084859002.2.2	*2.13*	*2.13.1 A,C,D,& E*	*FACT TEAM*
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.2***	***084859002.3.3***	**Quality of Life/Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 281,972	Year 3 Estimated Milestone Bundle Amount: $ 380,661	Year 4 Estimated Milestone Bundle Amount: $ 444,195	Year 5 Estimated Milestone Bundle Amount: $ 480,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 1,586,828			

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.2.3

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will provide for the recruitment, training and support of mental health consumers to provide peer support services. The peers will provide a variety of support services including group and individuals interventions with consumers of mental health services in the community. After analysis and agency readiness efforts have been put in place, peer providers would be recruited, hired and trained to provide interventions including whole health interventions. A minimum of 550 individuals would be served in this program, with 100 being served in YR 3, 150 in YR 4 and 200 in YR 5.

- Need for the project: Currently there are inadequate resources available for individuals and their families who suffer from chronic behavioral health conditions. This leads to more negative outcomes and a dependence on more costly community interventions to deal with crisis situations. A more comprehensive community approach to dealing with this population would increase individual's quality of life and result in more positive outcomes.

- Medicaid and Uninsured Target population: It is anticipated that of the 550 individuals who would be served in this program that 350 would have Medicaid, approximately 50 would have Medicare and the remaining would be without any benefits.

- Category 1 or 2 expected patient benefits: It is expected that by providing supportive services to this population that there would be a reduction in the utilization of more costly community resources such as ED visits, inpatient care, law enforcement interventions and incarcerations. It is also expected that those served in the program would have better health outcomes and a better overall quality of life.

- Category 3 outcomes: IT -10.1; Improved Quality of Life/Functional status based on improvements from baseline data.

Identifying Project and Provider Information: Recruit, train, and support consumers of mental health services to provide peer support services. 084859002.2.3 - HOTRMHMR/084859002

Project Description: Provide supportive services for individuals and families living with chronic behavioral health issues by utilizing peer support specialists who have made substantial progress in managing their own illness and who have recovered to the point where they are living successful lives in the community. Building on a project originally established under the State's Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer specialist training we will provide additional training in whole health. The peer specialist would work with consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes or COPD. While such training currently exists, very limited numbers of peers are trained due to resource limitations. The need for such services has repeatedly been documented and utilizing peer support specialists in this role is a demonstrated method to achieve more positive health outcomes. The Heart of Texas Region MHMR Center would work with the Local NAMI – Waco Chapter to recruit, train, and hire multiple peer support specialist and then establish a variety of peer support services for the community. Services would be provided in all six of the counties in our catchment area and would be available to both active consumers of the Center and those who do not qualify for Center services based on current target population requirements of the State.

Starting Point / Baseline: The HOTRMHMR Center has a long history of working with and supporting NAMI Waco in educating the community regarding services and supports available to individuals and families experiencing an SMI. While this experience has been positive, it has been severely limited in scope based on resources. The HOTRMHMR Center has also begun to utilize paid peer providers, but again due to limited resources this program is only beginning to impact the lives of the consumers and their families experiencing SMI and is only available to those currently in services.

Rationale: The State of Texas ranks 50th in per capita funding for mental health services (CAN-006). The lack of financial support has left most community mental health centers with large waiting lists for services. The resulting lack of community supports has led to increases in crisis visits to emergency departments (CAN-007), increased numbers of individuals utilizing an over-crowded state inpatient system (CNA-004), a increased number of individuals who are homeless, have chronic medical conditions and abuse substances, and an increased number of individuals being arrested and incarcerated in local jails and the Texas Department of Corrections (TDC). Education, advocacy and collaborative partnerships all are needed to meet the needs of individuals and families experiencing SMI in our communities. Project Options 2.18.1 will be used. The project will utilize a variety of evidence based interventions to impact the quality of support given to individuals with SMI and their families in the community. All required core elements will be addressed: a) The Center will train Twenty-five (25) administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system. Additionally, the Center will train key community partners in the use of peer specialists. b) The Center will contract with NAMI Waco to conduct readiness assessments of organizations that will integrate peer specialists in the network. c) The Center will contract with NAMI Waco to identify peer specialists interested in this type of work. d) The Center will contract with NAMI Waco to train identified peer specialists in whole health interventions including

conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders or health risks. e) The Center working with community partners will implement health risk assessments to identify existing and potential health risks for behavioral health consumers. f) The Center working with community partners will identify patients with serious mental illness who have health risks factors that can be modified. g) The Center will implement whole health peer support. h) The Center will connect patients to primary care and preventative services and i) The Center will track patient outcomes, review the interventions impact on participants and identify "lessons learned", opportunities to scale all of part of the interventions to a broader patient population and identify key challenges associated with expansion of the intervention including special consideration for safety-net populations. The Center will incorporate the peer whole health specialists into other 1115 projects such as the Community Clinic for Outpatient Services, the Integrated Health Clinic, the Geriatric Services project and the COPSD program. Project milestones will include P-1, P 2, P-3, P-4, P-5, P-6, P-7, and P-9. - Other project milestones were not selected based on the specific project design. Improvement milestones will be I-17. Other improvement milestones were not selected based on the specific project design or were used as a Category 3 outcome measure.

Related Category 3 Outcome Measure: The Category 3 outcome measure is OD-10 – Quality of Life/Functional Status. The improved level of functioning is an indicator that education/training and support services are being effective. The project will allow for a broader range of services and supports in the region and will help the regional goal of minimizing more costly services based on providing more appropriate levels of support. Category 4 is not applicable.

Relationship to Other Projects: The project ties indirectly with all of the HOTRMHMR projects by providing peer providers and a well educated community. It ties directly to project 084859002.2.1, 084859002.2.5, 084859002.2.6 and 084859002.2.7.

Relationship with Other Performing Providers' Projects in the RHP: This project indirectly ties into all regional projects by providing a well educated community and by offering services and supports not currently available to offset the cost of other services accessed when individuals and families experiencing stressful situations and don't know what other options are available.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to mental health education and support programs, particularly those that offer a peer provider component. Many community centers are expanding the use of peer providers, but few communities have actively engaged NAMI chapters that provide supportive services to those who do not qualify for community center services. A collaborative approach to addressing this issue is needed to reduce the impact felt by local hospitals and law enforcement entities.

Project Valuation: With 4.8% of the US population suffering with an SMI, the Region 16 population with a SMI would be 19,512 individuals. With only 10% of the regional SMI population being served in the community mental health system, it is critical to expand support programs for the communities in the region. The cost to provide this service would be $20.50 per individual with an SMI in the region for each year of the project.

084859002.2.3	*2.4.2*	*2.4.2*	**Recruit, train, and support consumers of mental health services to provide peer support services.**
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.1***	***084859002.3.4***	**Quality of Life / Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P-1 **Metric 1**– P-1.1 **Baseline/Goal:** P-1 Train administrators and key clinicians on understanding recovery, the value of peer support and how to integrate peer specialists into the organization P1.1 The Center will train 25 administrators and key staff P-1.2 The Center will conduct evaluations of participants and will achieve positive feedback	**Milestone 5– P-3** **Metric 5-** P-3.1 **Baseline/Goal:** P-3 The Center will contract with NAMI Waco to identify and train peer specialists to conduct whole health classes P-3.1 At least six (6) peer providers will be trained and hired **Data Source:** Employment and training records. **Milestone: 5 Estimated Incentive**	**Milestone 10 – P-3** **Metric 10** P-3.1 **Baseline/Goal:** P-3 The Center will contract with NAMI Waco to identify and train peer specialists to conduct whole health classes P-3.1 At least nine (9) peer providers will be trained and hired **Data Source:** Employment and training records **Milestone: 10 Estimated**	**Milestone 16 – P-3** **Metric 16** P-3.1 **Baseline/Goal:** P-3 The Center will contract with NAMI Waco to identify and train peer specialists to conduct whole health classes P-3.1 At least twelve (12) peer providers will be trained and hired **Data Source:** Employment and training records **Milestone: 16 Estimated**

084859002.2.3	*2.4.2*	*2.4.2*	**Recruit, train, and support consumers of mental health services to provide peer support services.**
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.1***	***084859002.3.4***	**Quality of Life / Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: Training records **Milestone: 1 Estimated Incentive Payment –** $40,768.50 **Milestone 2 –** P- 2 **Metric 2 –** P- 2.1 **Baseline/Goal**: P-2 The Center will conduct an organizational readiness assessment to determine what changes must occur to successfully integrate peers into the traditional workforce. P-2.1 The Center will conduct an assessment of all major program areas of the agency as well as any community partners interested in utilizing peer providers. **Data Source:** Conduct and document completion of readiness assessments	**Payment:** $ 29,353.40 **Milestone 6–** P-5 **Metric 6–** P-5.1 **Baseline / Goal:** P-5 The Center will identify health risks of consumers with serious mental illness P-5.1 The Center will identify at least one hundred (100) consumers with modifiable health risks. **Data Source**: Clinical records. **Milestone 6 Estimated Incentive Payment:** $29,353.40 **Milestone 7 –** P-6 **Metric 7** -P-7.1 & 7.2 **Baseline /Goal:** P-6 The Center will implement peer specialist services that produce person-centered wellness plans targeting individuals with	**Incentive Payment:** $ 24,461.16 **Milestone 11 –** P-5 **Metric 11–** P-5.1 **Baseline / Goal:** P-5 The Center will identify health risks of consumers with serious mental illness P-5.1 The Center will identify at least one hundred and fifty (150) consumers with modifiable health risks **Data Source:** Clinical records. **Milestone 11 - Estimated Incentive Payment:** $24,461.16 **Milestone 12 –** P-6 **Metric 12**-6.1 & 6.2 **Baseline /Goal:** P-6 The Center will implement peer specialist services that produce person-centered wellness plans	**Incentive Payment:** $ 23,971.83 **Milestone 17 –** P-5 **Metric 17 –** P-5.1 **Baseline / Goal:** P-5 The Center will identify health risks of consumers with serious mental illness P-5.1 The Center will identify at least two hundred (200) consumers with modifiable health risks **Data Source:** Clinical records. **Milestone 17- Estimated Incentive Payment:** $23,971.83 **Milestone 18–** P-6 **Metric 18** - P-6.1 & 6.2 **Baseline /Goal:** P-6 The Center will implement peer specialist services that produce person-centered wellness plans targeting individuals with

084859002.2.3	*2.4.2*	*2.4.2*	**Recruit, train, and support consumers of mental health services to provide peer support services.**
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.1***	***084859002.3.4***	**Quality of Life / Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Payment: $40,768.50 **Milestone 3 –**P- 3 **Metric 3–** P-3.1 **Baseline/Goal** P-3 The Center will contract with NAMI Waco to identify and train peer specialists to conduct whole health classes P-3.1 At least three (3) peer providers will be trained **Data Source:** Employment and training records **Milestone 3 Payment:** $ 40,768.50 **Milestone 4 –** P-4 **Metric 4.1** **Baseline/Goal:** P-4 The Center will select and implement a health risk assessment (HRA) tool	specific chronic disorders or identified health risk factors P-7.1 One hundred (100) consumers will receive peer support services P-7.2 At least 90% of all consumers involved in peer support services will have a person centered wellness plan **Data Source:** Clinical records **Milestone 7: Estimated Incentive Payment:** $29,353.40 **Milestone 8 –** P-7 **Metric 8 –** P-7.1 **Baseline/Goal:** P-7 The Center will evaluate and continuously improve peer support services P-7.1 Project planning and implementation documentation demonstrates plan, do, study,	targeting individuals with specific chronic disorders or identified health risk factors P-6.1 One hundred and fifty (150) consumers will receive peer support services P-6.2 At least 90% of all consumers involved in peer support services will have a person centered wellness plan **Data Source:** Clinical records **Milestone 12- Estimated Incentive Payment:** $24,461.16 **Milestone 13 –** P-7 **Metric 13 –** P-7.1 **Baseline/Goal:** P-7 The Center will evaluate and continuously improve peer support services P-7.1 Project planning and implementation documentation	specific chronic disorders or identified health risk factors P-6.1 Two hundred (200) consumers will receive peer support services P-6.2 At least 90% of all consumers involved in peer support services will have a person centered wellness plan **Data Source:** Clinical records **Milestone 18- Estimated Incentive Payment:** $23,971.83 **Milestone 19 –** P-7 **Metric 19–** P-7.1 **Baseline/Goal:** P-7 The Center will evaluate and continuously improve peer support services P-7.1 Project planning and implementation documentation

084859002.2.3	*2.4.2*	*2.4.2*	**Recruit, train, and support consumers of mental health services to provide peer support services.**
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.1***	***084859002.3.4***	**Quality of Life / Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
P-4.1 A tool will be identified for use with consumers **Data Source:** Document selection of tool. **Milestone 4 Payment:** $40,768.50	act quality improvement cycles **Data Source:** Documentation of CQI. **Milestone 8 - Estimated Incentive Payment:** $29,353.40 **Milestone 9** – P-9 **Metric 9** – P-9.1 **Baseline/Goal:** P-9 The Center will review project data and respond to it every week with tests of new ideas, practices, tools or solutions. This data will be collected with simple, interim measurement systems and will be based on self-reported data and sampling that is sufficient for the purposes of improvement P-9.1 Number of new ideas, practices, tools, solutions tested by each provider **Data Source:** Clinical Supervision	demonstrates plan, do, study, act quality improvement cycles **Data Source:** Documentation of CQI. **Milestone 12- Estimated Incentive Payment:** $24,461.16 **Milestone 14** – P-9 **Metric 14** – P-9.1 **Baseline/Goal:** P-9 The Center will review project data and respond to it every week with tests of new ideas, practices, tools or solutions. This data will be collected with simple, interim measurement systems and will be based on self-reported data and sampling that is sufficient for the purposes of improvement P-9.1 Number of new ideas, practices, tools, solutions tested	demonstrates plan, do, study, act quality improvement cycles **Data Source:** Documentation of CQI. **Milestone 19 Estimated Incentive Payment:** $23,971.83 **Milestone 20–** P-9 **Metric 20** – P-9.1 **Baseline/Goal:** Review Project and respond **Data Source:** Clinical supervision Report. **Milestone 20- Estimated Incentive Payment:** $23,971.83 **Milestone 21**– I-17 **Metric 21** – I-17.1 **Baseline/Goal:** I-17 Receipt of Recommended Preventative Services.

084859002.2.3	*2.4.2*	*2.4.2*	**Recruit, train, and support consumers of mental health services to provide peer support services.**	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.1***	***084859002.3.4***	**Quality of Life / Functional Status**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Report **Milestone 9: Estimated Incentive Payment:** $29,353.40		by each provider **Data Source:** Clinical Supervision Report **Milestone 14 - Estimated Incentive Payment:** $24,461.16 Milestone 15– I-17 Metric 15 – I-17.1 Baseline/Goal: I-17 Receipt of Recommended Preventative Services I-17.1 Fifteen (15) percent of individuals 18 years of age and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force **Data Source:** Clinical records **Milestone 15- Estimated Incentive Payment:** $24,461.16	I-17.1 Twenty (20) percent of individuals 18 years of age and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force **Data Source:** Clinical records **Milestone 21- Estimated Incentive Payment:** $23,971.83

084859002.2.3	*2.4.2*	*2.4.2*	**Recruit, train, and support consumers of mental health services to provide peer support services.**
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-10	***IT-10.1***	***084859002.3.4***	**Quality of Life / Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 163,075	Year 3 Estimated Milestone Bundle Amount: $ 146,767	Year 4 Estimated Milestone Bundle Amount: $ 146,767	Year 5 Estimated Milestone Bundle Amount: $ 143,831
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 600,440			

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.2.4

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will develop a team of professionals to identify and intervene with children or individuals with developmental disabilities with challenging behaviors. The team would respond to emergent behavioral crises as well as educate and support families dealing with individuals experiencing these types of issues. It is anticipated that 207 additional individuals will be served in this project, with 42 being served in YR 2, 50 in YR 3, 55 in YR 4 and 60 in YR 5.

- Need for the project: Currently there are a large number of children who do not qualify for mental health services and without interventions could potentially develop behaviors that would create more costly interventions in the future. Additionally, a growing number of individuals with developmental disabilities are being served in group homes and other locations where their challenging behaviors risk disruption of their placements. Without these types of interventions many will be diverted to more costly community providers such as emergency departments, inpatient psychiatric hospitals and nursing homes.

- Medicaid and Uninsured Target population: A large number of these individuals have Medicaid benefits (Approximately 75%), but do not have access to the type of trained professionals needed to improve these challenging behaviors.

- Category 1 or 2 expected patient benefits: It is expected that by providing these types of interventions to this population that there would be a significant reduction in the utilization of more costly community resources such as ED visits, inpatient care, state hospitalizations and nursing home placements.

- Category 3 outcomes: IT -6.1; Patient Satisfaction. Improved patient / provider satisfaction is anticipated.

Identifying Project and Provider Information: Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Community-Based Interventions for Children and Individuals with Challenging Behaviors. 084859002.2.4 - HOTRMHMR/084859002

Project Description: This project will develop a team of professionals to identify and intervene with children and individuals with challenging behaviors. This team will address root causes of the behaviors and develop and implement plans using research based methods and other best practices that will diminish the maladaptive behaviors while increasing more adaptive ones. These health care professionals will be trained in the areas of infant mental health, trauma, sensory integration, Autism Spectrum Disorders (ASD), Intellectual and Developmental Disabilities (IDD), developmental delays, and behavior management, including Applied Behavior Analysis. The program will provide direct interventions to the children and individuals, and support services and skills training for the family and other caregivers. The project will also employ a Community Behavior Support Team (CBST) to intervene with children, individuals and their families in crisis in an attempt to divert the person from other more restrictive settings, such as, hospitals, jails and other out of home placements. The CBST team will also educate the community about various evidenced based approaches, including Applied Behavior Analysis, and the application of these approaches to individuals with IDD, autism, developmental delays, trauma and other diagnoses as means to diminish challenging and disruptive behaviors. The reduction in the severity of these challenging behaviors will allow these individuals to maintain relationships with their families and other caregivers, and to appropriately participate in the community without the threat of out of home placements for either the short or long term. The goals of the project are as follows:

1. To provide a cost-effective, evidenced-based intervention program to children and individuals, who present with challenging and disruptive behaviors due to various issues and diagnoses, such as disrupted attachment, trauma, ASD, IDD and developmental delays.
2. To provide immediate response to emergent behavior crises for people with IDD/ASD and developmental delays with challenging behaviors.
3. To provide comprehensive behavior support education and training to those in the community most likely to be asked to intervene in a behavioral crisis situation with someone with IDD/ASD and developmental delays with challenging behaviors. It is expected that the following results will occur:

- Decrease the number of children and individuals at risk for out of home placement due to challenging behaviors.
- Increase the number of children receiving early and intensive intervention services, thereby, reducing the number of children who would later develop more challenging behaviors which would require additional and more costly community resources.
- Provide additional resources for the community for dealing with individuals with challenging behaviors, both early in development and later for those already experiencing difficulties.

- Educate the community about Applied Behavior Analysis and the application of these principles to individuals with challenging behaviors.
- Reduce the number of individuals who take medications for behavioral control.
- Decrease out of home placements including foster care, residential treatment centers, institutions, hospitals and jails for people in behavioral crisis. While it is expected that services provided in this project will achieve these reductions, it is difficult to create milestones or a Category 3 measurement that can adequately capture this data because services are provided preventatively and interventions improve functioning that reduce more costly interventions. When a diversion is created in the community the opportunity to measure the impact financially is limited.

Starting Point / Baseline: The HOTRMHMR Center has extensive experience in providing ECI and Developmental Disability services. Due to cutbacks in State funding over the past few years both programs have seen reductions in the capacity to serve all of those in need. Additionally, due to a large concentration of personal care homes in the area there has been a significant increase in inpatient placements for the dual diagnosed population in the region.

Rationale: It is estimated that over 200 children each year are evaluated by the ECI program, but are not eligible based on developmental delay alone (CNA-006). However, these children do present with challenging behaviors and other "red flags" that could be ameliorated with early intervention. Since most providers in our six county areas do not work with children under the age of 5 years old, these children languish for years only to present at school with serious behavioral problems (CNA-006). Heart of Texas Region MHMR and private providers currently serve 441 individuals with dual diagnosis (IDD/MI) and/or a diagnosis on the autism spectrum. It is estimated that of the 404 dually diagnosed individuals who are prescribed psychotropic medications, 264 individuals are taking medication for behavioral control while 144 are taking the medications solely for their mental illness. The Project Options would be 2.13.1; Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Core components are as follows: a). The HOTRMHMR Center will assess the size, characteristics and needs of the target population. At this point the identified population is individuals with challenging behaviors. These challenging behaviors will be addressed at a young age through interventions in the ECI program and also with the developmental disability department. b). A review of the literature has been completed and an aggressive outreach program utilizing a behavioral management therapist and a group of therapists and techs to implement and train family members and providers in ways to diminish these challenging behaviors appears to be the most promising best practice. c). The HOTRMHMR Center will develop a project evaluation plan that uses qualitative and quantitative metrics to determine outcomes. The patient satisfaction tool used will measure parent / provider satisfaction with the interventions provided. It is believed that enhanced satisfaction by these individuals will be reflective of more positive future outcomes. d). The design of the project will include a multitude of community-based services and supports. Organizations such as Baylor University, local ISD's private providers and other community service providers will be engaged to

create the most effective interventions possible. e). The project will assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. The Center will employ a staff specifically to work on assessment and analysis. Process milestones would include P-2, P-3 and P-4. Other process milestones are excluded based on project design. Improvement milestones would include I-5. Other improvement milestones are not applicable to this project. The reduction in the number of these individuals who access more costly community interventions ties in with the region's goals of serving individuals in the right setting with the appropriate types of interventions that would positively impact the individual's recovery rather than treat the symptoms. By the end of this project we anticipate a significant reduction in the number of community interventions needed to support these individuals in the community.

Related Category 3 Outcome Measure: The Category 3 outcome measure will be OD – 6 – Patient Satisfaction. Because many of the services provided in this project impact overall functioning and will have both short-term and long-term benefits patient satisfaction appears to be the best measure of project success. A measurement tool that recognizes parent/provider satisfaction is the best predictor available to future behaviors on the part of the participants. The project ties into the regional goal of providing the appropriate services to individuals in special categories that are historically high utilizers of other health care services.

Relationship to Other Projects: The project ties in with HOTRMHMR Center project 084859002.2.2, project 084859002.2.6 and project 084859002.1.1. These projects also work with special populations with at risk conditions, but that require different interventions to be successful in reaching substantial changes in behaviors. Category 4 is not applicable.

Relationship with Other Performing Providers' Projects in the RHP: This project ties into the RHP regional project dealing with emergency department screenings and the use of telehealth equipment to improve mental health screenings.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to mental health screenings and diversions from state and local inpatient settings and emergency departments. In Texas, the IDD population in particular is often placed into inpatient care settings and nursing homes because appropriate behavioral health plans and interventions have not been attempted. This leads to inappropriate placements in more costly settings. A collaborative approach to addressing this issue is needed to reduce the impact felt by local emergency departments, crisis centers and local and state inpatient facilities.

Project Valuation: The cost of serving each individual in the Behavioral Intervention Program would be $5,995 per consumer. This is based on CAM data and cost comparisons to similar best practice programs of this type.

084859002.2.4	*2.13.1*	*2.13.1 A,C,D, &E*	COMMUNITY-BASED INTERVENTIONS FOR CHILDREN AND INDIVIDUALS WITH CHALLENGING BEHAVIORS	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-6	***IT-6.1***	***084859002.3.5***	**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-2 **Metric 1** – P-2.1 **Baseline/Goal:** P-2 Design community-based specialized interventions for target population. P-2.1 Project plans which are based on evidence / experience and which address the project goals. **Data Source:** Project plan that is evidence based. **Milestone 1 Estimated Incentive Payment:** $ 49,770 **Milestone 2 – P-3** **Metric 2** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted	**Milestone 4** – P-3 **Metric 4** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve fifty (50) individuals in the project. **Data Source:** HOTRMHMR Clinical system. **Milestone 4 Payment:** $106,651 **Milestone 5– P-4** **Metric 5**– P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation		**Milestone 7** – P-3 **Metric 7** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve fifty-five (55) individuals in the project. **Data Source:** HOTRMHMR Clinical system. **Milestone 7 Payment:** $133,314 **Milestone 8– P-4** **Metric 8** – P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation	**Milestone 10** – P-3 **Metric 10** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Enroll and serve sixty (60) individuals in the project. **Data Source:** HOTRMHMR Clinical system. **Milestone 10 Payment:** $156,777 **Milestone 11 – P-4** **Metric 11** – P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation

084859002.2.4	2.13.1	2.13.1 A,C,D, &E	COMMUNITY-BASED INTERVENTIONS FOR CHILDREN AND INDIVIDUALS WITH CHALLENGING BEHAVIORS	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-6	***IT-6.1***	***084859002.3.5***	**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)**
complex needs. P-3.1 Enroll and serve forty-two (42) individuals in the project. **Data Source:** HOTRMHMR Clinical system. **Milestone 2 payment:** $49,770 **Milestone 3 – P-4** **Metric 3–** P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 3 Payment:** $49,770	demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 5 Estimated Incentive Payment:** $106,651 **Milestone 6 – I-5** **Metric 6 –** I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. **Data Source:** Assessment tool. **Milestone 6 Payment:** $106,651		demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 8 Estimated Incentive Payment:** $133,314 **Milestone 9– I-5** **Metric 9–** I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. **Data Source:** Assessment tool. **Milestone 9 Payment:** $133,314	demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 11 Estimated Incentive Payment:** $156,777 **Milestone 12 – I-5** **Metric 12 –** I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. **Data Source:** Assessment tool. **Milestone 12 Payment:** $156,777

084859002.2.4	*2.13.1*	*2.13.1 A,C,D, &E*	**COMMUNITY-BASED INTERVENTIONS FOR CHILDREN AND INDIVIDUALS WITH CHALLENGING BEHAVIORS**
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-6	***IT-6.1***	***084859002.3.5***	**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): $ 149,311	Year 3 Estimated Milestone Bundle Amount: $ 319,954	Year 4 Estimated Milestone Bundle Amount: $ 399,941	Year 5 Estimated Milestone Bundle Amount: $ 470,330
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 1,339,536			

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.2.5

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will establish an integrated program designed to meet the physical and behavioral health needs of the geriatric population. Many seniors with behavioral health issues have poor management of their physical health therefore reducing their quality of life and resulting in more costly interventions to deal with untreated health conditions. The team would take an assertive approach to assisting these individuals in getting the physical health care they need to have a better overall quality of life. It is anticipated an additional 360 individuals will be served in this project, with100 being served in YR 3, 120 in YR 4 and 140 in YR 5.

- Need for the project: Currently the geriatric population suffering from behavioral health issues cost the State of Texas $37 billion dollars on potentially preventable hospitalizations. Often this is due to seniors not following up on chronic health issues because of their mental health condition. An intervention where seniors receive integrated physical and behavioral health services with a strong community case management component could dramatically improve their quality of life and result in less costly health care services.

- Medicaid and Uninsured Target population: A large number of these individuals have Medicare benefits (Approximately 85%), while others have Medicaid or are uninsured. Of those receiving Medicare, approximately 55% are dual eligible with Medicaid benefits.

- Category 1 or 2 expected patient benefits: It is expected that by providing these types of interventions to this population it would significantly reduce their untreated physical health conditions leading to better overall quality of life and less costly health care services.

- Category 3 outcomes: IT -1.9; Depression Management. Project would seach remission of depressive symptoms in individuals with a major depression or dysthymia diagnosis.

Identifying Project and Provider Information: Expand Chronic Care Management Models. Integrated Geriatric Services. 084859002.2.5 - HOTRMHMR/084859002

Project Description: Establish an integrated program for seniors designed to meet their physical and behavioral health needs. The program would establish a team approach to meeting the complex physical and behavioral health issues facing seniors while attempting to significantly reduce the potentially preventable hospitalizations of this population. The individuals would be served by a contracted internal medicine physician, registered nurse, licensed professional counselor and two caseworkers. This approach would allow for significantly better health outcomes for these consumers and would also enhance the quality of life based on better management of physical and behavioral health issues. The goals would be as follows:

1. To reduce the potentially preventable hospitalizations of this high risk population by aggressively managing care.
2. To increase life expectancy by aggressively managing both physical and behavioral health issues.
3. To increase quality of life of participants by better managing chronic physical and behavioral health issues. The expected results of the project would be to increase the number of consumers served and the management of physical and behavioral health issues that lead to potentially preventable hospitalizations, decreased life expectancies and poorer quality of life due to complications of both conditions. Major challenges appear to be the engagement of seniors in participating in the project. Staff will be trained in motivational interviewing techniques and will utilize the contracted physician to assist in helping the seniors recognize the significant risk factors associated with ignoring their on-going health factors.

Starting Point / Baseline: The HOTRMHMR Center does not currently provide integrated geriatric services. In the past the HOTRMHMR Center did provide specialized geriatric services, but due to funding cuts the program was eliminated.

Rationale: From 2007-2010 the State of Texas spent 37 billion dollars on potentially preventable hospitalizations (CNA- 004). The cost per hospital episode was $27,625. Nearly 35% of all these hospitalizations were to individuals with a co-occurring mental health condition. The average age of these individuals was 64 years of age. Additionally, individuals with SMI have a 68% chance of having at least one chronic health related issue especially infectious disorders, pulmonary and cardiovascular diseases and diabetes (CNA-001 & CNA-002). Individuals with chronic mental health conditions often have difficulty accessing appropriate physical health care and often do not receive treatment for chronic health conditions. In the State of Texas individuals with a chronic mental health condition die 29 years younger than peers. For these reasons an integrated approach to the management of these two conditions makes sense. The Project Options 2.2.5 will be implemented. The program will specifically develop care management functions that integrate the primary and behavioral health needs of individuals. The program will include health care services provided by an internal medicine group. The program will also employ a RN, therapist and two caseworkers to ensure individuals engaged in the project have a strong integration of health services with an aggressive component to assist participants be successful in self management of their chronic conditions. Process milestones would include P-3, P-9 and P-11. Other process milestones will not be included based on project model. Improvement milestones include I-21.2. Other improvement milestones will be excluded due to the scope of the project and project design.

Related Category 3 Outcome Measure: The Category 3 outcome measure will be OD-1 – Primary Care and Chronic Disease Management. Utilizing specific health metrics to show overall project effectiveness gives concrete data to verify progress and ties into the regional goal of better health outcomes.

Relationship to Other Projects: The project ties in with HOTRMHMR Center project 084859002.2.5. These projects both work with special populations with at risk medical conditions, but require different interventions to be successful in reaching substantial changes in behaviors. Category 4 is not applicable.

Relationship with Other Performing Providers' Projects in the RHP: This project ties into most of the other RHP projects as it specifically deals with positive health outcomes. This project is unique as it works with a special population that has demonstrated issues with poor health outcomes.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to integrated health care services. In Texas several agencies already have a collaborative related to this issue and other new projects would meet with those Centers to review progress and address problems and needs of specific targeted areas.

Project Valuation: The project was valued utilizing Maeng's assessment of cost savings in a collaborative care model combined with data on health related issues within the SMI population to determine the size and scope of the project. It was determined that identifying those at the greatest risk and then tailoring an integrated health service delivery system to meet their needs would be the most effective way of combating the issue. At a cost of $5,201 per person served in the project, significant savings to the community would be achieved.

084859002.2.5	2.2.5	2.2.5	INTEGRATED GERIATRIC SERVICES	
Heart of Texas Region MHMR Center				084859002
Related Category 3 Outcome Measure(s): OD-1	**IT-1.9**	**084859002.3.6**	**Primary Care and Chronic Disease Management**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P-3 **Metric 1** – P-3.1 **Baseline/Goal:** P-3 Develop a comprehensive care management program. P-3.1 Documentation of care management program. **Data Source:** Documentation of care management program. **Milestone 1 Estimated Incentive Payment:** $ 84,008 **Milestone 2 – P-9** **Metric 2** – P-9.1 **Baseline/Goal:** P-9 Develop program to identify and manage chronic care patients needing further clinical intervention health services P-9.1 Increase the number of patients identified as needing screening test, preventative tests, or other clinical	**Milestone 4** – I-21.2 **Metric 4** – I-21.2.1 **Baseline/Goal:** I-21.2 Documentation of increased number of unique patients served by innovative program. I-21.2.1 One hundred (100) patients will be served by the program. **Data Source:** HOTRMHMR Clinical system. **Milestone 4 Payment:** $453,645		**Milestone 5** – I-21.2 **Metric 5** – I-21.2.1 **Baseline/Goal:** I-21.2 Documentation of increased number of unique patients served by innovative program. I-21.2.1 One hundred and twenty (120) patients will be served by the program. **Data Source:** HOTRMHMR Clinical system. **Milestone 1Payment:** $544,374	**Milestone 6** – I-21.2 **Metric 6** – I-21.2.1 **Baseline/Goal:** I-21.2 Documentation of increased number of unique patients served by innovative program. I-21.2.1 One hundred and forty (140) patients will be served by the program. **Data Source:** HOTRMHMR Clinical system. **Milestone 1Payment:** $622,400

084859002.2.5	2.2.5	2.2.5	INTEGRATED GERIATRIC SERVICES	
Heart of Texas Region MHMR Center				084859002
Related Category 3 Outcome Measure(s): OD-1	IT-1.9	084859002.3.6	**Primary Care and Chronic Disease Management**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
intervention **Data Source:** Increased number of patients identified as needing screenings and other clinical interventions. **Milestone 2 payment:** $84,008 **Milestone 3 – P-11** **Metric 3 –** P-11.1 **Baseline/Goal:** P-11 Develop and implement program to assist patient to better self-manage their chronic conditions P-11.1 Increase the number of patients enrolled in self management program. **Data Source:** Increased numbers of patients enrolled in self management programs. **Milestone 3 Payment:** $84,008				

084859002.2.5	*2.2.5*	*2.2.5*	*INTEGRATED GERIATRIC SERVICES*	
Heart of Texas Region MHMR Center				*084859002*
Related Category 3 Outcome Measure(s): OD-1	***IT-1.9***	***084859002.3.6***	**Primary Care and Chronic Disease Management**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 252,025	Year 3 Estimated Milestone Bundle Amount: $ 453,645		Year 4 Estimated Milestone Bundle Amount: $ 544,374	Year 5 Estimated Milestone Bundle Amount: $ 622,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 1,872,444				

Summary Information

Performing Provider: HOTRMHMR Center

Pass 1 Project

Project Unique ID #: 084859002.2.6

- Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

- Intervention(s): This project will establish a specialized program to work with individuals who have a mental health diagnosis that also have substance abuse issues. The program would work with treatment resistant individuals to successfully modify their behaviors. It is anticipated that an additional 180 individuals will be served in this project, with 50 being served in YR 3, 60 in YR 4 and 70 in YR 5.

- Need for the project: Currently there are not sufficient resources in the community mental health system to have specialized services for all those in need. By treating COPSD issues in a team treatment model it is expected that individuals will have improved outcomes and a reduction in more costly community services will be achieved.

- Medicaid and Uninsured Target population: It is estimated that only about 30% of these individuals have Medicaid while the majority will be uninsured.

- Category 1 or 2 expected patient benefits: It is expected that by providing these types of interventions to this population it would significantly reduce their utilization of more costly community services such as emergency departments, criminal justice system, inpatient hospitalization and detoxification facilities.

- Category 3 outcomes: IT -9.1; Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.

Identifying Project and Provider Information: Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. COPSD Program. 084859002.2.6 - HOTRMHMR/084859002

Project Description: Establish a Co-Occurring Psychiatric and Substance Use Disorder (COPSD) Team to provide intensive services to individuals with substance abuse and mental health issues. These individuals would be selected for the program based on identified substance use regardless of level of motivation to change. These individuals are treatment resistant and need specialized treatment services to successfully change their behaviors. Interventions would include intensive case management, medication management, psychosocial rehabilitation and substance abuse counseling. The goal of the project would be to reduce the number of individuals who access more costly treatment alternatives based on complex substance abuse and mental health issues. This population repeatedly are arrested, incarcerated and utilize a significant amount of community resources such as emergency department's visits, law enforcement contacts and inpatient psychiatric hospital beds. The expected outcomes of the project would seek a reduction of arrests, emergency room utilization and inpatient psychiatric care for participating individuals. The project would establish baseline data for each participant. We would then compare the pre-admission data with post-participation data to determine measurable progress in reducing preventable incarcerations / admissions.

Starting Point / Baseline: The HOTRMHMR Center has extensive experience in providing COPSD services but due to limited resources has not been able to develop a comprehensive program designed to work with this population. The end result is continued difficulties in keeping this population from accessing more costly community services.

Rationale: The HOTRMHMR Center serves individuals whose mental health care is significantly compromised because of substance abuse issues. These individuals are often arrested, become homeless, or access emergency departments and inpatient care because they have difficulty complying with their mental health treatment while engaged in substance abuse (CNA-007 & CNA-004). According to SAMHSA in 2009, 25.7% of all individuals suffering with chronic mental health issues also have a co-occurring diagnosis of substance abuse. Additionally, these individuals have a much greater likelihood of dropping out of traditional mental health services. The ability to provide more intensive community based services in a specialized treatment model will better assist in coordination between providers and will meet a service need for many individuals currently not receiving treatment due to lack of insurance or other resources (CNA-006). This cycle leads to greater utilization of other more costly community services. The project option would be 2.13.1; Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting including all core elements. The core elements would be addressed as follows: a). The HOTRMHMR Center will assess size, characteristics and needs of target populations. b). A review of the literature has been completed and the COPSD model will be used. Additionally, the project will include active case management and substance abuse counseling. A harm reduction model will be integrated into the larger program with additional improvements in designated functional status. c). The HOTRMHMR Center will develop project evaluation plan using qualitative and quantitative metrics to determine outcomes. d). Models will be designed which include an appropriate range of community-based services and residential options. The Center currently works closely with other substance abuse providers in the community including residential options. Inpatient treatment and detoxification services are also available through arrangement. Natural supports such as twelve step programs and peer providers will also be engaged. e). The HOTRMHMR Center will assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. The Center will hire a staff designated to administer and conduct analysis of the project. Process

milestones would include P-2, P-3 and P-4. Process milestones not included are due to project design. Improvement milestone would be I-5. Other improvement milestones not included are based on project design and not being relevant to project. The reduction in the number of these individuals who access more costly community interventions ties in with the region's goals of serving individuals in the right setting with the appropriate types of interventions that would positively impact the individual's recovery rather than treat the symptoms. By the end of this project we anticipate a significant reduction in the number of community interventions needed to support these individuals in the community.

Related Category 3 Outcome Measure: The Category 3 outcome measure will be OD – 9 – Right Care / Right Setting. Providing the right care in the right setting is important to reduce the overall costs associated with this difficult client population. Working with COPSD consumers and increasing function will impact all other areas such as emergency department utilization, homelessness, inpatient hospitalizations, criminal justice involvement and other physical health complications. The project ties into the regional goal of providing the appropriate services to individuals in special categories that are historically high utilizers of other health care services.

Relationship to Other Projects: The project ties in with HOTRMHMR Center project 084859002.2.2 and project 084859002.2.4 These projects also work with special populations with at risk conditions, but that require different interventions to be successful in reaching substantial changes in behaviors. Category 4 is not applicable.

Relationship with Other Performing Providers' Projects in the RHP: This project ties into the RHP regional project dealing with emergency department screenings and the use of telehealth equipment to improve mental health screenings.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to mental health screenings and diversions from state and local inpatient settings and emergency departments. Substance abuse issues are a significant factor faced by providers in the health care industry. A collaborative approach to addressing this issue is needed to reduce the impact felt by local hospitals, law enforcement entities and other health care providers.

Project Valuation: Utilizing data from the Bluebonnet Trails Jail Diversion Study, the baseline community cost to serve this target group would be approximately $37,500 per person/per year. The services provided in this project utilizing the COPSD model would be $3,505 per participant.

084859002.2.6	***2.13.1***	***2.13.1 A,C,D,& E***	***COPSD PROGRAM***

Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-9	***IT-9.1***	***084859002.3.7***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P-2 **Metric 1** – P-2.1 **Baseline/Goal**: P-2 Design community-based specialized interventions for target population. P-2.1 Project plans that are based on evidence / experience and which address the project goal. **Data Source:** Project plan is evidence based. **Milestone 1 Estimated Incentive Payment:** $ 34,592 **Milestone 2 – P-3** **Metric 2**– P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Twenty-five (25) individuals will be enrolled and served in this project. **Data Source:** HOTRMHMR	**Milestone** 4– P-3 **Metric 4** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Fifty (50) individuals will be enrolled and served in this project. **Data Source:** HOTRMHMR Clinical system. **Milestone 4 Payment:** $62,265 **Milestone 5** – P-4 **Metric 5** – P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan do, study, act quality improvement cycles. **Data Source:** Documentation of CQI.	**Milestone** 7– P-3 **Metric 7** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Sixty (60) individuals will be enrolled and served in this project. **Data Source:** HOTRMHMR Clinical system. **Milestone 7 Payment:** $74,718 **Milestone 8** – P-4 **Metric 8**– P-4.1 **Baseline /Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan do, study, act quality improvement cycles. **Data Source:** Documentation of CQI.	**Milestone 10** – P-3 **Metric 10** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with targeted complex needs. P-3.1 Seventy (70) individuals will be enrolled and served in this project. **Data Source:** HOTRMHMR Clinical system. **Milestone 10 Payment:** $85,427.33 **Milestone 11 –** P-4 **Metric 11** – P-4.1 **Baseline /Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan do, study, act quality improvement cycles. **Data Source:** Documentation of CQI.

084859002.2.6	*2.13.1*	*2.13.1 A,C,D,& E*	*COPSD PROGRAM*
Heart of Texas Region MHMR Center			*084859002*
Related Category 3 Outcome Measure(s): OD-9	***IT-9.1***	***084859002.3.7***	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Clinical system. **Milestone 2 payment:** $34,592 **Milestone 3 – P-4** **Metric 3** – P-4.1 **Baseline /Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan do, study, act quality improvement cycles. **Data Source:** Documentation of CQI. **Milestone 3 Payment:** $34,592	**Milestone 5 Payment:** $62,265 **Milestone 6**- I-5 **Metric 6** – I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 10% of individuals in the project will show improved functioning on standardized instruments. **Data Source:** HOTRMHMR Clinical system. **Milestone 6 Payment:** $62,265	**Milestone 8 Payment:** $74,718 **Milestone 9**- I-5 **Metric 9** – I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 15% of individuals in the project will show improved functioning on standardized instruments. **Data Source:** HOTRMHMR Clinical system. **Milestone 9 Payment:** $74,718	**Milestone 11 Payment:** $85,427.33 **Milestone 12**- I-5 **Metric 12** – I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 20% of individuals in the project will show improved functioning on standardized instruments. **Data Source:** HOTRMHMR Clinical system. **Milestone 12 Payment:** $85,427.33
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 103,775	Year 3 Estimated Milestone Bundle Amount: $ 186,795	Year 4 Estimated Milestone Bundle Amount: $ 224,154	Year 5 Estimated Milestone Bundle Amount: $ 256,282
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 771,006			

Summary Information

Performing Provider: HOTRMHMR Center

Pass 3 Project

Project Unique ID #: 084859002.2.7

· Provider: Community Mental Health Center in Central Texas covering McLennan, Falls, Hill, Bosque, Limestone and Freestone Counties.

· Intervention(s): This project will establish a community clinic for outpatient services to work with individuals who do not qualify for traditional community center services based on not having a targeted qualifying diagnosis. The clinic would provide outpatient counseling, short-term psychiatric services, medications and case management designed to assist individual in learning more appropriate coping mechanisms. It is anticipated that an additional 1,050 individuals will be served in this project, with 300 being served in YR 3, 350 in YR 4 and 400 in YR 5.

· Need for the project: Currently individuals who do not qualify for community center services based on diagnoses or who do not have insurance benefits that allow them to go to a private provider do not have access to counseling and medication services. These individuals often engage in at-risk behaviors that require interventions in more costly community services. With appropriate treatment many of these individuals can deal with life circumstances in a more appropriate manner and can have a higher quality of life.

· Medicaid and Uninsured Target population: It is estimated that only about 20% of these individuals have Medicaid while the majority will be uninsured.

· Category 1 or 2 expected patient benefits: It is expected that by providing these types of interventions to this population it would significantly reduce their utilization of costly community services such as emergency departments, the criminal justice system and inpatient hospitalization.

· Category 3 outcomes: IT -9.2; ED appropriate utilization; reduce ED visits for targeted population of behavioral health and substance abuse.

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I. Category 2: Program Innovation and Redesign

Identifying Project and Provider Information: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Community Clinic for Outpatient Services. 084859002.2.7 HOTRMHMR/084859002

Project Description: Establish a community clinic for outpatient services designed to work with individuals who do not qualify as target population for on-going community center services. These individuals have serious Axis II conditions that lead to high hospitalizations and crisis care interventions. They also tend to exhibit higher than average substance abuse issues, suicides and suicidal ideations, emergency department contacts, inpatient care and health related services. The clinic would employ licensed clinicians, a psychiatrist, RN, caseworkers and support and billing staff. The clinic would have a strong orientation towards outpatient counseling while utilizing medications for short-term stabilization and to assist with other clinical interventions. The clinic would serve to eliminate the waiting list for services at the HOTRMHMR Center and Family Health Clinic and would be a resource for the DePaul Center and the State Hospital system for aftercare interventions. Goals of the project would include:

1. To provide a targeted intervention to assist individuals who otherwise would access more costly and less appropriate services such as emergency departments and inpatient hospitals.
2. To provide an aftercare alternative for individuals who are leaving more structured inpatient settings such as DePaul or the state hospital system.
3. To provide an aftercare alternative for individuals who have accessed crisis services such as the Mobile Crisis Outreach Team (MCOT), the Crisis Care Center or other community providers.

Because of limitations imposed by the Department of State Health Services only individuals with a diagnosis of Schizophrenia, Bipolar Disorder or Major Depression are eligible for on-going services at the HOTRMHMR Center. Many of these individuals also do not qualify for Medicaid benefits and therefore are left without suitable options for counseling and medication services. Because Axis II diagnoses are not biologically related but are developed due to traumatic events such as child abuse, sexual assault, military trauma and other significant trauma related events these individuals are also prone to self-destructive behaviors. These behaviors coupled with poor coping skills can lead to very poor outcomes. Many of these outcomes can result in behaviors that lead to interventions in more costly locations and with poorer results. The clinic would provide the appropriate types of interventions within the proper setting to assist individuals learn new and better coping skills. This project fits into the regional goal of serving more consumers in a manner that reduces their risk for additional more costly services in the future.

Starting Point / Baseline: The HOTRMHMR Center does not currently provide on-going services to individuals with these diagnoses. The HOTRMHMR Center does provide crisis intervention and inpatient hospital services for this population. In FY 12, 1,990 MCOT assessments were completed, 853 crisis assessments were completed at the Crisis Care Center and 1,119 assessments were completed at the McLennan County Jail. Additionally, 1,099 bed days were utilized at DePaul Center and 16,174 bed days were used in the state hospital system.

Rationale: Based on data from the HOTRMHMR Center Admissions Department, 743 individuals were screened in FY 12 for diagnostic appropriateness for on-going services at the Center. Of these, 298 were determined not to meet the target population for services at the Center and had to be referred out. Most of these individuals did not have a payer source and therefore were unlikely to receive the care needed (CNA-006). Because of the lack of appropriate services, many of these individual's conditions worsened and many accessed other more costly service points such as the emergency departments, inpatient hospitals and jails (CNA-007 & CNA – 003). Additionally, many of these individuals engage in high risk behaviors such as alcohol / substance use and sexual promiscuity. These individuals have poor interpersonal relationships and are at greater risk for divorce, child abuse, domestic violence and suicide (CNA-007). Veterans experiencing PTSD symptoms are also at risk for all of the symptoms noted above.

Outpatient counseling combined with case management and some limited medication services has proven to be the most successful approach to dealing with individuals in this population. Project Options 2.13.1; Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population with all core components would be used. a) Assess size, characteristics and needs of target populations. The core population served in this project would be individuals with an Axis II diagnosis that need counseling services to assist them with better coping skills. The project would serve up to 1,050 individuals over the five year period, with 300 individuals being treated in YR 3, 350 in YR 4 and 400 in YR 5.b). A review of the literature and analysis of experience in working with this population led to the design of this project. The outpatient model combined with case management and psychiatric support will have an effect in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalizations, decreased mental and physical functioning status, and in promoting correspondingly positive health and social outcomes/quality of life; c). The project will develop an evaluation plan using qualitative and quantitative metrics to determine outcomes; d). The model will include an appropriate range of community-based services and residential supports to impact the negative outcomes targeted; e). The project will assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Process milestones P-1, P-2, P-3 and P-4 would be implemented. Other process milestones would not be used based on pre-identified community needs or programmatic design. Improvement milestones I-5 would be selected for use.

Related Category 3 Outcome Measure: The Category 3 outcome measure is OD-9 – Right Care, Right Setting. Utilizing specific outcome metrics to show overall project effectiveness gives concrete data to verify progress and ties into the regional goal of better use of community resources.

Relationship to Other Projects: The project ties in with HOTRMHMR Center project 084859002.2.4 and project 084859002.2.6. These projects also work with special populations with at risk medical conditions, but that require different interventions to be successful in reaching substantial changes in behaviors. Category 4 is not applicable.

Relationship with Other Performing Providers' Projects in the RHP: This project ties into several other projects that attempt to reduce inappropriate use of emergency department resources.

Plan for Learning Collaborative: This project lends itself to participation in a collaborative of other RHP and statewide projects related to targeting specific behavioral health interventions to prevent unnecessary use of services in a specified setting.

Project Valuation: The valuation of this project was based on current cost of serving individuals in the HOTRMHMR Center combined with savings achieved by reducing inpatient hospitalizations, criminal justice involvement and emergency department visits. The project size was determined utilizing waiting list numbers, state and local need assessments and underserved populations. At a cost of $5,527 per person served, the potential savings per person is significant. The average state hospital episode for the HOTRMHMR Center is $16,000. Based on Bluebonnet MHMR Jail Diversion Project data the annual cost of diverting an individual from the criminal justice system is $37,500. Local inpatient costs the HOTRMHMR Center $345,000 per year. The average cost per emergency department visit exceeds $3,000 per visit. These figures do not include the cost to the community in lost tax revenue from unemployment and lost work productivity.

084859002.13	***2.13.1***		***COMMUNITY CLINIC FOR OUTPATIENT SERVICES***
Heart of Texas Region MHMR Center		***084859002***	
Related Category 3 Outcome Measure(s):OD-9	***IT-9.2***	***084859002.13***	**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-1 **Metric 1** – P-1.1 **Baseline/Goal:** P-1 Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. P-1.1 Determine the number of individuals , demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization and ED utilization to be served. **Data Source:** Documented needs assessment. **Milestone 1 Estimated Incentive Payment:** $ 630,065.50 **Milestone 2** – P-2 **Metric 2**– P-2.2 **Badseline/Goal:** P-2 Design community based specialized interventions for target populations P-2.1 Design a plan based on	**Milestone 3** – P-3 **Metric 3** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with complex needs. P-3.1 Serve three hundred (300) individuals in the project in YR 3. . **Data Source:** Clinical records **Milestone 3 Payment:** $ 699,353 **Milestone 4 – P-4** **Metric 4**– 4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles.	**Milestone 5** – P-3 **Metric 5** – P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with complex needs. P-3.1 Serve three hundred and fifty (350) individuals in the project in YR 4. **Data Source:** Clinical records **Milestone 5 Payment:** $511,500 **Milestone 6 – P-4** **Metric6**– P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Center IT system.	**Milestone 8** – P-3 **Metric 8**– P-3.1 **Baseline/Goal:** P-3 Enroll and serve individuals with complex needs. P-3.1 Serve four hundred (400) individuals in the project in YR 5. **Data Source:** Clinical records **Milestone 8 Payment:** $ 536,715 **Milestone 9 – P-4** **Metric 9** – P-4.1 **Baseline/Goal:** P-4 Evaluate and continuously improve interventions. P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Data Source:** Center IT system. **Milestone 9 Estimated Incentive Payment:** $ 536,715

084859002.13	***2.13.1***		***COMMUNITY CLINIC FOR OUTPATIENT SERVICES***
Heart of Texas Region MHMR Center		***084859002***	
Related Category 3 Outcome Measure(s):OD-9	***IT-9.2***	***084859002.13***	**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)**
evidence / experience and which addresses the project goal. **Data Source:** Documentation of establishing community clinic for outpatient services. **Milestone 2 payment:** $ 630,065.50	**Data Source:** Center IT system. **Milestone 4 Estimated Incentive Payment:** $ 699,353	**Milestone 6 Estimated Incentive Payment:** $ 511,500 **Milestone 7**- I-5 **Metric 7** – I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 Fifteen percent (15%) of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. **Data Source:** Center IT system **Milestone 7 Payment:** $ 511,500	**Milestone 10**- I-5 **Metric 10** – I-5.1 **Baseline/Goal:** I-5 Functional Status I-5.1 Twenty -five percent (25%) of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. **Data Source:** Center IT system **Milestone 10 Payment:** $ 536,715
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,260,131	Year 3 Estimated Milestone Bundle Amount: $1,398,706	Year 4 Estimated Milestone Bundle Amount: $ 1,534,500	Year 5 Estimated Milestone Bundle Amount: $ 1,610,145
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 5,803,482			

Pass 1 Project

- Provider: Hillcrest Baptist Medical Center *(TPI 138962907*) is a Private, Non-Profit Hospital in Waco, TX. HBMC is a faith-based institution that serves as the primary safety net hospital and only Level 2 trauma center in a 40-mile radius. HBMC is in McLennan County with a population of 225,000 and serves an above state average number of Medicaid and indigent patients.
- Intervention(s): This project will implement a Palliative Care program, which provides a more appropriate level and place of care for a large portion of the chronically ill. Hillcrest Palliative Care will be based in this facility but plans to serve as a regional project which acts as a resource and referral destination for the partners in RHP 16. This includes outpatient visits, inpatient consults, care transitions, social resource utilization, and spiritual guidance. There were 334 potential Palliative Care referrals admitted to Hillcrest last year, along with 245 inpatient expirations, both of which could benefit from the project.
- Need for the project: We currently only have hospice care available in this region, so palliative care will be a completely new line of service for the patients in our service area. This project will provide care that meets the triple aim of right care, right place, and right time for a number of chronically ill patients who don't qualify for hospice care.
- Medicaid and Uninsured Target population: Palliative care and planning considers the wishes of the patient and plans to focus on quality of life rather than curative medicine. Lack of planning is more prevalent in the indigent and underserved population, plus our community has rates of poverty higher than state averages. We anticipate a majority of consults will be with Medicaid eligible or indigent patients that lack the resources to pay for this type of care otherwise..
- 1 or 2 expected patient benefits: The project seeks to enroll patient into the new Palliative Care program and grow the number of consults over the lifetime of the project. The number of patients that receive a consult before death in the hospital should increase over baseline by 10% and 20% respectively in DY 4 and DY 5.
- Category 3 outcomes: We have 3 non-standalone measures that are intended to capture the outcome improvements that we are seeking to implement with this program.
    - *IT-13.1 We hope to increase the number of palliative care patients that screen positive for pain and receive a clinical assessment within 24 hours.*
    - *IT-13.2 We hope to document treatment preferences for life-sustaining measures in an increasing number of palliative care patients' records.*
    - *IT-13.5 We hope to document the religious/spiritual preferences and wishes for an increasing percentage of palliative care patients.*

Project Option: 2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: PALLIATIVE CARE PROGRAM.
Unique Project ID: 138962907.2.1
Performing Provider Name/TPI: Hillcrest Baptist Medical Center (TPI: 138962907)

Project Description
Hillcrest Baptist Medical Center proposes to plan, implement, and grow a new Palliative Care program for patients in the hospital and the region to benefit from a more appropriate care setting based on a holistic approach to patient quality of life.

Target Population: We are targeting all patients enrolled in the Palliative Care program at Hillcrest Baptist Medical Center. The uninsured make up 27% of the RHP 16 population, which equates to over 100,000 people. There are over 70,000 people living below the poverty rate with the majority coming from HBMC's primary market of McLennan County. As the safety net hospital, HBMC sees a large percentage of the local Medicaid and indigent populations, so this project will be ideally suited to reach the largest portion of the more than 70,000 impoverished residents. According to estimates, there would be 334 appropriate referrals for Palliative Care admitted to Hillcrest last year alone. Hillcrest also had 245 inpatient expirations in FY12, who will additionally be a focus for the project. We are hoping to provide palliative care consultations to 15-20% of this group during DY4 and DY5, which would have meant 37-49 patients receiving this portion of our service.

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.

Hillcrest's palliative care program will include:

- Hiring additional providers, including a full-time nurse practitioner, medical director, social workers, chaplain, and other team members on a per needed basis.
- A hub for regional partners to seek a consult from the Palliative Care program. They would be able to refer patients to the program or utilize the resources in order to get patients set up with the most appropriate care. The Hillcrest Palliative Care team will lead the way in training other programs within the region, acting as a resource base for other providers, and help transition patients between the different care settings.
- Outpatient visits in an office setting, inpatient consults, care transitions, social resource utilization, and other ancillary services needed to meet the quality of life needs of the indigent and Medicaid populations in RHP 16.

Goals and Relationship to Regional Goals:
Project Goals:

- Increase the number of palliative care patients transitioned from acute care into home care, hospice, or a skilled nursing facility
- Reduce the number of patients that died in the hospital without a palliative care consultation
- Improve quality of life metrics such as pain assessment, treatment preferences, and spiritual/religious preferences in order to deliver more appropriate and cost-effective care.

This project meets the following regional goals:

- Reduce potentially preventable hospitalizations by ensuring that patients are receiving the right care, in the right place, and at the right time. These programs offer a more holistic view of the patient and attempt to reduce the unnecessary hospitalization of patients based on inappropriate or overly aggressive care.
    - CNA-004 Potentially Preventable Hospitalizations , including Diabetes with short-term and long-term complications
- Patient satisfaction is a need identified by our community. This palliative care program is meant to target the quality of life needs for each individual patient, which is perfectly aligned with the goal of increasing patient satisfaction. The project will enable providers to develop a holistic plan based on each patient's desires and wishes.
    - CNA-010 Measuring and monitoring patient satisfaction
- The inappropriate utilization of the Emergency Room can be very common among patients with chronic or long-term conditions that lead to suffering and a diminished quality of life. The appropriate, team-based approach to care can be guided by a focus on improving a patient's suffering while avoiding emergent or acute treatment settings that offer no benefit to the patient's quality of life goals.
    - CNA-007 Inappropriate utilization of Emergency Room

Challenges

Hillcrest seeks to implement a new Palliative Care program, which doesn't currently exist. The lack of intellectual capital and experience will be challenging as the protocols and necessary treatment algorithms will need to be developed from the ground up. There is limited experience in this specialized area, so the right professionals will need to be brought in to help launch the program. There is also limited understanding by the providers in the region, so a great deal of education and outreach will be required. The regional collaborative will be an important part of the program as roughly 17% of Hillcrest's inpatient discharges come from the other counties in Region 16. This means that coordination of care between regional partners will be key to offering such a transformative program to as many regional patients as possible.

5-Year Expected Outcome for Provider and Patients:

We expect this project will increase the incidence of care transitions from an acute-care setting, to a more appropriate venue, such as a nursing home or home care. This project will likely reduce costs associated with end-of-life care by reducing unnecessary inpatient costs. As a result, we expect that this project will quality of life issues for individual patients such as pain assessments, religious/spiritual preferences, and overall treatment preferences. The goal is to address each patient's needs upfront in order to focus on quality of life rather than solely curative needs, which should help to lower unnecessary and expensive medical treatments.

Starting Point/ Baseline

A palliative care program does not formally exist at this time, so the baseline in DY 2 is 0. Baseline data will be established in DY3.

Rationale:

Hillcrest Baptist Medical Center identified potentially 334 inpatient admissions that would have been likely candidates for Palliative Care over a year period from March 2011 through February 2012. Based on the costs associated with these patients, if even 20% had participated in a Palliative Care program that kept them out of the acute setting, then the cost savings were projected to be approximately $28 Million. These startling statistics show the high cost of providing care to chronically ill patients in such an expensive and often unnecessary setting. The acute care setting is also not ideal when it comes to maximizing a person's quality of life. This program would seek to more appropriately provide care in a setting that is best for the patient while also helping to avoid some of the steep costs that come from preventable admissions, readmissions, and emergency room visits.

Providing palliative care services will improve patient outcomes and quality of life. 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.

Hillcrest Baptist Medical Center currently offers a hospice program through the Scott & White Hospice Care program. This program would work closely with the overall Palliative Care program in order to provide appropriate transitions between the various levels of care. While hospice care is important for patients in their final stages of life, palliative care offers a much wider range of patients the same type of benefits and treatment goals but with much earlier and longer-term intervention periods. 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.

A study of variability in access to palliative care on a state-by-state analysis has been completed by the Center to Advance Palliative Care (capc.org). There exists great variability between states and different sizes of hospitals with Texas offering one of the lower rates of palliative care programs compared to the rest of the nation. 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. For these patients, improving access to non-hospice palliative care is a key strategy both to improve quality and, in multiple studies, to reduce costs.

Project Core Components:

Hillcrest will accomplish each of the following required core components as follows:

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

In DY 2 of the Waiver, Hillcrest will develop a business plan and submit the plan to HHSC demonstrating its intent to implement a palliative care. (Milestone 1)

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility

In DYs 3, 4, and 5, Hillcrest will implement the Palliative Care program (Milestone 3). The palliative care team will help to transition these patients to the settings above that are more appropriate than the acute care setting. The IT-10 (Milestones 5 and 7) will measure the number of in-hospital deaths that received a palliative care consult, which will help to measure the reach and effect of transitioning these patients to a more appropriate setting. The goals will be to successfully implement the program (P-5) and improve IT-10 by 10% and 20% over baseline during DY 4 and DY5 respectively.

c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time.

Hillcrest will implement a patient/family survey during DY3, when the full program is implemented. This survey will be used to measure effectiveness and for quality purposes with a goal of improving scores over time. These results can be shared as part of the CQI: P-11 metric in order to establish best practices and share insights. (Milestones 2,4,6,8, and 10)

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.

HBMC will meet this component through face-to-face learning (i.e. meetings or seminars) at least twice per year (Milestones 2,4,6,8, and 10) with other providers and the RHP to promote collaborative learning around shared or similar projects. These meetings with regional partners provide the opportunity to discuss best practices, areas of opportunity, care hand-off challenges, available resources, and optimal education/outreach efforts. The goal will be to participate in all of these meetings for DYs 2-5.

Process Improvement Milestones:

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

- **Milestone 3: P-5** Implement/expand a palliative care program
- **Milestones 2, 4, 6, 8, and 10: CQI: P-11** 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.
- **Milestones 7 and 9: I-10** Among patients who died in the hospital, increase the proportion of those who received palliative care consults (Goal: DY4 - 15% of inpatients that expire in the hospital, which would have been 37 out of 245 for FY12 and DY5-20% of inpatient expirations or 49 out of 245 based on FY12 data)

New initiative for the Hillcrest Baptist Medical Center

A palliative care program does not currently exist at Hillcrest and yet it is ideally suited for the triple aim of provided the right care, in the right place, and at the right time. Hillcrest currently offers case management services, social workers for care transitions, and chaplain services for inpatient care, but these programs do not act in unison to address what current and future options will be best based on the patient's expected quality of life.

Related Category 3 Outcome Measure(s) – 3 Non-Standalone Measures

OD-13 Palliative Care

138962907.3.1

IT-13.1 Pain assessment (NQF-1637) *(Non-standalone measure)*

Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

a. Numerator: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
b. Denominator: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.

- Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

c. Data Source: EHR, Claims
d. Rationale/Evidence: Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

138962907.3.2

IT-13.2 Treatment Preferences (NQF 1641) *(Non-standalone measure)*

Percentage of patients with chart documentation of preferences for life sustaining treatments.

a. Numerator: Patients whose medical record includes documentation of life sustaining preferences
b. Denominator: Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
    - Exclusions: patients with length of stay < 1 day in palliative care or<7 days in hospice.
c. Data Source: EHR, Claims
d. Rationale/Evidence: Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

138962907.3.3

IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) *(Non-standalone measure)*

a. Numerator: Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.
b. Denominator: Total number of patient's discharged from hospice or palliative care during the designated reporting period.
c. Data Source: EHR, Claims
d. Rationale/Evidence: One of the unique aspects of hospice care involves a true interdisciplinary approach providing care for both the physical and psychosocial and spiritual needs of the patient and caregiver. Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met. This measure will help agencies improve processes for addressing spiritual/religious concerns for patients and families receiving hospice care.

Relationship to other Projects

None.

Relationship to other Performing Providers' Projects in the RHP

Works collaboratively with the care transitions projects at both Coryell Memorial Hospital (134772611.1.2) and Hamilton General Hospital (121792903.2.3). HBMC will act as a hub for the region in terms of education and consults for palliative care.

Plan for Learning Collaborative

RHP 16 will meet quarterly to discuss the current state of the region's projects, issues related to those projects, and the populations served by the region. RHP 16 will also meet to discuss opportunities to learn from successes and failures during the implementation of the projects.

Project Valuation

As the safety net hospital, HBMC sees a large percentage of the local Medicaid and Indigent populations so this project will be ideally suited to reach the largest portion of the more than 70,000 impoverished residents. According to our estimates, there would be 334 appropriate referrals for Palliative Care admitted to Hillcrest alone. Hillcrest also had 245 inpatient expirations in FY12, who will additionally be a focus for the project. We are hoping to provide palliative care consultations to 15-20% of this group during DY4 and DY5, which would have meant 37-49 patients receiving this portion of our services. Our estimates show that 20% of these Palliative Care eligible patients could account for as much as $28 million a year in avoidable inpatient hospital costs.

The project is currently valued at $7,425,000. In determining the value of this project, Hillcrest considered the extent to which more personalized and appropriate care will enable the indigent and Medicaid populations to utilize services that are not currently available to them. The community will benefit through improved resource utilization and more appropriate care geared toward the patient's wishes and beliefs. The valuation takes into account considerable cost avoidance and savings through reductions in acute care, curative-based medical interventions. This project is a top priority as there are very few planning resources available to chronic patients in the indigent and Medicaid communities, other than just basic end-of-life hospice care.

138962907.2.1	***2.10.1 A-D***	138962907.2.1	***PALLIATIVE CARE PROGRAM***
Hillcrest Baptist Medical Center			*138962907*
Related Category 3 Outcome Measure(s): OD - 13	***IT-13.1*** ***IT-13.2*** ***IT-13.5***	138962907.3.1 138962907.3.2 138962907.3.3	***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 Goal: Develop a business case for palliative care. Metric **P-1.1** Business case Data Source Submission of business case write-up; documentation of planning activities Milestone 1 Estimated Incentive Payment *(maximum amount): $1,062,500* Milestone 2 **CQI: P-11** Participate in face□to□face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to	Milestone 3 **P-5** Implement/expand a palliative care program Goal: Implement program Metric **P-5.1** Implement comprehensive palliative care program Data Source Charter for Palliative care program; Operational Plan; palliative care team and hiring agreements. Palliative Care Program Milestone 3 Estimated Incentive Payment *(maximum amount): $1,000,000* Milestone 4 **CQI: P-11** Participate in face□to□face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to	Milestone 5 **I-10** Among patients who died in the hospital, increase the proportion of those who received palliative care consults Metric **I-10.1** Percent of total in-hospital deaths who had a palliative care consult Goal: 15% of inpatient expirations, which would have been 37 out of 245 patients in FY12. Data Source EHR, Claims Milestone 5 Estimated Incentive Payment *(maximum amount): $937,500* Milestone 6 **CQI: P-11** Participate in face□to□face learning (i.e. meetings or seminars) at least	Milestone 7 **I-10** Among patients who died in the hospital, increase the proportion of those who received palliative care consults Metric **I-10.1** Percent of total in-hospital deaths who had a palliative care consult Goal: 20% of inpatient expirations, which would have been 49 out of 245 patients in FY12. Data Source EHR, Claims Milestone 7 Estimated Incentive Payment *(maximum amount): $712,500* Milestone 8 **CQI: P-11** 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

138962907.2.1	***2.10.1 A-D***	138962907.2.1	***PALLIATIVE CARE PROGRAM***
Hillcrest Baptist Medical Center			*138962907*
Related Category 3 Outcome Measure(s): OD - 13	***IT-13.1*** ***IT-13.2*** ***IT-13.5***	138962907.3.1 138962907.3.2 138962907.3.3	***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)**
promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric **P-11.1** 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. Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,062,500	promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric **P-11.1** 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. Milestone 4 Estimated Incentive Payment: $ 1,000,000	twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric **P-11.1** 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. Milestone 6 Estimated Incentive Payment: $ 937,500	learning around shared or similar projects. Goal: Participate in all semi-annual meetings. Metric **P-11.1** 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. Milestone 8 Estimated Incentive Payment: $ 712,500

138962907.2.1	***2.10.1 A-D***	138962907.2.1	***PALLIATIVE CARE PROGRAM***	
Hillcrest Baptist Medical Center				*138962907*
Related Category 3 Outcome Measure(s): OD - 13	***IT-13.1*** ***IT-13.2*** ***IT-13.5***	138962907.3.1 138962907.3.2 138962907.3.3	***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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,125,000	Year 3 Estimated Milestone Bundle Amount: $2,000,000		Year 4 Estimated Milestone Bundle Amount: $1,875,000	Year 5 Estimated Milestone Bundle Amount: $1,425,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $7,425,000				

Summary Information

Performing Provider: South Limestone Hospital District

Pass 1 Project

Project Unique ID #: 140714001.2.1

- Provider: South Limestone Hospital District is a 20 bed Critical Access hospital in Groesbeck, Texas serving the southern portion of Limestone County, the entire county population is 23,634.

- Intervention(s): This project will implement wound care which is a chronic disease process that causes hospitalization and ER utilization. The services will provide access to wound care intervention that currently requires traveling great distances for care.

- Need for the project: We currently do not have wound care services. The need for wound care services have prompted hospital administration to recognize the growing need in Limestone County for a program that will alleviate hospitalization and ER visits due to advanced chronic wounds. This will be a new program.

- Medicaid and Uninsured Target population: The target population is our patients with potentially preventable hospitalizations, including diabetes, peripheral vascular disease, and other disease processes that cause skin breakdown ultimately resulting in chronic wounds with short term and long term complications. Approximately 5,320 of Limestone County is Medicaid eligible, 6,112 are without health insurance, and 5,549 are living below the poverty level (indigent), so we expect they will benefit from wound care treatment; many of the patients will be from one of the many nursing homes in the Limestone where many patients are dual eligible and without adequate transportation to providers of wound care services.

- Category 2 expected patient benefits: ~~The project seeks to increase the number of new patients enrolled in program by three patients a week in DY 4 and DY 5.~~ The project seeks to increase the number of patients enrolled in the program from year to year. In DY 2 the goal is to see 350 paitents; then increasing by 42% in DY3 to 500 total patients for the year; then by 50% in DY 4 to 750 patients; and finally to 1,000 patients in DY 5 which would be an increase of 33% over DY 4. By increasing the number of new patients served, the program will reduce the number of individuals suffering from non-healing wounds simply because of lack of access to care. Individuals will have improved life from healed chronic wounds.

- Category 3 outcomes: IT-6.1 South Limestone Hospital District (SLHD) will survey patient in the wound care clinic to determine patient satisfaction. We will be utilizing the

HCAHPS Survey to measure. The target of this project is to improve patient satisfaction by 3% at the end of the project (DY5).

1. The first measure is to determine whether patients are getting timely care, appointments, and information. Patients benefit because timely care, appointments, and information leads to better clinical results, thereby reducing the duration of treatment and stress from the inability of accessing care in a timely manner.

2. The second measure is patients' overall health/functional status. This clearly is the goal of the treatment process. We want the patient health and functionality to be the optimal. By surveying patients we can adjust treatment methods to realize the best results possible.

Expand Chronic Care Management Models-RHP Project 140714001.2.1
South Limestone Hospital District/140714001

Project Description: The goal of this project is to develop and implement a wound care treatment management interventions that are geared toward improving effective management of chronic wounds (hard to heal wounds) improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Wound care management initiatives use population based approaches to create practical, supportive, evidence based interactions between patients and providers to improve the management of chronic wound care conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. The chronic wound conditions may be diabetic ulcers, pressure ulcers, peripheral vascular disease and other chronic disease processes. Goals of the project include: 1. effectively heal chronic wounds, 2. Identify and manage chronic wounds reducing the need for hospitalization and emergency care. The current challenge of reaching these goals is finding physicians and staff qualified to treat chronic wounds. The expected 5-year outcomes of the project would be reduction in chronic wounds derived from diabetic ulcers, pressure ulcers, vascular disease and other chronic disease processes that break down skin/tissue components. The project seeks to increase the number of patients enrolled in the program from year to year. In DY 2 the goal is to see 350 patients; then increasing by 42% in DY3 to 500 total patients for the year; then by 50% in DY 4 to 750 patients; and finally to 1,000 patients in DY 5 which would be an increase of 33% over DY 4. This project will decrease potentially preventable hospitalizations related to diabetes long term complications which is cited in the CNA-004 for Region 16.

- **Starting Point/Baseline:** Currently we have no program for chronic wound care treatment.

- **Rationale**: In our current system, more often than not, patients receive services in by hospitalization and emergent care settings for conditions that could be managed in a more coordinated manner if provided in a wound care clinic. This often results in more costly, less coordinated care and a lack of appropriate follow up care. Patients may experience barriers in accessing wound care specialists and staff. By enhancing access to wound care specialist/staff the results will be better health outcomes, appropriate utilization and reduced cost of services.

Project 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.
South Limestone Hospital District will be initiating a wound care program. We currently do not have a wound care clinic to treat chronic wounds. a) Design and implement care teams that are tailored to the patient's health
care needs, including non physician health professionals, such as
pharmacists doing medication management; case managers providing care
outside of the clinic setting via phone, email, and home visits; nutritionists
offering culturally and linguistically appropriate education; and health

coaches helping patients to navigate the health care system
b) Ensure that patients can access their care teams in person or by phone or email
c) 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
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.

Performance Milestones selected:
P-9. Milestone: Develop program to identify and manage chronic care patients needing further clinical intervention
P-3. Milestone: Develop a comprehensive care management program

P-2. Milestone: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high quality clinical and chronic disease care

Improvement Milestones:
I-17. Milestone: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally
I-21. Milestone: Improvements in access to care of patients receiving chronic care management services using innovative project option.

Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction
As per the RHP 16 Community Needs Assessment, Measuring Patient Satisfaction is a need of the region. We will be utilizing the HCAHPS Survey to measure. This measure fully addresses the issue by survey patients on satisfaction levels with the following measures:
(1) Are getting timely care, appointments, and information;
(2) Patient's overall health status/functional status.

An expansion of the specialty clinic will provide a greater access to care, save the patients time and money by having the ability to be treated locally, and improve overall patient health and satisfaction.

- **Relationship to other Projects:** N/A

- **Relationship to Other Performing Providers' Projects in the RHP:** Anticipated changes in RHP 16, according to the Community Needs Assessments, as the baby boomers move into the Medicare age, greater needs will exist for access to care,

especially relating to chronic health needs. Transportation will become more of an issue as well, impacting the need for improved access at the Community level for both primary and specialty care. RHP 16 has a variety of health issues to address, but as with all of Texas, the following stand out in particular: adult diabetes 9.9%, range 7.8-10.9%. Chronic conditions of diabetes are circulatory diseases, such as peripheral vascular disease; with poor circulation in extremities are the leading causes of chronic wound care issues. Long term diabetes complications are thought to result from long-term poor control of diabetes. Coryell Memorial Healthcare System Project 1.9 Expand Specialty Care Capacity, 1.1 Expand Primary Care Capacity, and 2.2 Expand Chronic Care Management Models relate to South Limestone Hospital District 2.2 Expand Chronic Care Management Models by way of Chronic Wound Care Clinic.

- **Collaborative:** Meet regularly to evaluate program

- **Project Valuation:** The needs for a wound care program warrant the valuation of this project. For FY 12 the Limestone Medical Clinic had unique patients with wound care needs and we were unable to properly serve the needs of those patients. The residents of Limestone County are forced to leave Limestone ~~County~~ Hospital District in which taxes are paid for the provision of services to go to other facilities to receive healthcare services for wound care treatment. The needs of the local population based on population age and financial class indicate the need to reduce costs, provide efficiencies and improve the quality and continuum of care for these patients by allowing access to wound care locally. The project seeks to increase the number of patients enrolled in the program from year to year. In DY 2 the goal is to see 350 paitents; then increasing by 42% in DY3 to 500 total patients for the year; then by 50% in DY 4 to 750 patients; and finally to 1,000 patients in DY 5 which would be an increase of 33% over DY 4.

140714001.2.1	***2.2.1***	***2.2.1 a, b, c, d, and E***	***Expand Chronic care models***	
South Limestone Hospital District				*140714001*
Related Category 3 Outcome Measure(s):	*IT-6.1*	140714001.3.1	*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 *RHP 16-P9*: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 Increase the number of patients identified as needing wound care treatment Baseline: /Goal: Baseline none Goal is 3 patients per week Data Source: EMR Milestone 1 Estimated Incentive Payment *(maximum amount):* $$204,820 **Milestone 2** RHP 16-P□3. Develop a comprehensive care management program Metric 1 Increase the number of patients enrolled in a care management program over baseline Baseline: /Goal: Baseline none ~~Goal is 3 patients per week~~	**Milestone 3** P□2. Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high□quality clinical and chronic disease care Metric 1 Increase percent of staff trained Baseline/Goal: None Goal is to train 100% of relevant wound care staff in the chronic care model Data Source: HR and training program materials Milestone 3 Estimated Incentive Payment *(maximum amount):* $$234,413.50 **Milestone 2** RHP 16-P□3. Develop a comprehensive care management program Metric 1 Increase the number of patients enrolled in a care management program over baseline		**Milestone 4** I□17. Milestone: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 X additional patients receive care under the chronic care model for wound care Goal: 3 patients per week Data Source: Registry Milestone 4 Estimated Incentive Payment *(maximum amount):* $239,867 **Milestone 2** RHP 16-P□3. Develop a comprehensive care management program Metric 1 Increase the number of patients enrolled in a care management program over baseline Baseline: /Goal: Baseline 500/Goal is 750 patients in DY4 Data Source: EMR	**Milestone 5** I□21. Milestone: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 Increase percentage of target population reached in wound care Goal: 3 patients per week Data Source: Registry Milestone 5 Estimated Incentive Payment *(maximum amount):* $205,513 **Milestone 2** RHP 16-P□3. Develop a comprehensive care management program Metric 1 Increase the number of patients enrolled in a care management program over baseline Baseline: /Goal: Baseline 750/Goal is 1000 patients in DY5 Data Source: EMR

140714001.2.1	***2.2.1***	***2.2.1 a, b, c, d, and E***	***Expand Chronic care models***	
South Limestone Hospital District				*140714001*
Related Category 3 Outcome Measure(s):	*IT-6.1*	140714001.3.1	*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)**
Goal is 350 patients in DY2 Data Source: EMR Milestone2 Estimated Incentive Payment *(maximum amount):* $204,820	Baseline: /Goal: Baseline 350/Goal is 500 patients in DY3 Data Source: EMR Milestone 2 Estimated Incentive Payment *(maximum amount):* $$237,413.50		Milestone 2 Estimated Incentive Payment *(maximum amount):* $239,867	Milestone 2 Estimated Incentive Payment *(maximum amount):* $205,513
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $409,640	Year 3 Estimated Milestone Bundle Amount: $474,827		Year 4 Estimated Milestone Bundle Amount: $479,734	Year 5 Estimated Milestone Bundle Amount: $411,026
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $1,775,227				

Category 3

Category 3 DSRIP Project Narrative-RHP 16
Central Counties Services – Project 081771001.3.1

Outcome Domain: OD-6: Patient Satisfaction
Title of Outcome Measure (Improvement Target): I-T-6.2 Other Improvement Target**:** Improvement over patient baseline satisfaction scores with behavioral health services delivered via telemedicine technology.
Unique RHP Outcome Identification Number: 081771001.3. 1

Title of Category 1 Project: 081771001.1.1 - Replacement/expansion of Center's telemedicine/telehealth system
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD-6 Patient Satisfaction
  - IT-6-2: Other Improvement Target: Improvement over patient baseline satisfaction scores with behavioral health services delivered via telemedicine technology.

The basis for demonstrating the positive impact of this telemedicine/telehealth system upgrade/expansion is through measuring the patient's satisfaction level regarding their behavioral health services received through this improved telemedicine/telehealth system. Patient satisfaction with services delivered through the telemedicine technology will be obtained through patient surveys which they will complete after every third appointment. The survey would have some open-ended questions on it which would encourage patients to identify what they like about telemedicine services and what they don't like about telemedicine services. Their comments, along with monitoring other satisfaction/ dissatisfaction indicators (no-show rates, anxious behavior prior to, or after a telemedicine session, etc.) will help Center staff to make improvements in how telemedicine services are scheduled, facilitated, followed-up on, etc. to increase our patient satisfaction with services provided via telemedicine technology to their highest potential satisfaction level.

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Process Milestones:
DY-2

Not Applicable

DY-3

- P-2 Establish a baseline rate

Outcome Improvement Target for each Year:

DY-4

- **IT-6.2** Other Improvement Target:– Improvement over patient baseline satisfaction scores on behavioral health services provided via telemedicine/telehealth technology, TBD% improvement over patient satisfaction baseline scores.

DY-5

- **IT-6.**2 Other Improvement Target: Achieve a TBD% improvement over patient satisfaction baseline scores on services provided via telemedicine/telehealth technology.

Rationale:
Patient level of satisfaction with their services is a touchstone measure for the patient's confidence in the services they are receiving, and how willing they are to adhere to their service provider's directions regarding their medication, suggested behavior/lifestyle changes encouraged by their provider, and their attendance/participation at their assigned service appointments. The therapeutic relationship between a behavioral health patient and his/her caregiver is an essential element for treatment improvement/success. This therapeutic relationship grows or improves over time as more and more contact occurs between the patient and the care-giving person. Our Center equates the level of patient satisfaction with Center services to the level of the patient's bonding in the therapeutic relationship with Center care-giving staff, and a reflection of the patients' prospect/belief for positive management/improvement of their behavioral health problems and its symptoms. Thus, we would also expect our patient's level of satisfaction/comfort level with services delivered via telemedicine to increase over time as the patient becomes more familiar with telemedicine service delivery dynamics and technology. Measuring patient satisfaction with our behavioral health services delivered through telemedicine technology will inform us if the use of such technology is a barrier to increased satisfaction/trust/confidence in our services, or if the use of such technology facilitates increased satisfaction/trust/confidence in our services by being perceived as less threatening than receiving services directly in a face-to-face manner. Our citizens are becoming more informed and comfortable with the use of technology in their everyday lives and hopefully will be very accepting of behavioral health services delivered via telemedicine technology.

The outcome measurement process for this project, whether paper-based or electronically based, will involve training appropriate staff on how to administer the survey instrument uniformly. It includes the design of an automated system to track the survey results on a patient-by-patient basis and at a patient group level. This includes the development of periodic reports that analyzes the satisfaction trends for individual patients and at the patient group level. These reports will inform the "plan, do, study, act" process for improving our Center's patient telemedicine experience. The outcome measurement of patient satisfaction with services delivered via the telemedicine technology will also include service delivery/receiving site analysis (lighting, background colors, extraneous noise levels, etc.) to seek and implement ways that service delivery via this technology can become more satisfactory from the patient's perspective.

Outcome Measure Valuation: It includes the design of an automated system to track the survey results on a patient-by-patient basis and at a patient group level. This includes the development of periodic reports that analyzes the satisfaction trends for individual patients and at the patient group level, and facilitating a group change process which responds to the satisfaction survey feedback. These improvements in the telemedicine service delivery system will also be incorporated into the Center's telehealth/telemedicine training manual and clinical protocols. The Center's telemedicine improvement process may include consultation with TV production/technical staff, speech and presentation skill

consultants, hearing-impairment and visual-impairment consultants, etc. to continuously improve the telepsychiatry delivery system and insure that the system accommodates individuals with sensory difficulties. The valuation process for this project includes the cost of training (including the opportunity costs from not being in service production) of professional staff that is recommended by this quality improvement process and the advice of consulting experts on telemedicine/video production quality improvement. The valuation for this improvement outcome also takes into account the no-show reduction savings from patients whose satisfaction with services delivered via telemedicine technology prompts improved attendance.

Central Counties Services 081771001.1.1 (Project 1.11.2) Related Category 3 Measures			
081771001.3.1	**IT-6. 2**	**Other Improvement Target: Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.1**		
Starting Point/Baseline:	**No baseline measures regarding patient satisfaction with telemedicine services have been established at this time**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-2]: *(see page 363 of the Planning Protocol)* Establish baseline rate **Data Source:** CG-CAHPS, other recognized, validated surveys identified through internet searches. The outcome data from the completion of the selected satisfaction survey will be used as the baseline to measure improvement. (The Center expects that at least 50% of the patients [100 patients served per month] will score in the moderate to high satisfaction range.) **Process Milestone 1 Incentive Payment: $22,958**	**Outcome Improvement Target 1** [IT-6. 2]: Improvement over baseline of patient satisfaction scores with services provided to them via the newly updated telemedicine/ telehealth technology among those patients who have received 9 or more services via the telemedicine/telehealth technology. **Improvement Target:** Achieve improvement over baseline (e.g. if the satisfaction survey is scored on a 100 point scale with the score of 1-35 = poorly satisfied; 36-70 = moderately satisfied; & 71-100 = highly satisfied) The Center would expect 60% of the patients [180]served per month to score in the moderate to high satisfaction range: satisfied =	**Outcome Improvement Target 2** [IT-6. 2]: Improvement over baseline of patient satisfaction scores with services provided to them via the newly updated telemedicine/ telehealth technology among those patients who have received 15 or more services via the telemedicine/telehealth technology. **Improvement Target:** Achieve 20% improvement over baseline, once the baseline is known (e.g. if the satisfaction survey is scored on a 100 point scale with the score of 1-35 = poorly satisfied; 36-70 = moderately satisfied; & 71-100 = highly satisfied) The Center would expect 70% of the patients [280] served per month to score in the moderate to high satisfaction range: satisfied = deriving positive value from the

		deriving positive value from the service **Data Source:** The outcome data from the completion of the ECHO™ satisfaction surveys. **Outcome Improvement Target 1 Estimated Incentive Payment: $25,257**	services.) **Data Source:** The outcome data from the completion of the ECHO™ satisfaction survey. **Outcome Improvement Target 2 Estimated Incentive Payment: $59,974**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $22,958**	**Year 4 Estimated Outcome Amount: $25,257**	**Year 5 Estimated Outcome Amount: $59,974**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $108,189			

Pass 3
Category 3 DSRIP Project Narrative
Central Counties Services – 081771001.3.2

Outcome Domain: OD-1 – Primary Care and Chronic Disease Management
Title of Outcome Measure (Improvement Target): IT-1.18 – Follow-Up After Hospitalization for Mental Illness- NQF 0576
Unique RHP Outcome Identification Number: 081771001.3.8

Title of Category 1 Project: 081771001.1.2 – 1.10.12 Enhance improvement capacity through technology
Performing Provider TPI #: 081771001

Outcome Measure Description:

- **OD-1 – Primary Care and Chronic Disease Management**
  - **IT-1.18 – Follow-Up After Hospitalization for Mental Illness- NQF 057**

This outcome measure tracks what percentage of persons discharged from a psychiatric hospital receive an outpatient follow-up session within 30 days from being discharged. This outcome measure also tracks what percentage of persons discharged from a psychiatric hospital receive an outpatient follow-up session within 7 days from being discharged. This outcome measure strives to reach 100% but cannot do so because of lack of compliance with aftercare appointments by persons with severe and persistent mental illness.

Process Milestones:

- **DY2:**
  - Not Applicable
- **DY3:**
  - P-3: Develop and test data systems
  - P-2: Establish baseline rates for IT-1.18 - # of 7-day and 30-day hospital discharge follow-ups.

Outcome Improvement Targets for Each Year:

- **DY4:**
  - IT-1.18: Follow-up after hospitalization for mental illness – NQF 0567
- **DY5:**

- IT-1.18: Follow-up after hospitalization for mental illness – NQF 0567

Rationale:
The Center is convinced that through the use of organizational system improvement projects and having improved data support that it can increase its service capacity and its ability to better track persons being discharged from psychiatric hospitals in a timely manner to insure their introduction/re-introduction to supportive outpatient services and access to their needed medication support. This Outcome Measure was chosen because of its importance as a patient decision point to pursue continuing service support or totally disengaging themselves from the behavioral health service system. For those patients who were suicidal at the time of being hospitalized, they are at higher than average risk of suicide within 30 days of their hospital discharge. When discharged from the hospital their medications have brought more control over their disorganized thinking patterns and they are more able to formulate suicide plans and have the mental organization to carry them out. Thus, it is imperative to get them re-involved with the local behavioral health treatment system so that their suicidal risk can be assessed, their treatment/medications continued in order to consolidate and build on the symptom management gains from their hospitalization. The patients also benefit from feeling supported as they work to re-establish their living arrangements and support system engagement in their home community.

"Nationally, only 42% of initial appointments following psychiatric hospitalization are kept. Missed appointments increase the likelihood of re-hospitalization and increase costs of outpatient care. Among several recent studies that have examined the phenomenon of lack of outpatient follow-up after hospital discharge, rates of failure to attend a first outpatient appointment have ranged from 18 to 67%, with a median rate of 58%. Over time periods ranging from one to nine years approximately 30% of patients disengage from mental health treatment services. Taken together, research suggests that a significant proportion of individuals with serious mental illness are not engage in mental health treatment as a result of dropping out of some form of care." (p.3 National Quality Forum publication #0576 –www.qualityforum.org/WorkArea/linkit.aspx?Linkidentifier=id&ItemID=70617) . The target improvement percentages will be set based on the baseline established in DY3. This outcome measure strives to reach 100% of the discharges receiving a prompt post-discharge appointment, but cannot do so because of lack of compliance with aftercare appointments by persons with severe and persistent mental illness.

Outcome Measure Valuation:
The valuation for implementing this post-psychiatric hospital discharge follow-up outcome measure includes staff costs for discharge planning and scheduling of follow-up, post-discharge outpatient appointments while the patients are still hospitalized in the state psychiatric hospital system. It also includes the staff service costs for providing the first post-discharge clinical service appointment. (Our Center had 496 state psychiatric hospital admissions in FY11. Of the 496 admissions, 12 were children under 18 years of age. 20 of these admissions were forensic admissions to restore competency to stand trial, and were discharged back to the referring County jail. 203 (41%) of these admissions were readmissions of people who had been previously hospitalized, while 293 (59%) were first

admissions to the state psychiatric hospital system. Between 9 and 10 patients are hospitalized and discharge per week in FY11.) The valuation takes into account the volume of discharged psychiatric hospital patients who have to be closely tracked each week to insure their attendance at their first post-discharge behavioral health session. The valuation of this outcome measure also takes into account the personal and system cost avoidance that can be achieved when the number of readmissions and incarcerations is reduced. It further takes into account the financial and personal cost avoidance of suicide attempts and completions being reduced by a timely follow-up behavioral health session.

The valuation of this outcome includes a portion of the Center's indirect program support and administrative overhead costs.

Central Counties Services – 081771001.3.2 Related Category 1 Project – 081771001.1.5 (Project 1.10.2)			
081771001.3.2	**IT-1.18**	**Follow-up after hospitalization for mental illness**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.2**		
Starting Point/Baseline:	**Established in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-3] (See Planning Protocol, p. 363): Develop and test data systems. **Data Source**: Written test outcome/ certification that system is functioning within design specifications **Process Milestone 1 Estimated Incentive Payment: $67,205.00** **Process Milestone 2** [P-2] (See Planning Protocol, p. 363): Establish baseline rates for outpatient follow-up within 7 days and within 30 days after hospitalization for mental illness over the previous 6 month period. **Data Source:** The Center's electronic health record system, state and local psychiatric	**Outcome Improvement Target 1** [IT-1.18]: Follow-up after hospitalization for mental illness – NQF 0576 a. Numerator: • Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. • Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or	**Outcome Improvement Target 2 Target** [IT-1.18]: Follow-up after hospitalization for mental illness – NQF 0576) a. Numerator: • Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. • Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

	hospital data systems. **Process Milestone 2 Estimated Incentive Payment: $67,205.00**	partial hospitalizations that occur on the date of discharge. b. Denominator: Persons 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between September 1 and August 31 of the measurement year. The denominator for this measure is based on discharges, not persons. Include all discharges for persons who have more than one discharge on or between September 1 and August 31 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the person was transferred. Although rehospit-alization might not be for a selected mental health disorder, it is probably for a	b. Denominator: Persons 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between September 1 and August 31 of the measurement year. The denominator for this measure is based on discharges, not persons. Include all discharges for persons who have more than one discharge on or between September 1 and August 31 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the person was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. **Improvement Target:** Rate 1. TBD% improvement over DY3 baseline in follow-up within 30 days Rate 2. TBD% improvement over DY3 baseline in follow-up

		related condition. **Improvement Target:** Rate 1. TBD% improvement in DY3 baseline in follow-up within 30 days Rate 2. TBD% improvement in DY3 baseline in follow-up within 7 days **Data Source:** Center electronic health record system and the data systems of psychiatric hospitals. **Outcome Improvement Target 1 Estimated Incentive Payment: $151,879**	within 7 days **Data Source:** Center electronic health record system and the data systems of psychiatric hospitals. **Outcome Improvement Target 2 Estimated Incentive Payment: $366,948**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $134,410**	**Year 4 Estimated Outcome Amount: $151,879**	**Year 5 Estimated Outcome Amount: $366,948**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $653,237			

Category 3 DSRIP Project Narrative – RHP 16
Central Counties Services – 081771001.3.3

Outcome Domain: OD-1 – Primary Care and Chronic Disease Management
Title of Outcome Measure (Improvement Target): IT-1.18 – Follow-Up After Hospitalization for Mental Illness- NQF 0576
Unique RHP Outcome Identification Number: 081771001.3.3

Title of Category 1 Project: 081771001.1.3 – 1.10.2 Enhance improvement capacity through technology
Performing Provider TPI #: 081771001

Outcome Measure Description:

- **OD-1 – Primary Care and Chronic Disease Management**
  - **IT-1.18 – Follow-Up After Hospitalization for Mental Illness- NQF 057**

This outcome measure tracks what percentage of persons discharged from a psychiatric hospital receive an outpatient follow-up session within 30 days from being discharged. This outcome measure also tracks what percentage of persons discharged from a psychiatric hospital receive an outpatient follow-up session within 7 days from being discharged. This outcome measure strives to reach 100% but cannot do so because of lack of compliance with aftercare appointments by persons with severe and persistent mental illness.

Process Milestones:

- **DY2:**
  - Not Applicable
- **DY3:**
  - P-3: Develop and test data systems
  - P-2: Establish baseline rates for IT-1.18 - # of 7-day and 30-day hospital discharge follow-ups.

Outcome Improvement Targets for Each Year:

- **DY4:**
  - IT-1.18: Follow-up after hospitalization for mental illness – NQF 0567
- **DY5:**
  - IT-1.18: Follow-up after hospitalization for mental illness – NQF 0567

Rationale:
The Center is convinced that through the use of organizational system improvement projects and having improved data support that it can increase its service capacity (Milestone 8: 2,000 more behavioral health service encounters than in DY-3and 4,000 more in DY5 over DY3)and its ability to better track persons being discharged from psychiatric hospitals in a timely manner to insure their introduction/re-introduction to supportive outpatient services and access to their needed medication support. This Outcome Measure was chosen because of its importance as a patient decision point to pursue continuing service support or totally disengaging themselves from the behavioral health service system. For those patients who were suicidal at the time of being hospitalized, they are at higher than average risk of suicide within 30 days of their hospital discharge. When discharged from the hospital their medications have brought more control over their disorganized thinking patterns and they are more able to formulate suicide plans and have the mental organization to carry them out. Thus, it is imperative to get them re-involved with the local behavioral health treatment system so that their suicidal risk can be assessed, their treatment/medications continued in order to consolidate and build on the symptom management gains from their hospitalization. The patients also benefit from feeling supported as they work to re-establish their living arrangements and support system engagement in their home community.

"Nationally, only 42% of initial appointments following psychiatric hospitalization are kept. Missed appointments increase the likelihood of re-hospitalization and increase costs of outpatient care. Among several recent studies that have examined the phenomenon of lack of outpatient follow-up after hospital discharge, rates of failure to attend a first outpatient appointment have ranged from 18 to 67%, with a median rate of 58%. Over time periods ranging from one to nine years approximately 30% of patients disengage from mental health treatment services. Taken together, research suggests that a significant proportion of individuals with serious mental illness are not engage in mental health treatment as a result of dropping out of some form of care." (p.3 National Quality Forum publication #0576 –www.qualityforum.org/WorkArea/linkit.aspx?Linkidentifier=id&ItemID=70617). The target improvement percentages will be set based on the baseline established in DY3. This outcome measure strives to reach 100% of the discharges (estimated to be 1,200+ during DY-3 through DY-5) receiving a prompt post-discharge appointment, but cannot do so because of lack of compliance with aftercare appointments by persons with severe and persistent mental illness.

Outcome Measure Valuation:
The valuation for implementing this post-psychiatric hospital discharge follow-up outcome measure includes staff costs for discharge planning and scheduling of follow-up, post-discharge outpatient appointments while the patients are still hospitalized in the state psychiatric hospital system. It also includes the staff service costs for providing the first post-discharge clinical service appointment. (Our Center had 496 state psychiatric hospital admissions in FY11. Of the 496 admissions, 12 were children under 18 years of age. 20 of these admissions were forensic admissions to restore competency to stand trial, and were discharged back to the referring County jail. 203 (41%) of these admissions were readmissions of people who had been previously hospitalized, while 293 (59%) were first

admissions to the state psychiatric hospital system. Between 9 and 10 patients are hospitalized and discharge per week in FY11.) The valuation takes into account the volume of discharged psychiatric hospital patients who have to be closely tracked each week to insure their attendance at their first post-discharge behavioral health session. The valuation of this outcome measure also takes into account the personal and system cost avoidance that can be achieved when the number of readmissions and incarcerations is reduced. It further takes into account the financial and personal cost avoidance of suicide attempts and completions being reduced by a timely follow-up behavioral health session.

The valuation of this outcome includes a portion of the Center's indirect program support, administrative overhead costs and inflation costs.

This valuation reflects 20.5% of the total valuation (Region 16 contains 20.5% of our service region's population) while 79.5% of this project's valuation will be reflected in our project submitted to Region 8 (08177101.1.

Central Counties Services – 081771001.3.3 Related Category 1 Project – 081771001.1.3 (Project 1.10.2)			
081771001.3.3	**IT-1.18**	**Follow-up after hospitalization for mental illness**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.2**		
Starting Point/Baseline:	**Established in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-3] (See Planning Protocol, p. 363): Develop and test data systems. **Data Source**: Written test outcome/ certification that system is functioning within design specifications **Process Milestone 1 Estimated Incentive Payment: $10,886** **Process Milestone 2** [P-2] (See Planning Protocol, p. 363): Establish baseline rates for outpatient follow-up within 7 days and within 30 days after hospitalization for mental illness over the previous 6 month period. **Data Source:** The Center's electronic health record system, state and local psychiatric hospital data systems. **Process Milestone 2 Estimated Incentive Payment: $10,886**	**Outcome Improvement Target 1** [IT-1.18]: Follow-up after hospitalization for mental illness – estimated to be 400+ per year - NQF 0576 c. Numerator: • Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. • Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. d. Denominator: Persons 6 years and	**Outcome Improvement Target 2 Target** [IT-1.18]: Follow-up after hospitalization for mental illness – estimated to be 400+ per year - NQF 0576) c. Numerator: • Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. • Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. d. Denominator: Persons 6 years and

		older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between September 1 and August 31 of the measurement year. The denominator for this measure is based on discharges, not persons. Include all discharges for persons who have more than one discharge on or between September 1 and August 31 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the person was transferred. Although rehospit-alization might not be for a selected mental health disorder, it is probably for a related condition. **Improvement Target:** Rate 1. TBD% improvement in DY3 baseline in follow-up within 30 days Rate 2. TBD% improvement in DY3 baseline in follow-up within 7 days **Data Source:** Center electronic health record system and the data systems of psychiatric hospitals.	older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between September 1 and August 31 of the measurement year. The denominator for this measure is based on discharges, not persons. Include all discharges for persons who have more than one discharge on or between September 1 and August 31 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the person was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. **Improvement Target:** Rate 1. TBD% improvement over DY3 baseline in follow-up within 30 days Rate 2. TBD% improvement over DY3 baseline in follow-up within 7 days **Data Source:** Center electronic health record system and the data systems of psychiatric hospitals. **Outcome Improvement Target 2 Estimated Incentive Payment: $82,037 ~~201,636~~**

		Outcome Improvement Target 1 Estimated Incentive Payment: $44,444	
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $21,772**	**Year 4 Estimated Outcome Amount: $ 44,444**	**Year 5 Estimated Outcome Amount: $82,037**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $148,253			

Category 3
OD12-IT-12.1 – Breast Cancer Screening
Old: 134772611.3.1/ New: 134772611.3.13
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-12.1 – Breast Cancer Screening

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Improvement Targets (DY4 and DY5)**
    - **OD-12-Primary Care and Primary Prevention**
      - **IT-12.1 Breast Cancer Screening**
      - Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.
      - Denominator: Number of women aged 40 – 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded
      - Data Source: EMR, IT

- **Rationale:** Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after symptoms occur. 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 improvement targets will be established in DY2 for implementation in DY3.

- **Outcome Measure Valuation:**
  - CMH will engage the physicians and staff to determine the appropriate target population within the existing patient base. Based on the size of Coryell County, expected growth, physician shortage designation and high number of ER visits, we anticipate long term savings if patients are able to access primary care and receive preventive treatment and diagnostic tests in order to avoid costly emergency room visits and extended inpatient care. Certain preventive screening tests carry a high economic value, particularly those related to cancer. They can also impact unnecessary costs related to complications from late stage cancer treatments and end of life care. In Coryell County, from 2005 – 2009, there were more than 1,183 documented cases of invasive cancer, as reported by the Texas Department of State Health Services.
  - According to Partnership for Prevention, the most cost effective preventive services are those related to cancer such as breast cancer, colorectal cancer, and cervical cancer. Colorectal screenings, as measured by a quality adjusted life year (QALY) which is the cost of treatment compared to the cost of the screening test, have a measured QALY of 0$ to $13,999 QALY. Cervical cancer screening has a QALY of $14,000 - $34,999.[11] These three screenings are also identified as some of the most valuable preventive clinical services that should be offered in a medical practice.[12]

[11] Reforming Disease Prevention and Health Promotion, AHRQ 2009 Annual Conference, Steven H. Woolf, MD, MPH
[12] Am J Prev Med. 2006 Jul;31(1):52-61.

Old: 134772611.3.1/ New: 134772611.3.13	*3.IT-12.1*	Breast Cancer Screening	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR Process Milestone 1 Estimated Incentive Payment: $16,276.50 **Process Milestone 2** [P-3]: Develop and test data systems: Data Source: IT Process Milestone 2 Estimated Incentive Payment: $16,276.50	**Process Milestone 3 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $18,866.50 **Process Milestone 4 [**P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Meeting Notes Process Milestone 4 Estimated Incentive Payment: $18,866.50	**Outcome Improvement Target 1 [**IT-12.1]: Breast Cancer Screening Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,548	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 2 Estimated Incentive Payment*:* $144,789

Old: 134772611.3.1/ New: 134772611.3.13	*3.IT-12.1*	Breast Cancer Screening	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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: $32,553	Year 3 Estimated Outcome Amount: $37,733	Year 4 Estimated Outcome Amount: $60,548	Year 5 Estimated Outcome Amount: $144,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $275,622			

Category 3
OD12-IT-12.2 – Cervical Cancer Screening
Old: 134772611.3.2/ New: 134772611.3.14
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-12.2 – Cervical Cancer Screening

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Improvement Targets (DY4 and DY5)**
    - **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.
      - Data Source: EMR, IT

- **Rationale:** Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after symptoms occur. 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 improvement targets will be established in DY2 for implementation in DY3.

- **Outcome Measure Valuation:**
  - CMH will engage the physicians and staff to determine the appropriate target population within the existing patient base. Based on the size of Coryell County, expected growth, physician shortage designation and high number of ER visits, we anticipate long term savings if patients are able to access primary care and receive preventive treatment and diagnostic tests in order to avoid costly emergency room visits and extended inpatient care. Certain preventive screening tests carry a high economic value, particularly those related to cancer. They can also impact unnecessary costs related to complications from late stage cancer treatments and end of life care. In Coryell County, from 2005 – 2009, there were more than 1,183 documented cases of invasive cancer, as reported by the Texas Department of State Health Services.
  - According to Partnership for Prevention, the most cost effective preventive services are those related to cancer such as breast cancer, colorectal cancer, and cervical cancer. Colorectal screenings, as measured by a quality adjusted life year (QALY) which is the cost of treatment compared to the cost of the screening test, have a measured QALY of 0$ to $13,999 QALY. Cervical cancer screening has a QALY of $14,000 - $34,999.[13] These three screenings are also identified as some of the most valuable preventive clinical services that should be offered in a medical practice.[14]

[13] Reforming Disease Prevention and Health Promotion, AHRQ 2009 Annual Conference, Steven H. Woolf, MD, MPH
[14] Am J Prev Med. 2006 Jul;31(1):52-61.

Old: 134772611.3.2 *New: 134772611.3.14*	*3.IT-12.2*	*Cervical Cancer Screening*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR Process Milestone 1 Estimated Incentive Payment*:* $16,276.50 **Process Milestone 2** [P-3]: Develop and test data systems: Data Source: IT Process Milestone 2 Estimated Incentive Payment: $16,276.50	**Process Milestone 3 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $18,866.50 **Process Milestone 4 [**P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Meeting Notes Process Milestone 4 Estimated Incentive Payment: $18,866.50	**Outcome Improvement Target 1 [**IT-12.1]: Cervical Cancer Screening Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,548	**Outcome Improvement Target 2** [IT-12.1]: Cervical Cancer Screening Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 2 Estimated Incentive Payment*:* $144,789

Old: 134772611.3.2 *New: 134772611.3.14*	*3.IT-12.2*	*Cervical Cancer Screening*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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): $32,553	Year 3 Estimated Outcome Amount: $37,733	Year 4 Estimated Outcome Amount: $60,548	Year 5 Estimated Outcome Amount: $144,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $275,622			

Category 3
OD12-IT-12.3 – Colorectal Cancer Screening
Old: 134772611.3.3/ New: 134772611.3.15
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-12.3 – Colorectal Cancer Screening

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Improvement Targets (DY4 and DY5)**
    - **OD-12-Primary Care and Primary Prevention**
      - **IT-12.3 Colorectal Cancer Screening**
      - Numerator: Number of adults aged 50 -75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, colonoscopy every 10 years.
      - Denominator: Number of adults aged 50 – 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.
      - Data Source: EMR, IT

- **Rationale:** Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after symptoms occur. 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 improvement targets will be established in DY2 for implementation in DY3.

- **Outcome Measure Valuation:**
  - CMH will engage the physicians and staff to determine the appropriate target population within the existing patient base. Based on the size of Coryell County, expected growth, physician shortage designation and high number of ER visits, we anticipate long term savings if patients are able to access primary care and receive preventive treatment and diagnostic tests in order to avoid costly emergency room visits and extended inpatient care. Certain preventive screening tests carry a high economic value, particularly those related to cancer. They can also impact unnecessary costs related to complications from late stage cancer treatments and end of life care. In Coryell County, from 2005 – 2009, there were more than 1,183 documented cases of invasive cancer, as reported by the Texas Department of State Health Services.
  - According to Partnership for Prevention, the most cost effective preventive services are those related to cancer such as breast cancer, colorectal cancer, and cervical cancer. Colorectal screenings, as measured by a quality adjusted life year (QALY) which is the cost of treatment compared to the cost of the screening test, have a measured QALY of 0$ to $13,999 QALY. Cervical cancer screening has a QALY of $14,000 - $34,999.[15] These three screenings are also identified as some of the most valuable preventive clinical services that should be offered in a medical practice.[16]

[15] Reforming Disease Prevention and Health Promotion, AHRQ 2009 Annual Conference, Steven H. Woolf, MD, MPH
[16] Am J Prev Med. 2006 Jul;31(1):52-61.

Old: 134772611.3.3 *New: 134772611.3.15*	*3.IT-12.3*	*Colorectal Cancer Screening*	
Coryell Memorial Hospital			*134772611.1.1*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR Process Milestone 1 Estimated Incentive Payment*:* $16,276.50 **Process Milestone 2** P-3: Develop and test data systems: Data Source: IT Process Milestone 2 Estimated Incentive Payment: $16,276.50	**Process Milestone 3** P-2: Establish baseline rates Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $18,866.50 **Process Milestone 4** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Meeting Notes Process Milestone 4 Estimated Incentive Payment: $18,866.50	**Outcome Improvement Target 1** IT-12.1: Colorectal Cancer Screening Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,548	**Outcome Improvement Target 2** IT-12.1: Colorectal Cancer Screening Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 2 Estimated Incentive Payment*:* $144,789

Old: 134772611.3.3 *New: 134772611.3.15*	*3.IT-12.3*	*Colorectal Cancer Screening*	
Coryell Memorial Hospital			*134772611.1.1*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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: $32,553	Year 3 Estimated Outcome Amount: $37,733	Year 4 Estimated Outcome Amount: $60,548	Year 5 Estimated Outcome Amount: $144,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $275,622			

Category 3
OD1-IT-1.7: Controlling High Blood Pressure
Old: 134772611.3.4/ New: 134772611.3.16
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-1.7 – Controlling high blood pressure

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Improvement Targets (DY4 and DY5)**
    - **OD-1-Primary Care and Chronic Disease Management**
      - **IT-1.7 Controlling high blood pressure**
      - Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year
      - Denominator: Patients 18 – 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension
      - Data Source: EMR, IT

- **Rationale:** High blood pressure can be treated effectively if patients have access to timely primary care appointments and if they are compliant with physician instructions on how to maintain and improve their current health status. Expanding primary care will enable physicians to monitor their patients more effectively. The clinic will contact patients within 5 – 7 days following emergency room visits for follow-up care to recommend treatment or refer patients to programs that will enable them to better self-manage their health conditions (community health and wellness programs). Outcome improvement targets will be determined in DY 2 for implementation in DY 3.

- **Outcome Measure Valuation:**
  - CMH will engage the physicians and staff to determine the appropriate target population within the existing patient base. Based on the size of Coryell County, expected growth, physician shortage designation and high number of ER visits, we anticipate significant cost savings if patients are able to access primary care and receive treatment in order to avoid costly emergency room visits and extended inpatient care. Blood pressure should be checked regularly since high blood pressure symptoms may not always be visible or distinguishable from other conditions. According to the Centers for Disease Control and Prevention, high blood pressure contributes to 2 of the top 3 leading causes of death in America: Heart Disease and Stroke. In 2009, about 3 in 10 adults in Texas had high blood pressure. Between 2006 and 2010, 431 deaths were attributed to heart disease in Coryell County.[17]
  - Long term costs in the U.S. associated with uncontrolled blood pressure exceeds $93 billion. In Texas, the estimated Medicaid reimbursement for high blood pressure increased from $51 million in 2009 to $58 million in 2010. (Texas Health and Human Services Commission). Studies have shown that hypertension (high blood pressure) therapies have been associated with a 35 to 40 percent reduction in stroke incidence, 20 to 25 percent reduction in heart attack and more than 50 percent reduction in heart failure.[18] At this time, local funding does not exist for the expansion of primary care or a cardiovascular disease prevention program.

[17] Surveillance Report: Cardiovascular Disease in Texas, Texas Department of State Health Services

[18] National Institutes of Health. "The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure." 2003 December. Bethesda, Maryland. Retrieved from http://www.nhlbi.nih.gov/guidelines/hypertension/express.pdf on April 10, 2012.

Old: 134772611.3.4/ New: 134772611.3.16	*3.IT-1.7*	*Controlling High Blood Pressure*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR Process Milestone 1 Estimated Incentive Payment*:* $16,276.50 **Process Milestone 2** [P-3]: Develop and test data systems: Data Source: IT Process Milestone 2 Estimated Incentive Payment: $16,276.50	**Process Milestone 3 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $18,866.50 **Process Milestone 4 [**P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Meeting Notes Process Milestone 4 Estimated Incentive Payment: $18,866.50	**Outcome Improvement Target 1 [**IT-1.7]: Controlling high blood pressure Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,548	**Outcome Improvement Target 2** [IT-12.1]: Controlling high blood pressure Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 2 Estimated Incentive Payment*:* $144,789

Old: 134772611.3.4/ New: 134772611.3.16	*3.IT-1.7*	*Controlling High Blood Pressure*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.1/ New: 134772611.1.4*		
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: $32,553	Year 3 Estimated Outcome Amount: $37,733	Year 4 Estimated Outcome Amount: $60,548	Year 5 Estimated Outcome Amount: $144,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $275,622			

IT-3.1 – All Cause 30 day readmission rate
Old: 134772611.3.5/ New: 134772611.3.17
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-3.1 – All Cause 30 day readmission rate

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2 Establish baseline rates
    - P-3 Develop and test data systems

  - **Improvement Targets (DY4 and DY5)**
    - **OD-1-Primary Care and Chronic Disease Management**
      - **IT-3.1 All Cause 30 day readmission rate**
      - Numerator: The number of unplanned all-cause 30-day readmissions.
      - Denominator:
      - Data Source: EMR, IT

- **Rationale:** Maintaining and improving the quality of life for patients by initiating a program to reduce the number of unplanned readmissions is possible with proper treatment, care management and adherence to wellness programs. Outcome improvement targets will be established in DY2 for implementation in DY3.

- **Outcome Measure Valuation:** According to the Texas Department of State Health Services, Coryell County has an average hospital charge of $14,621 for COPD. Between 2005 – 2010, there were 526 hospitalizations for COPD. Expanding specialty care, especially for those with chronic conditions, will enable patients to receive timely follow-up appointments locally. Coryell County is a medical underserved area with over 70,000 residents who do not have adequate access to a wide range of specialists and specialty care including Pulmonary and Cardiac Rehabilitation and Counseling to address lifestyle changes such as smoking cessation and weight loss.

Old: 134772611.3.5/ New: 134772611.3.17	*IT-3.1*	*All cause 30 day readmission rate*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.1.2/ New: 134772611.1.5*		
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)**
Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, IT Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $70,113	**Process Milestone 2 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 2 Estimated Incentive Payment: $40,635 **Process Milestone 3 [**P-3] Develop and test data systems Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $40,635	**Outcome Improvement Target 1 [**IT-3.1]: All Cause unplanned 30 day readmission rate Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 1 Estimated Incentive Payment*:* $130,410	**Outcome Improvement Target 2 [**IT-3.1]: All Cause unplanned 30 day readmission rate Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 2 Estimated Incentive Payment*:* $311,852
Year 2 Estimated Outcome Amount: $70,113	Year 3 Estimated Outcome Amount: $81,270	Year 4 Estimated Outcome Amount: $130,410	Year 5 Estimated Outcome Amount: $311,852
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $593,645			

Category 3
OD9-IT-9.2 ED appropriate utilization
Old: 134772611.3.6/ New:134772611.3.18
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-9.2 – ED appropriate utilization

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  - **Improvement Targets (DY4 and DY5)**
    - **OD-9-Right Care, Right Setting**
      - **IT-9.2 – ED Appropriate utilization**
      - Reduce ED visits for patients enrolled in PCMH
      - Data Source: EMR, IT

- **Rationale:**
  Emergency rooms fulfill the need for certain populations to receive needed healthcare, specifically those who don't have adequate transportation or lack of transportation during normal clinic hours and those who cannot afford to visit a primary care physician. In Coryell County, more than 4,000 patients accessed the local emergency room in 2011 for non-emergent care which results in overcrowding and less quality of care. By improving access and educating the target population regarding appropriate levels of care and providing them with the benefits of a medical home, it is highly probable that the number of emergency room visits will decline. Coryell Memorial will identify patients who frequently abuse the emergency room for non-urgent care, determine the

reasons for using the emergency department, and then engage the patient(s) with appropriate education and treatment plan(s). Improvement targets will be identified in DY2 and implemented DY3.

- **Outcome Measure Valuation:**
  CMH will engage the physicians and staff to determine the appropriate target population within the existing patient base. Based on the size of Coryell County, expected growth, physician shortage designation and high number of ER visits (which has an average charge of $1,100 per visit), we anticipate significant cost savings to the patient, Medicare and Medicaid if patients are able to access primary care and receive treatment in order to avoid costly emergency room visits and extended inpatient care. At this time, local funding does not exist for the implementation of the PCMH.

Old: 134772611.3.6 *New: 134772611.3.18*	*IT-9.2*	*ED appropriate utilization*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.1/* *New: 134772611.2.5*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, IT Process Milestone 1 Estimated Incentive Payment*:* $150,243	**Process Milestone 2 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 2 Estimated Incentive Payment: $58,050.33 **Process Milestone 3 [**P-3]: Develop and test data systems Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $58,050.33 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EMR, IT Process milestone 4 Estimated Incentive Payment: $58,050.34	**Outcome Improvement Target 1 [**IT-9.2]: Reduce Emergency Department visits for target population Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 1 Estimated Incentive Payment*:* $279,452	**Outcome Improvement Target 2** [IT-9.2]: Reduce Emergency Department visits for target population Improvement Target: TBD Data Source: EMR, IT Outcome Improvement Target 2 Estimated Incentive Payment*:* $668,254

Old: 134772611.3.6 *New: 134772611.3.18*	*IT-9.2*	*ED appropriate utilization*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.1/* *New: 134772611.2.5*		
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: $150,243	Year 3 Estimated Outcome Amount: $174,151	Year 4 Estimated Outcome Amount: $279,452	Year 5 Estimated Outcome Amount: $668,254
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,272,100			

Category 3
OD11-IT-11.3 – Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.
Old: 134772611.3.7/ New: 134772611.3.19
Coryell Memorial Healthcare System (CMHS)/134772611
Pass 3b

Outcome Measure:
IT-11.3 – Improve utilization rates of clinical preventive services – screening for type 2 diabetes mellitus in minority population

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  - **Improvement Targets (DY4 and DY5)**
    - **OD-11-Utilization rate for type 2 diabetes mellitus screening**
      - **IT-11.3 – Percent improvement over baseline of current utilization rate**
      - TBD
      - Data Source: EMR, IT

- **Rationale:**
  Health Promotion/health literacy programs will be introduced to the target population by providing helpful information concerning local resources using the latest technology, healthy strategies for improved quality of life and opportunities for face-to-face training and education. Those participating in the program will receive training and education from a community health worker along with local providers. Improved utilization rates for preventive screenings will result in fewer costly inpatient and outpatient medical services, greater adherence to preventive health screenings, and higher participation rates in programs related to weight loss, diet and self-management. Improvement targets will be determined in DY 2 for implementation in DY3.

- **Outcome Measure Valuation:**
  CMHS will engage existing stakeholders including hospitals, physicians, and representatives from community wellness programs to develop a regional health promotion/health literacy program using evidence-based approaches that will include the use of community health workers. These programs will be designed to reach the target population in the most efficient and cost effective manner. Individuals and families will be engaged in a variety of health promotion and health literacy initiatives focused on wellness and prevention. It will require additional staff and resources to establish the baseline, develop and implement communication tools and delivery methods and frequently survey the population for areas of success and needed improvement. Based on the size of RHP 16, expected growth, and the rising number of adults and children with multiple chronic conditions, the health literacy programs designed for this project will help RHP 16 achieve the goals of Triple Aim by educating, promoting and delivering quality health care. At this time, local funding does not exist for the expansion of regional health promotion/health literacy program.

Old: 134772611.3.7/ New: 134772611.3.19	*IT-11.3*	*Addressing Health Disparities in Minority Populations*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.2/ New: 134772611.2.6*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, IT Process Milestone 1 Estimated Incentive Payment*:* $50,081	**Process Milestone 2 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 2 Estimated Incentive Payment: $29,025 **Process Milestone 3 [**P-3]: Develop and test data systems Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $29,025	**Outcome Improvement Target 1 [**IT-11.3]: Percent improvement over current utilization for type 2 diabetes mellitus screening Improvement Target: 20% Data Source: Patient Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $93,151	**Outcome Improvement Target 2 [**IT-11.3]: Percent improvement over current utilization for type 2 diabetes mellitus screening Improvement Target: 40% Data Source: Patient Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $222,751
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $50,081	Year 3 Estimated Outcome Amount: $58,050	Year 4 Estimated Outcome Amount: $93,151	Year 5 Estimated Outcome Amount: $222,751
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $424,033			

Category 3
OD11-IT-11.3 – Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.
Old: 134772611.3.7/New: 134772611.3.20
Coryell Memorial Healthcare System (CMHS)/134772611
Pass 3b

Outcome Measure:
IT-11.3 – Improve utilization rates of clinical preventive services – screening for high blood pressure in minority population

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  - **Improvement Targets (DY4 and DY5)**
    - **OD-11-Utilization rate for high blood pressure screening**
      - **IT-11.3 – Percent improvement over baseline of current utilization rate**
      - TBD
      - Data Source: EMR, IT

- **Rationale:**
  Health Promotion/health literacy programs will be introduced to the target population by providing helpful information concerning local resources using the latest technology, healthy strategies for improved quality of life and opportunities for face-to-face training and education. Those participating in the program will receive training and education from a community health worker along with local providers. Improved utilization rates for preventive screenings will result in fewer costly inpatient and outpatient medical services, greater adherence to preventive health screenings, and higher participation rates in programs related to weight loss, diet and self-management. Improvement targets will be determined in DY 2 for implementation in DY3.

- **Outcome Measure Valuation:**
  CMHS will engage existing stakeholders including hospitals, physicians, and representatives from community wellness programs to develop a regional health promotion/health literacy program using evidence-based approaches that will include the use of community health workers. These programs will be designed to reach the target population in the most efficient and cost effective manner. Individuals and families will be engaged in a variety of health promotion and health literacy initiatives focused on wellness and prevention. It will require additional staff and resources to establish the baseline, develop and implement communication tools and delivery methods and frequently survey the population for areas of success and needed improvement. Based on the size of RHP 16, expected growth, and the rising number of adults and children with multiple chronic conditions, the health literacy programs designed for this project will help RHP 16 achieve the goals of Triple Aim by educating, promoting and delivering quality health care. At this time, local funding does not exist for the expansion of regional health promotion/health literacy program.

Old: 134772611.3.7/ New: 134772611.3.20	*IT-11.3*	*Addressing Health Disparities in Minority Populations*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.2/ New: 134772611.2.6*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, IT Process Milestone 1 Estimated Incentive Payment*:* $50,081	**Process Milestone 2 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 2 Estimated Incentive Payment: $29,025 **Process Milestone 3 [**P-3]: Develop and test data systems Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $29,025	**Outcome Improvement Target 1 [**IT-11.3]: Percent improvement over current utilization for high blood pressure screening Improvement Target: 20% Data Source: Patient Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $93,151	**Outcome Improvement Target 2 [**IT-11.3]: Percent improvement over current utilization for high blood pressure screening Improvement Target: 40% Data Source: Patient Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $222,752
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $50,081	Year 3 Estimated Outcome Amount: $58,050	Year 4 Estimated Outcome Amount: $93,151	Year 5 Estimated Outcome Amount: $222,752
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $424,034			

Category 3
OD11-IT-11.3 – Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.
Old: 134772611.3.7/ New: 134772611.3.21
Coryell Memorial Healthcare System (CMHS)/134772611
Pass 3b

Outcome Measure:
IT-11.3 – Improve utilization rates of clinical preventive services – screening for lipid disorders in minority population

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  - **Improvement Targets (DY4 and DY5)**
    - **OD-11-Utilization rate for lipid disorders screening**
      - **IT-11.3 – Percent improvement over baseline of current utilization rate**
      - TBD
      - Data Source: EMR, IT

- **Rationale:**
  Health Promotion/health literacy programs will be introduced to the target population by providing helpful information concerning local resources using the latest technology, healthy strategies for improved quality of life and opportunities for face-to-face training and education. Those participating in the program will receive training and education from a community health worker along with local providers. Improved utilization rates for preventive screenings will result in fewer costly inpatient and outpatient medical services, greater adherence to preventive health screenings, and higher participation rates in programs related to weight loss, diet and self-management. Improvement targets will be determined in DY 2 for implementation in DY3.

- **Outcome Measure Valuation:**
  CMHS will engage existing stakeholders including hospitals, physicians, and representatives from community wellness programs to develop a regional health promotion/health literacy program using evidence-based approaches that will include the use of community health workers. These programs will be designed to reach the target population in the most efficient and cost effective manner. Individuals and families will be engaged in a variety of health promotion and health literacy initiatives focused on wellness and prevention. It will require additional staff and resources to establish the baseline, develop and implement communication tools and delivery methods and frequently survey the population for areas of success and needed improvement. Based on the size of RHP 16, expected growth, and the rising number of adults and children with multiple chronic conditions, the health literacy programs designed for this project will help RHP 16 achieve the goals of Triple Aim by educating, promoting and delivering quality health care. At this time, local funding does not exist for the expansion of regional health promotion/health literacy program.

Old: 134772611.3.7/ New: 134772611.3.21	*IT-11.3*	*Addressing Health Disparities in Minority Populations*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.2/ New:134772611.2.6*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, IT Process Milestone 1 Estimated Incentive Payment*:* $50,081	**Process Milestone 2 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 2 Estimated Incentive Payment: $29,025 **Process Milestone 3 [**P-3]: Develop and test data systems Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $29,025	**Outcome Improvement Target 1 [**IT-11.3]: Percent improvement over current utilization for lipid disorder screening Improvement Target: 20% Data Source: Patient Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $93,151	**Outcome Improvement Target 2 [**IT-11.3]: Percent improvement over current utilization for lipid disorder screening Improvement Target: 40% Data Source: Patient Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $222,751
Year 2 Estimated Outcome Amount: $50,081	Year 3 Estimated Outcome Amount: $58,050	Year 4 Estimated Outcome Amount: $93,151	Year 5 Estimated Outcome Amount: $222,751
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $424,033			

Category 3
OD10-IT-10.1 – Quality of Life/ Functional Status
Old: 134772611.3.8/ New: 134772611.3.22
Coryell Memorial Healthcare System/134772611
Pass 3b

Outcome Measure:
IT-10.1 – Quality of Life – Improvement in quality of life scores using evidence based and validated assessment tool for target population

- **Outcome Measure Description:**
  - **Process Milestones (DY2 and DY3)**
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
    - P-3: Develop and test data systems
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  - **Improvement Targets (DY4 and DY5)**
    - **OD-10-Quality of Life**
      - **IT-10.1 Quality of Life**
      - Improve quality of life scores
      - Data Source: Assessment tool (PedsQL)

- **Rationale:**
  More than 38,000 children are enrolled in Medicaid throughout RHP 16 and another 17.4% of the child population under the age of 17 are considered uninsured. This indicates that many youth do not have access to or financial resources for preventive health services. This project will enable multiple community stakeholders to work together towards prevention and treatment of childhood obesity. RHP 16 has determined that surveys are the best way to determine participant satisfaction and engagement throughout the 7 county region.

- **Outcome Measure Valuation:**

- The harmful effects of obesity can increase health risks today and in the future[19]
  - Children with obesity have higher blood pressure and cholesterol which can cause cardiovascular disease.
  - Type 2 diabetes
  - Breathing problems such as sleep apnea and asthma which can affect their learning at school
  - Joint problems
  - Gastro-esophageal reflux
  - Emotional and social issues
- Future health risks include
  - Obesity in adulthood
  - Obesity related diseases such as cardiovascular, diabetes and cancer

The RHP 16 Childhood Obesity Task Force will develop a strategic plan that will include the initial QOL scores for the target population and then based on that information implement programs that will impact those scores in the short and long term. Community health leaders, professionals and school nurses will address the obesity epidemic by implementing these programs in schools, after school programs, churches and at home. Ultimately, as PedsQOL scores improve, RHP 16 should experience lower health related costs, improved mental health, and improved performance at school.

[19] Centers for Disease Control and Prevention

Old: 134772611.3.8 *New: 134772611.3.22*	*IT-10.1*	*Quality of Life/ Functional Status*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.3/ New:134772611.2.7*		
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)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, IT Process Milestone 1 Estimated Incentive Payment*:* $150,243	**Process Milestone 2 [**P-2]: Establish baseline rates Data Source: EMR, IT Process Milestone 2 Estimated Incentive Payment: $58,050.33 **Process Milestone 3 [**P-3]: Develop and test data systems Data Source: EMR, IT Process Milestone 3 Estimated Incentive Payment: $58,050.33 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Process Milestone 4 Estimated Incentive Payment: $58,050.34	**Outcome Improvement Target 1 [**IT-10.1]: Demonstrate improvement in quality of life (QOL) scores as measured by evidence based and validated assessment tool Improvement Target: 1% improvement in QOL scores from DY3 Data Source: PedsQL Outcome Improvement Target 1 Estimated Incentive Payment*:* $279,452	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life (QOL) scores as measured by evidence based and validated assessment tool Improvement Target: 3% improvement in QOL scores from DY4 Data Source: PedsQL Outcome Improvement Target 2 Estimated Incentive Payment*:* $668,254

Old: 134772611.3.8 *New: 134772611.3.22*	*IT-10.1*	*Quality of Life/ Functional Status*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*Old: 134772611.2.3/ New:134772611.2.7*		
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: $150,243	Year 3 Estimated Outcome Amount: $174,151	Year 4 Estimated Outcome Amount: $279,452	Year 5 Estimated Outcome Amount: $668,254
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,272,100			

Category 3
OD-1-IT-1.20 Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental illness
134772611.3.9
Coryell Memorial Hospital/134772611

Outcome Measure Description:

OD-1 Primary Care and Chronic Disease Management
IT-1.20 Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental Illness

m. Numerator:
   - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
   - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.

n. Denominator: Members 6 years and older as of the date of ED visit who were seen in the emergency department setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator of this measure is based on ED visits, not members. Include all ED visits for members who have more than one ED visit on or between January 1 and December 1 of the measurement year.

o. Data Source: EHR, Claims

p. Rationale/Evidence: This measure assesses the percentage of ED visits for members 6 years of age and older who were seen for treatment of mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
   Rate 1: The percentage of members who received follow-up within 30 days of ED visit
   Rate 2: The percentage of members who received follow-up within 7 days of ED visit

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Rate 1: Establish baseline rate for the percentage of members who received follow-up within 30 days of ED visit
  - P-2 – Rate 2: Establish baseline rate for the percentage of members who received follow-up within 7 days of ED visit
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline
  - Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline
- DY5:
  - Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline
  - Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline

Rationale:

Process milestones P-1 and P-3 were chosen in order to test the current resources available in the region, and monitor resources as a psychiatric telemedicine program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports and resources currently available to measure and monitor information related to the regional psychiatric telemedicine system. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for Rate 1 and Rate 2 with P-2.

The access of psychiatric telemedicine care within the emergency department will allow for better follow-up of care after initial treatment in the emergency department. Increasing access to the care that is recommended for the patient will allow for more continuity of care for our patient population that is seeking mental health care.

Improvement targets were chosen for Rate 1 and Rate 2 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program. The outcome measures addressed by this project are largely affected by social determinants other than increased access to services. For instance, transportation issues and cultural and behavioral issues will affect a patient's ability to use the resources offered.

Outcome Measure Valuation:

This outcome measure has been valued at $1,156,903. Valuation for the outcome measure considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 1 project to Introduce, Expand, or Enhance Telemedicine/Telehealth and its Category 3 outcome for increasing the percentage of members who receive follow-up mental healthcare after ED visit achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates the further development of a better coordinated care delivery system. The scope of the project will impact a significant percentage of our county population making this a large project for our facility. Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project.

134772611.3.9	OD-1, IT-1.20	Other outcome improvement target: Follow-up after emergency department visit for Mental Illness	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	Unique Category 1 identifier –134772611.1.3		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $64,343 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $64,343	**Process Milestone 3** [P-2]: Establish baseline rate for Rate 1 - the percentage of members who received follow-up within 30 days of ED visit and Rate 2 - the percentage of members who received follow-up within 7 days of ED visit Data Source: EHR reports, referral records Process Milestone 3 Estimated Incentive Payment: $78,670 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $78,670	**Outcome Improvement Target 1** [IT-1.20]: Follow-up after emergency department visit for Mental Illness Improvement Target: Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline Data Source: EHR reports, referral records Outcome Improvement Target 1 Estimated Incentive Payment: $255,617	**Outcome Improvement Target 2** [IT-1.20]: Follow-up after emergency department visit for Mental Illness Improvement Target: Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline Data Source: EHR reports, referral records Outcome Improvement Target 2 Estimated Incentive Payment: $615,260

134772611.3.9	OD-1, IT-1.20	Other outcome improvement target: Follow-up after emergency department visit for Mental Illness	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	Unique Category 1 identifier –134772611.1.3		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $128,686	Year 3 Estimated Outcome Amount: $157,340	Year 4 Estimated Outcome Amount: $255,617	Year 5 Estimated Outcome Amount: $615,260
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,156,903			

Category 3
OD-13-IT-13.1 Pain Assessment
134772611.3.10
Coryell Memorial Hospital/134772611

Outcome Measure Description:
OD-13 Palliative Care
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)

- Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 –Establish baseline rate for each non-standalone measure
    - IT-13.1 Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.1 Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline
- DY5:
  - IT-13.1 Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline

Rationale:
Process milestones P-1 and P-3 were chosen in order to test the current resources available in the region, and monitor resources as a palliative care program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports and resources currently available to measure and monitor information related to the palliative care project. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for the three non-standalone measures with P-2 and also continue to develop and test the data systems to ensure accurate baselines and further data will be measured effectively.

Improvement targets were chosen for all three non-standalone measures based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program.

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program. As a companion project, these outcome measures are also supportive data for HBMC to validate the resources they are providing for the regional partners.

Outcome Measure Valuation:

This outcome measure has been valued at $308,506. The valuation process for the outcome measures considers multiple factors. This outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. It also ensures that we are focused on improving patient outcomes and quality of life. The associated Category 2 project is designed to improve the health care infrastructure to better serve the patients of Coryell Memorial Hospital to provide appropriate and quality end-of-life care.

134772611.3.10	*IT-13.1*	*Pain assessment (NQF-1637) (Non-standalone measure)*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*134772611.2.4*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $17,158 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $17,158	**Process Milestone 3** [P-2]: Establish baseline rate for each non-standalone measure Data Source: EHR reports, program records Process Milestone 3 Estimated Incentive Payment: $20,978.50 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $20,978.50	**Outcome Improvement Target 1** [IT-13.1]: Pain assessment Improvement Target: Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $68,164	**Outcome Improvement Target 2** [IT-13.1]: Pain assessment Improvement Target: Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $164,069
Year 2 Estimated Outcome Amount: $34,316	Year 3 Estimated Outcome Amount: $41,957	Year 4 Estimated Outcome Amount: $68,164	Year 5 Estimated Outcome Amount: $164,069
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $308,506			

Category 3
OD-13-IT-13.2 Treatment Preferences
134772611.3.11
Coryell Memorial Hospital/134772611

Outcome Measure Description:
OD-13 Palliative Care
IT-13.2 Treatment Preferences (NQF-1641) (Non-standalone measure)

- Percentage of patients with chart documentation of preferences for life sustaining treatments

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 –Establish baseline rate for each non-standalone measure
    - IT-13.2 Percentage of patients with chart documentation of preferences for life sustaining treatments
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.2 Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline
- DY5:
  - IT-13.2 Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline

Rationale:
Process milestones P-1 and P-3 were chosen in order to test the current resources available in the region, and monitor resources as a palliative care program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports and resources currently available to measure and monitor information related to the palliative care project. In order to

report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for the three non-standalone measures with P-2 and also continue to develop and test the data systems to ensure accurate baselines and further data will be measured effectively.

Improvement targets were chosen for all three non-standalone measures based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program.

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program. As a companion project, these outcome measures are also supportive data for Hillcrest Baptist Medical Center to validate the resources they are providing for the regional partners.

Outcome Measure Valuation:

This outcome measure has been valued at $308,506. The valuation process for the outcome measures considers multiple factors. This outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. It also ensures that we are focused on improving patient outcomes and quality of life. The associated Category 2 project is designed to improve the health care infrastructure to better serve the patients of Coryell Memorial Hospital to provide appropriate and quality end-of-life care.

134772611.3.11	*IT-13.2*	*Treatment preferences (NQF-1641) (Non-standalone measure)*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*134772611.2.4*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $17,158 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $17,158	**Process Milestone 3** [P-2]: Establish baseline rate for each non-standalone measure Data Source: EHR reports, program records Process Milestone 3 Estimated Incentive Payment: $20,978.50 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $20,978.50	**Outcome Improvement Target 1** [IT-13.2]: Treatment preference Improvement Target: Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $68,164	**Outcome Improvement Target 2** [IT-13.2]: Treatment preference Improvement Target: Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $164,069
Year 2 Estimated Outcome Amount: $34,316	Year 3 Estimated Outcome Amount: $41,957	Year 4 Estimated Outcome Amount: $68,164	Year 5 Estimated Outcome Amount: $164,069
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $308,506			

Category 3
OD-13-IT-13.5 Percent of Patients Receiving Hospice or Palliative Care Services
134772611.3.12
Coryell Memorial Hospital/134772611

Outcome Measure Description:
OD-13 Palliative Care
IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 –Establish baseline rate for each non-standalone measure
    - IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:
- DY4:
  - IT-13.5 Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline
- DY5:
  - IT-13.5 Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline

Rationale:

Process milestones P-1 and P-3 were chosen in order to test the current resources available in the region, and monitor resources as a palliative care program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports and resources currently available to measure and monitor information related to the palliative care project. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for the three non-standalone measures with P-2 and also continue to develop and test the data systems to ensure accurate baselines and further data will be measured effectively.

Improvement targets were chosen for all three non-standalone measures based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program.

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program. As a companion project, these outcome measures are also supportive data for Hillcrest Baptist Medical Center to validate the resources they are providing for the regional partners.

Outcome Measure Valuation:

This outcome measure has been valued at $308,506. The valuation process for the outcome measures considers multiple factors. This outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. It also ensures that we are focused on improving patient outcomes and quality of life. The associated Category 2 project is designed to improve the health care infrastructure to better serve the patients of Coryell Memorial Hospital to provide appropriate and quality end-of-life care.

134772611.3.12	*IT-13.5*	*Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)*	
Coryell Memorial Hospital			*134772611*
Related Category 1 or 2 Projects:	*134772611.2.4*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $17,158 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $17,158	**Process Milestone 3** [P-2]: Establish baseline rate for each non-standalone measure Data Source: EHR reports, program records Process Milestone 3 Estimated Incentive Payment: $20,978.50 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $20,978.50	**Outcome Improvement Target 1** [IT-13.5]: Improvement Target: Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $68,164	**Outcome Improvement Target 2** [IT-13.5]: Improvement Target: Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $164,069
Year 2 Estimated Outcome Amount: $34,316	Year 3 Estimated Outcome Amount: $41,957	Year 4 Estimated Outcome Amount: $68,164	Year 5 Estimated Outcome Amount: $164,069
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $308,506			

Pass 3B

OD-6 Patient Satisfaction
(TPI 137075109) 1.1 Expand Primary Care Capacity
Old: 137075109.3.1
New: 137075109.3.4

IT-6.1 – Percent improvement over baseline of patient satisfaction scores
Goodall-Witcher Hospital Authority

Outcome Measure Description: Percent improvement over baseline of patient satisfaction scores for the following patient satisfaction domains that the provider has targeted:
Patients:
(2) Are getting timely care, appointments, and information

At project's inception, baseline data and targets will be established. These results will determine improvement processes and measurement goals.

Rationale: Improving a patient satisfaction tool will give us appropriate feedback on both the positive and negative aspects experienced by our patients. The goal of increasing our primary care capacity is to improve the patient experience, thereby allowing the patient to fully engage and focus on their health outcomes. Early prevention and detection will greatly decrease both costs and anxiety. Lower income populations do not always feel they have a system advocate but the survey will provide a tool for their experiences to be counted. The satisfaction survey will be a direct measurement tool of our strengths and weaknesses. Our goal will be a satisfaction score of 80% with a direct intervention and follow-up for negative ratings. Authors Robert Bolus and Jennifer Pitts state that "Patient-centered outcomes have taken center stage as the primary means of measuring effectiveness of healthcare care delivery. It is commonly acknowledged that patients' reports of their health and quality of life, and their satisfaction with the quality of care and services, are as important as many clinical health measures." (http://www.managedcaremag.com/archives /9904/9904.patsatis.html. 01 October 2012).

Outcome Measure Valuation: The following formula will be used to value each outcome measure:

Numerator: Percent improvement in targeted patient satisfaction domain
Denominator: Number of patients who were administered the survey
Data Source: Patient Survey

Our telephone survey will be completed by an independent company specializing in quality care improvement surveys. It is intended to provide both positive and negative comments from all patients that access care through Clifton Medical Clinic. The goal will allow direct patient feedback regarding ease of obtaining an appointment, courtesy of registration staff, respect for patients' privacy, knowledge, skills, and courtesy of nursing, laboratory, radiology and provider staff. We will conduct fifty surveys per month per provider to assess the satisfaction of our patients. The patients we serve are from our rural community and are typically from an economically and socially underprivileged population. By utilizing a

quality improvement tool, areas of preventative care can be discussed at time of survey with patients. Our community assessment supports methods to engage our citizens in regards to their healthcare needs.

New: 137075109.3.4 Old: 137075109.3.1	*IT-6.1*	*Patient Satisfaction*	
Goodall-Witcher Hospital Authority			*137075109*
Related Category 1 or 2 Projects:	New: 137075109.1.3 Old: 137075109.1.1		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $61,577	**Process Milestone 2** P- 2 Establish baseline rates Data Source: Documentation of surveys Process Milestone 2 Estimated Incentive Payment: 71,377	**Outcome Improvement Target 1** [IT-6.1]: TBD Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $114,534	**Outcome Improvement Target 2** [IT-6.1]: TBD Data Source: Patient Survey Outcome Improvement Target 2Estimated Incentive Payment*:* $273,887
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $61,577	Year 3 Estimated Outcome Amount: $71,377	Year 4 Estimated Outcome Amount: $114,534	Year 5 Estimated Outcome Amount: $273,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $521,375			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Pass 3B

OD-1 Primary Care and Chronic Disease Management
(137075109) 1.7 *Introduce, Expand, or Enhance Telemedicine/Telehealth*
Old: 137075109.3.2
New: 137075109.3.5

IT-1.20 – Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental Illness
Goodall-Witcher Hospital Authority

Outcome Measure Description:

OD-1 Primary Care and Chronic Disease Management
IT-1.20 Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental Illness

q. Numerator:
   - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
   - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
r. Denominator: Members 6 years and older as of the date of ED visit who were seen in the emergency department setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator of this measure is based on ED visits, not members. Include all ED visits for members who have more than one ED visit on or between January 1 and December 1 of the measurement year.
s. Data Source: EHR, Claims
t. Rationale/Evidence: This measure assesses the percentage of ED visits for members 6 years of age and older who were seen for treatment of mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
   Rate 1: The percentage of members who received follow-up within 30 days of ED visit
   Rate 2: The percentage of members who received follow-up within 7 days of discharge

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Rate 1: Establish baseline rate for the percentage of members who received follow-up within 30 days of ED visit

- P-2 – Rate 2: Establish baseline rate for the percentage of members who received follow-up within 7 days of ED visit
- P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline
  - Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline
- DY5:
  - Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline
  - Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline

Rationale: Process milestones P-1 and P-3 were chosen in order to test the current resources available in the region, and monitor resources as a psychiatric telemedicine program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports and resources currently available to measure and monitor information related to the regional psychiatric telemedicine system. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for Rate 1 and Rate 2 with P-2.

Improvement targets were chosen for Rate 1 and Rate 2 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program. The outcome measures addressed by this project are largely affected by social determinants other than increased access to services. For instance, transportation issues and cultural and behavioral issues will affect a patient's ability to use the services offered.

The access of psychiatric telemedicine care within the emergency department will allow for better follow-up of care after initial treatment in the emergency department. Increasing access to the care that is recommended for the patient will allow for more continuity of care for our patient population that is seeking mental health care.

Outcome Measure Valuation:

Valuation for the outcome measure considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 1 project to Introduce, Expand, or Enhance Telemedicine/Telehealth and the Category 3 outcome achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates the further development of a better coordinated care delivery system. The scope of the project will impact a significant percentage of our county population making this a large project for our facility. Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project.

New: 137075109.3.5 Old: 137075109.3.2	*OD-1, IT-1.20*	*Other Outcome Improvement Target:* *Follow-up after emergency department visit for Mental Illness*	
Goodall-Witcher Hospital Authority			137075109
Related Category 1 or 2 Projects:	*Unique Category 1 identifier –* *New:* 137075109.1.4 Old: 137075109.1.2		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $11,343 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated	**Process Milestone 3** [P-2]: Establish baseline rate for Rate 1 - the percentage of members who received follow-up within 30 days of ED visit and Rate 2 - the percentage of members who received follow-up within 7 days of ED visit Data Source: EHR reports, referral records Process Milestone 3 Estimated Incentive Payment: $13,148 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated	**Outcome Improvement Target 1** [IT-1.20]: Follow-up after emergency department visit for Mental Illness Improvement Target: Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline Data Source: EHR reports, referral records Outcome Improvement Target	**Outcome Improvement Target 2** [IT-1.20]: Follow-up after emergency department visit for Mental Illness Improvement Target: Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline Data Source: EHR reports, referral records Outcome Improvement Target

New: 137075109.3.5 Old: 137075109.3.2	*OD-1, IT-1.20*	*Other Outcome Improvement Target:* *Follow-up after emergency department visit for Mental Illness*	
Goodall-Witcher Hospital Authority			137075109
Related Category 1 or 2 Projects:	*Unique Category 1 identifier –* *New:* 137075109.1.4 Old: 137075109.1.2		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Incentive Payment: $11,343	Incentive Payment: $13,148	1 Estimated Incentive Payment*:* $42,197	2 Estimated Incentive Payment*:* $100,906
Year 2 Estimated Outcome Amount: : $22,686	Year 3 Estimated Outcome Amount: $26,296	Year 4 Estimated Outcome Amount: $42,197	Year 5 Estimated Outcome Amount: $100,906
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $192,085			

Pass 2

OD-6 Patient Satisfaction
(TPI 137075109) 1.9 Expand Specialty Care Capacity
137075109.3.3

IT-6.1 – Percent improvement over baseline of patient satisfaction scores
Goodall-Witcher Hospital Authority

Outcome Measure Description: Percent improvement over baseline of patient satisfaction scores for the following patient satisfaction domains that the provider has targeted:
Patients:
(3) Patient's rating of doctor access to specialist

At project's inception, baseline data and targets will be established. These results will determine improvement processes and measurement goals.

Rationale: Improving a patient satisfaction tool will give us appropriate feedback on both the positive and negative aspects experienced by our patients. The goal of expanding access to specialty care is to improve the patient experience, thereby allowing the patient to fully engage and focus on their health outcomes. Timely treatment of medical issues by specialist will greatly decrease both costs and anxiety. Lower income populations don't always feel they have a system advocate but the survey will provide a tool for their experiences to be counted. The satisfaction survey will be a direct measurement tool of our strengths and weaknesses. Our satisfaction goal will be determined after the baseline period with a direct intervention and follow-up for negative ratings.

Authors Robert Bolus and Jennifer Pitts state that "Patient-centered outcomes have taken center stage as the primary means of measuring effectiveness of healthcare care delivery. It is commonly acknowledged that patients' reports of their health and quality of life, and their satisfaction with the quality of care and services, are as important as many clinical health measures." (http://www.managedcaremag.com/archives /9904/9904.patsatis.html. 01 October 2012).

Outcome Measure Valuation: The following formula will be used to value each outcome measure:

Numerator: Percent improvement in targeted patient satisfaction domain
Data Source: Patient survey
Denominator: Number of patients who were administered the survey
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.

Our telephone survey will be completed by an independent company specializing in quality care improvement surveys. It is intended to provide both positive and negative comments from all patients that access care through Clifton Medical Clinic. The goal will allow direct patient feedback. The patients we serve are from our rural community and are typically from an economically and socially underprivileged population. By utilizing a quality improvement tool, areas of preventative care can be discussed at time of survey with patients. Our community assessment supports methods to engage our citizens in regards to their healthcare needs.

137075109.3.3	*IT-6.1*	*Patient Satisfaction*	
Goodall-Witcher Hospital Authority			*137075109*
Related Category 1 or 2 Projects:	137075109.1.3		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $47,553	**Process Milestone 2** P- 2 Establish baseline rates Data Source: Documentation of surveys Process Milestone 2 Estimated Incentive Payment: $73,026	**Outcome Improvement Target 1** [IT-6.1]: TBD Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $97,742	**Outcome Improvement Target 2** [IT-6.1]: TBD Data Source: Patient Survey Outcome Improvement Target 2Estimated Incentive Payment*:* $182,571
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $47,553	Year 3 Estimated Outcome Amount: $73,026	Year 4 Estimated Outcome Amount: $97,742	Year 5 Estimated Outcome Amount: $182,571
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $400,892			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): New: 121792903.3.13; Old: 121792903.3.1

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-9.2 ED Appropriate utilization

- Reduce all ED visits

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rate for ED utilization
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - Reduce all ED visits by TBD% below DY3
- DY5:
  - Reduce all ED visits by TBD% below DY4

Rationale:

Reducing Emergency Department visits is the goal of this project because of the high utilization of our ED for non-emergent cases. 60% of our Emergency Department visits for FY 2012 were non-emergent visits. Reducing non-emergent ED visits is an achievable outcome measure since the project will expand primary care clinic hours, expand primary care clinic staffing and increase primary clinic volume of visits to ensure people in our community get timely quality care in the most cost effective and appropriate setting.

Outcome Measure Valuation:

The valuation for this outcome measure is $841,430. Valuation for the outcome measure of reduced emergency department visits considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 1 project to Expand Primary Care Capacity and its Category 3 outcome for reducing emergency department visits achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates the furthered development of a better coordinated care delivery system. Medicaid patient and uninsured patients with potentially limited resources will have improved access to cost-efficient care. With a 31.2% adult uninsured population in Hamilton County and a Medicaid enrollment of over 1600, the community need

exists for providing additional access to the clinic setting to reduce the cost burden associated utilizing the emergency department for non-emergent medical care. The scope of the project will impact a large percentage of our county population making this a large project for our facility. Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project.

New: 121792903.3.13 *Old: 121792903.3.1*	*OD-9.IT-9.2*	*ED appropriate utilization*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*Unique Category 1 identifier – New: 121792903.1.3* *Old: 121792903.1.1*		
Starting Point/Baseline:	*To be developed in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $49,683.50 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $49,683.50	**Process Milestone 3** [P-2]: Establish baseline rate for ED utilization Data Source: EHR Process Milestone 3 Estimated Incentive Payment: $57,590 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $57,590	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Improvement Target: Reduce all ED visits by TBD% below baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $184,823	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Improvement Target: Reduce all ED visits by TBD% below baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $441,970
Year 2 Estimated Outcome Amount: $99,367	Year 3 Estimated Outcome Amount: $115,180	Year 4 Estimated Outcome Amount: $184,823	Year 5 Estimated Outcome Amount: $441,970
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $841,340			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-1.20 Other Outcome Improvement Target: Follow-up after emergency department visit for Mental illness

Unique RHP outcome identification number(s): New: 121792903.3.14; Old: 121792903.3.8

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

OD-1 Primary Care and Chronic Disease Management
IT-1.20 Other Outcome Improvement Target:
Follow-up after emergency department visit for Mental Illness

u. Numerator:
    - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.
    - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after emergency department visit. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of ED visit.

v. Denominator: Members 6 years and older as of the date of ED visit who were seen in the emergency department setting with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator of this measure is based on ED visits, not members. Include all ED visits for members who have more than one ED visit on or between January 1 and December 1 of the measurement year.

w. Data Source: EHR, Claims

x. Rationale/Evidence: This measure assesses the percentage of ED visits for members 6 years of age and older who were seen for treatment of mental health disorders and who had an outpatient visits, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
   Rate 1: The percentage of members who received follow-up within 30 days of ED visit
   Rate 2: The percentage of members who received follow-up within 7 days of ED visit

Process Milestones:

- DY2:

    - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3 – Develop and test data systems
- DY3:
    - P-2 – Rate 1: Establish baseline rate for the percentage of members who received follow-up within 30 days of ED visit
    - P-2 – Rate 2: Establish baseline rate for the percentage of members who received follow-up within 7 days of ED visit
    - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
    - Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline
    - Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline
- DY5:
    - Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline
    - Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline

Rationale:

Process milestones P-1 and P-3 were chosen in order to identify the current services available in the region, and monitor additional resources available as a psychiatric telemedicine program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports currently available to measure and monitor information related to the regional psychiatric telemedicine system. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for Rate 1 and Rate 2 with P-2.

The access of psychiatric telemedicine care within the emergency department will allow for better follow-up of care after initial treatment in the emergency department. We will not have to send the patient 70 miles away to receive care for crisis services and then try and re-integrate the patient back home. Increasing access to the care that is recommended for the patient will allow for more continuity of care for our patient population that is seeking mental health care. The emergency department is the targeted area because of the high utilization by the Medicaid and uninsured population. In our 2012 Fiscal Year (October 2011-September 2012), 47% of the patients treated in the emergency department were Medicaid and uninsured. They also accounted for 43% of the charges but only 22% of the collections in the same year. Implementing the telemedicine program will provide a better resource for the Medicaid and uninsured population to receive appropriate care following their emergency department encounter, thereby reducing the need for them to utilize the emergency department for further non-urgent mental health needs in the future.

Improvement targets were chosen for Rate 1 and Rate 2 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program. The outcome measures addressed by this project are largely affected by social determinants other than increased access to services. For instance, transportation issues and cultural and behavioral issues will affect a patient's ability to use the services offered.

Outcome Measure Valuation:

This outcome measure has been valued at $408,631. Valuation for the outcome measure considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 1 project to Introduce, Expand, or Enhance Telemedicine/Telehealth and its Category 3 outcome for increasing the percentage of members who receive follow-up mental healthcare after ED visit achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates the further development of a better coordinated care delivery system. The scope of the project will impact a significant percentage of our county population making this a large project for our facility. Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project.

New: 121792903.3.14 *Old: 121792903.3.8*	*OD-1, IT-1.20*	*Other outcome improvement target:* *Follow-up after emergency department visit for Mental Illness*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*Unique Category 1 identifier – New: 121792903.1.4* *Old: 121792903.1.2*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $22,726.50 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $22,726.50	**Process Milestone 3** [P-2]: Establish baseline rate for Rate 1 - the percentage of members who received follow-up within 30 days of ED visit and Rate 2 - the percentage of members who received follow-up within 7 days of ED visit Data Source: EHR reports, referral records Process Milestone 3 Estimated Incentive Payment: $27,787 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $27,787	**Outcome Improvement Target 1** [IT-1.20]: Follow-up after emergency department visit for Mental Illness Improvement Target: Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline Data Source: EHR reports, referral records Outcome Improvement Target 1 Estimated Incentive Payment*:* $90,286	**Outcome Improvement Target 2** [IT-1.20]: Follow-up after emergency department visit for Mental Illness Improvement Target: Rate 1: Increase the percentage of members who received follow-up within 30 days of ED visit by TBD% over baseline Rate 2: Increase the percentage of members who received follow-up within 7 days of ED visit by TBD% over baseline Data Source: EHR reports, referral records Outcome Improvement Target 2 Estimated Incentive Payment*:* $217,318

New: 121792903.3.14 *Old: 121792903.3.8*	*OD-1, IT-1.20*	*Other outcome improvement target:* *Follow-up after emergency department visit for Mental Illness*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*Unique Category 1 identifier – New: 121792903.1.4* *Old: 121792903.1.2*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $45,453	Year 3 Estimated Outcome Amount: $55,574	Year 4 Estimated Outcome Amount: $90,286	Year 5 Estimated Outcome Amount: $217,318
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $408,631			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-2.1 Congestive Heart Failure Admission rate

Unique RHP outcome identification number: New: 121792903.3.15; Old: 121792903.3.3

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-2.1- Congestive Heart Failure Admission rate

Process Milestone:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rates
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
  - IT-2.1 Reduce Congestive Heart Failure admission rate %TBD
- DY5:
  - IT-2.1 Reduce Congestive Heart Failure admission rate %TBD

Rationale:

In DY2 the process measures P-1 through P-3 were chosen to assess available resources and develop accurate reports for the evaluation of the congestive heart failure admission rate in order to establish baseline data. By DY3 the continued development of data systems to improve reporting features will be accomplished as well as PDSA cycles for better data collection and intervention activities.

The improvement target is set to begin measurement in DY4 and was chosen to reflect the effect of the Chronic Care Management project on potentially preventable hospitalizations. Previous data used to analyze need for the project demonstrated CHF as one of the highest cost potentially preventable hospitalizations in Hamilton County and across RHP 16.

Outcome Measure Valuation:

The valuation for this outcome measure is $715,139. The valuation process for reducing the Congestive Heart Failure Admission considers that this outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. The associated Category 2 project (121792903.2.6) is designed to improve the health care infrastructure to better serve the Medicaid and uninsured residents of our county and to develop and maintain a coordinated care delivery system. Ultimately, the improved outcomes will be achieved while containing cost growth. The community need is apparent based on DSHS supporting data on potentially preventable hospitalizations in Hamilton County. Not only will congestive heart failure patients requiring inpatient treatment be impacted, but outpatients can be enrolled as well as a means to prevent use of acute services. This outcome measure will have a large scope of involvement for its achievement.

New: 121792903.3.15 *Old: 121792903.3.3*	*3.IT-2.1*	*Congestive Heart Failure Admission Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.6* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project plan Process Milestone 1 Estimated Incentive Payment: $28,154 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $28,154 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 3 Estimated Incentive Payment: $28,154	**Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $48,951.50 **Process Milestone 5** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR reports Process Milestone 5 Estimated Incentive Payment: $48,951.50	**Outcome Improvement Target 1** [IT-2.1]: Improvement Target: Reduce Congestive Heart Failure admission rate %TBD Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $157,100	**Outcome Improvement Target 1** [IT-2.1]: Improvement Target: Reduce Congestive Heart Failure admission rate %TBD Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $375,674

New: 121792903.3.15 *Old: 121792903.3.3*	*3.IT-2.1*	*Congestive Heart Failure Admission Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.6* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $84,462	Year 3 Estimated Outcome Amount: $97,903	Year 4 Estimated Outcome Amount: $157,100	Year 5 Estimated Outcome Amount: $375,674
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $715,139			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-3.2 – Congestive Heart Failure 30 day readmission rate

Unique RHP outcome identification number(s): New: 121792903.3.16; Old: 121792903.3.2

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-3.2 – Congestive Heart Failure 30 day readmission rate

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rate for CHF 30 day readmission rate
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - Reduce the CHF 30 day readmission rate by 3% below baseline
- DY5:
  - Reduce the CHF 30 day readmission rate by 5% below baseline

Rationale:

Process milestones P-1 was selected due to the lack of current Chronic Disease Management Program for Congestive Heart Failure patients and limited resources available for collecting and analyzing readmission data. P-2 and P-3 were chosen based on the need for developing accurate reports for establishing baseline data.

Improvement target 3.2 was chosen based on the expectation that the elements of the Chronic Disease Management Program for Congestive Heart Failure patients, appreciated in project option 2.2.2, are based on evidence-based models and standardized clinical protocols designed to prevent increased healthcare costs and hospital readmissions. With the program implementation for safe, effective,

and efficient care transitions, the risk for potentially preventable readmissions decreases due to better coordination of care lending to successful disease management.

With a large elderly population we have a greater incidence of congestive heart failure.
According to a published fact sheet from the National Heart, Lung, and Blood Institute (NHLB), CHF is the most common diagnosis in hospital patients age 65 years and order. Also in that age group, one fifth of all hospitalizations have a primary or secondary diagnosis of heart failure.
The project goal for category 2.2 is focused on the assessment of the patient's risk of developing complications, identifying symptoms early, and implementing intervention to prevent utilization of acute or emergency services. The nature of our heart failure clinic design matches each element of the 2.2 project goal. We have identified our CHF population as a group of patients that have high utilization rates within our system at 36% for acute care hospitalizations. Furthermore, these patients are also at a high risk for readmission thereby supporting the need for a population specific program utilizing evidence-based protocols for disease management.

Outcome Measure Valuation:
The valuation for this outcome measure is $673,073. Valuation for the outcome measure of reduced CHF hospital readmissions considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 2 project for the Chronic Disease Management Program form Heart Failure patients and its Category 3 outcome for reducing CHF 30 day readmission rates achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates the furthered development of a better coordinated care delivery system.

Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project. Cost avoidance from decreased readmission rates through the implementation of the heart failure clinic is projected at $182,000 per year. This value does not encompass the improvement in clinical outcomes from the implementation and use of established practice guidelines, improved care coordination, active follow-up to ensure the best outcome, and patients better trained about their condition and self-management. Valuation considered the hospital charges of $1,020,095 for CHF Potentially Preventable Hospitalizations for Hamilton County (DSHS 2005-2010), inpatient volume of CHF patients, current readmission rates, and the community need for access to care.

New: 121792903.3.16 *Old: 121792903.3.2*	*OD-3.IT-3.2*	*Congestive Heart Failure Readmission Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier – New: 121792903.2.6* *Old: 121792903.2.1*		
Starting Point/Baseline:	*To be developed in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $39,747 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $39,747	**Process Milestone 3** [P-2]: Establish baseline rate for CHF 30 day readmission rate Data Source: EHR reports Process Milestone 3 Estimated Incentive Payment: $46,072 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $46,072	**Outcome Improvement Target 1** [IT-3.2]: Congestive Heart Failure 30 day readmission rate Improvement Target: Reduce the CHF 30 day readmission rate by 3% below baseline Data Source: EHR reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $147,859	**Outcome Improvement Target 2** [IT-3.2]: Congestive Heart Failure 30 day readmission rate Improvement Target: Reduce the CHF 30 day readmission rate by 5% below baseline Data Source: EHR reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $353,576
Year 2 Estimated Outcome Amount: $79,494	Year 3 Estimated Outcome Amount: $92,144	Year 4 Estimated Outcome Amount: $147,859	Year 5 Estimated Outcome Amount: $353,576
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $673,073			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission rate

Unique RHP outcome identification number: New: 121792903.3.17; Old: 121792903.3.4

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate

Process Milestone:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rates
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
  - IT-2.5 Reduce Chronic Obstructive Pulmonary Disease (COPD) admission rate %TBD
- DY5:
  - IT-2.5 Reduce Chronic Obstructive Pulmonary Disease (COPD) admission rate %TBD

Rationale:

In DY2 the process measures P-1 through P-3 were chosen to assess available resources and develop accurate reports for the evaluation of the chronic obstructive pulmonary disease admission rate in order to establish baseline data. By DY3 the continued development of data systems to improve reporting features will be accomplished as well as PDSA cycles for better data collection and intervention activities.

The improvement target is set to begin measurement in DY4 and was chosen to reflect the effect of the Chronic Care Management project on potentially preventable hospitalizations.

Outcome Measure Valuation:

The valuation for this outcome measure is $694,105. The valuation process for reducing the COPD admission rate considers that this outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. The associated Category 2 project (121792903.2.7) is designed to improve the health care infrastructure to better serve the Medicaid and uninsured residents of our county and to develop and maintain a coordinated care delivery system. Ultimately, the improved outcomes will be achieved while containing cost growth.

New: 121792903.3.17 *Old: 121792903.3.4*	*3.IT-2.5*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.7* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project plan Process Milestone 1 Estimated Incentive Payment: $27,326 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $27,326 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 3 Estimated Incentive Payment: $27,326	**Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $47,511.50 **Process Milestone 5** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR reports Process Milestone 5 Estimated Incentive Payment: $47,511.50	**Outcome Improvement Target 1** [IT-2.5]: Improvement Target: Chronic Obstructive Pulmonary Disease Admission Rate Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $152,479	**Outcome Improvement Target 2** [IT-2.5]: Improvement Target: Chronic Obstructive Pulmonary Disease Admission Rate Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $364,625

New: 121792903.3.17 *Old: 121792903.3.4*	*3.IT-2.5*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.7* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $81,978	Year 3 Estimated Outcome Amount: $95,023	Year 4 Estimated Outcome Amount: $152,479	Year 5 Estimated Outcome Amount: $364,625
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $694,105			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-2.9 Uncontrolled Diabetes Admissions Rate

Unique RHP outcome identification number: New: 121792903.3.18; Old: 121792903.3.5

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-2.9 Uncontrolled Diabetes Admissions Rate

Process Milestone:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rates
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
  - IT-2.9 Reduce Uncontrolled Diabetes admission rate %TBD
- DY5:
  - IT-2.9 Reduce Uncontrolled Diabetes admission rate %TBD

Rationale:

In DY2 the process measures P-1 through P-3 were chosen to assess available resources and develop accurate reports for the evaluation of the uncontrolled diabetes admission rate in order to establish baseline data. By DY3 the continued development of data systems to improve reporting features will be accomplished as well as PDSA cycles for better data collection and intervention activities.

The improvement target is set to begin measurement in DY4 and was chosen to reflect the effect of the Chronic Care Management project on potentially preventable hospitalizations.

Outcome Measure Valuation:

This outcome measure is valued at $694,105. The valuation process for reducing the uncontrolled diabetes admission rate considers that this outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. The associated Category 2 project is designed to improve the health care infrastructure to better serve the Medicaid and uninsured residents of our county and to develop and maintain a coordinated care delivery system. Ultimately, the improved outcomes will be achieved while containing cost growth.

New: 121792903.3.18 *Old: 121792903.3.5*	*3.IT-2.9*	*Uncontrolled Diabetes Admissions Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.7* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project plan Process Milestone 1 Estimated Incentive Payment: $27,326 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $27,326 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 3 Estimated Incentive Payment: $27,326	**Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $47,511.50 **Process Milestone 5** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR reports Process Milestone 5 Estimated Incentive Payment: $47,511.50	**Outcome Improvement Target 1** [IT-2.9]: Improvement Target: Reduce Uncontrolled Diabetes admission rate %TBD Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $152,479	**Outcome Improvement Target 2** [IT-2.9]: Improvement Target: Reduce Uncontrolled Diabetes admission rate %TBD Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $364,625

New: 121792903.3.18 *Old: 121792903.3.5*	*3.IT-2.9*	*Uncontrolled Diabetes Admissions Rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.7* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $81,978	Year 3 Estimated Outcome Amount: $95,023	Year 4 Estimated Outcome Amount: $152,479	Year 5 Estimated Outcome Amount: $364,625
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*):* $694,105			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-2.10 Flu and pneumonia admission rate

Unique RHP outcome identification number: New: 121792903.3.19; Old: 121792903.3.6

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-2.10 Flu and pneumonia admission rate

Process Milestone:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rates
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
  - IT-2.10 Reduce flu and pneumonia admission rate %TBD
- DY5:
  - IT-2.10 Reduce flu and pneumonia admission rate %TBD

Rationale:

In DY2 the process measures P-1 through P-3 were chosen to assess available resources and develop accurate reports for the evaluation of the flu and pneumonia admission rate in order to establish baseline data. According to the rationale statement from the planning protocol, "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." This outcome measure will help to evaluate and monitor the impact of the Chronic Care Management project with the intention of reducing potentially preventable hospitalizations. A focus for the greatest area of potential impact is on potentially preventable hospitalizations related to bacterial pneumonia. According to the DSHS potentially preventable hospitalization data from 2005-1010, bacterial pneumonia is the leading

source for hospital charges in Hamilton County. The yearly average in hospital charges related to bacterial pneumonia in Medicaid patients nears $243,000. By DY3 the continued development of data systems to improve reporting features will be accomplished as well as PDSA cycles for better data collection and intervention activities.

The improvement target is set to begin measurement in DY4 and was chosen to reflect the effect of the Chronic Care Management project on potentially preventable hospitalizations.

Outcome Measure Valuation:

This outcome measure is valued at $694,105. The valuation process for reducing the flu and pneumonia admission rate considers that this outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. The DSHS data from 2005-2010 Potentially Preventable Hospitalizations report for Hamilton County reflects $1,214,714 in hospital charges related to bacterial pneumonia. This cost results in bacterial pneumonia generating the most hospital charges for potentially preventable hospitalizations in Hamilton County. The associated Category 2 project (121792903.2.7) is designed to improve the health care infrastructure to better serve the Medicaid and uninsured residents of our county and to develop and maintain a coordinated care delivery system. Reducing unnecessary hospital admissions is the primary goal for the Chronic Care Management project by shifting patients to the appropriate outpatient healthcare service and thereby reducing preventable acute care utilization. Ultimately, the improved outcomes will be achieved while containing cost growth.

New: 121792903.3.19 *Old: 121792903.3.6*	*3.IT-2.10*	*Flu and pneumonia admission rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.7* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project plan Process Milestone 1 Estimated Incentive Payment*:* $27,326 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $27,326 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 3 Estimated Incentive Payment: $27,326	**Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $47,511.50 **Process Milestone 5** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR reports Process Milestone 5 Estimated Incentive Payment: $47,511.50	**Outcome Improvement Target 1** [IT-2.10]: Improvement Target: Flu and pneumonia Admission Rate Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $152,479	**Outcome Improvement Target 2** [IT-2.10]: Improvement Target: Flu and pneumonia admission Rate Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $364,625
Year 2 Estimated Outcome Amount: $81,978	Year 3 Estimated Outcome Amount: $95,023	Year 4 Estimated Outcome Amount: $152,479	Year 5 Estimated Outcome Amount: $364,625

New: 121792903.3.19 *Old: 121792903.3.6*	*3.IT-2.10*	*Flu and pneumonia admission rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.7* *Old: 121792903.2.2*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $694,105			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30 day readmission rate

Unique RHP outcome identification number: New: 121792903.3.20; Old: 121792903.3.7

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-3.1- All cause 30 day readmission rate

Process Milestone:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 – Establish baseline rates
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems
  - P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.1 Reduce all cause 30 day readmission rate by 3% below baseline
- DY5:
  - IT-3.1 Reduce all cause 30 day readmission rate by 5% below baseline

Rationale:

Process milestone P-1 was selected due to the lack of a current Care Transitions program and the limited resources available for collecting and analyzing readmission data. P-2 and P-3 were chosen based on the need for developing accurate reports for establishing baseline data. In DY2 the process milestones 1-3 will be recognized in order to establish timely baseline data. DY3 will be inclusive of P-3 to continue the development of data systems and a better means for internally analyzing data which will lead to furthering the process milestone P-4 for conducting Plan Do Study Act to improve data collection and intervention activities. P-4 also coincides with project option 2.12.1 (g) as a quality improvement mechanism to help with identifying lessons learned and opportunities within the project.

Improvement target 3.1 will be measured starting in DY4 and was chosen based on the expectation that the elements of the Care Transitions program (121792903.2.8) are based on evidence-based models and standardized clinical protocols designed to prevent increased healthcare costs and hospital readmissions. With the program implementation for safe, effective, and efficient care transitions, the risk for potentially preventable readmissions decreases due to better coordination of care lending to successful disease management.

Outcome Measure Valuation:

This outcome measure is valued at $757,206. Valuation for the outcome measure of reduced hospital readmissions considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 2 project for the Care Transitions program and its Category 3 outcome for reducing all cause 30 day readmission rates achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates the furthered development of a better coordinated care delivery system. Medicaid patient and uninsured patients with potentially limited resources will receive better care and more support during the post-acute phase of recovery. With a 31.2% adult uninsured population in Hamilton County, the community need exists for providing best practice to reduce cost burden associated with readmission from unfunded or Medicaid patients. The scope of the project will touch all inpatient discharges from Hamilton General Hospital, an estimated 2,000 per year making this a large project for our facility. Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project.

New: 121792903.3.20 *Old: 121792903.3.7*	*3.IT-3.1*	*All cause 30 day readmission rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.8* *Old: 121792903.2.3*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project plan Process Milestone 1 Estimated Incentive Payment: $29,810 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $29,810 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 3 Estimated Incentive Payment: $29,810	**Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $51,831 **Process Milestone 5** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR reports Process Milestone 5 Estimated Incentive Payment: $51,831	**Outcome Improvement Target 1** [IT-3.1]: Improvement Target: Reduce all cause 30 day readmission rate by 3% below baseline Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $166,341	**Outcome Improvement Target 2** [IT-3.1]: Improvement Target: Reduce all cause 30 day readmission rate by 5% below baseline Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $397,773

New: 121792903.3.20 *Old: 121792903.3.7*	*3.IT-3.1*	*All cause 30 day readmission rate*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.8* *Old: 121792903.2.3*		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $89,430	Year 3 Estimated Outcome Amount: $103,662	Year 4 Estimated Outcome Amount: $166,341	Year 5 Estimated Outcome Amount: $397,773
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $757,206			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-13.1 Pain assessment

Unique RHP outcome identification number(s): New: 121792903.3.21; Old: 121792903.3.9

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

OD-13 Palliative Care

IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)

- Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 –Establish baseline rate for each non-standalone measure
    - IT-13.1 Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.1 Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline
- DY5:
  - IT-13.1 Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline

Rationale:

Process milestones P-1 and P-3 were chosen in order to identify the current services available in the region, and monitor additional resources available as a palliative care program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports currently available to measure and monitor information related to the palliative care project. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for the three non-standalone measures with P-2 and also continue to develop and test the data systems to ensure accurate baselines and further data will be measured effectively.

Improvement targets were chosen for all three non-standalone measures based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program.

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program.

Outcome Measure Valuation:

This outcome measure has been valued at $136,211. The valuation process for the outcome measures considers multiple factors. This outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. It also ensures that we are focused on improving patient outcomes and quality of life. The associated Category 2 project is designed to improve the health care infrastructure to better serve the patients of Hamilton General Hospital to provide appropriate and quality end-of-life care.

New: 121792903.3.21 *Old: 121792903.3.9*	*IT-13.1*	*Pain assessment (NQF-1637) (Non-standalone measure)*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.9* *Old: 121792903.2.4*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $7,575.50 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $7,575.50	**Process Milestone 3** [P-2]: Establish baseline rate for each non-standalone measure Data Source: EHR reports, program records Process Milestone 3 Estimated Incentive Payment: $9,262.50 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $9,262.50	**Outcome Improvement Target 1** [IT-13.1]: Pain assessment Improvement Target: Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,096	**Outcome Improvement Target 2** [IT-13.1]: Pain assessment Improvement Target: Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD% over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $72,439
Year 2 Estimated Outcome Amount: $15,151	Year 3 Estimated Outcome Amount: $18,525	Year 4 Estimated Outcome Amount: $30,096	Year 5 Estimated Outcome Amount: $72,439
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $136,211			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-13.2 Treatment Preferences

Unique RHP outcome identification number(s): New: 121792903.3.22; Old: 121792903.3.10

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

OD-13 Palliative Care

IT-13.2 Treatment Preferences (NQF-1641) (Non-standalone measure)

- Percentage of patients with chart documentation of preferences for life sustaining treatments

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 –Establish baseline rate for each non-standalone measure
    - IT-13.2 Percentage of patients with chart documentation of preferences for life sustaining treatments
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.2 Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline
- DY5:
  - IT-13.2 Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline

Rationale:

Process milestones P-1 and P-3 were chosen in order to identify the current services available in the region, and monitor additional resources available as a palliative care program is implemented in the region. As a result of the impending new program, these milestones

will address the lack of accurate reports currently available to measure and monitor information related to the palliative care project. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for the three non-standalone measures with P-2 and also continue to develop and test the data systems to ensure accurate baselines and further data will be measured effectively.

Improvement targets were chosen for all three non-standalone measures based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program.

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program.

Outcome Measure Valuation:

This outcome measure has been valued at $136,211. The valuation process for the outcome measures considers multiple factors. This outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. It also ensures that we are focused on improving patient outcomes and quality of life. The associated Category 2 project is designed to improve the health care infrastructure to better serve the patients of Hamilton General Hospital to provide appropriate and quality end-of-life care.

New: 121792903.3.22 *Old: 121792903.3.10*	*IT-13.2*	*Treatment preferences (NQF-1641) (Non-standalone measure)*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.9* *Old: 121792903.2.4*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $7,525.50 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $7,525.50	**Process Milestone 3** [P-2]: Establish baseline rate for each non-standalone measure Data Source: EHR reports, program records Process Milestone 3 Estimated Incentive Payment: $9,262.50 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $9,262.50	**Outcome Improvement Target 1** [IT-13.2]: Treatment preference Improvement Target: Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,096	**Outcome Improvement Target 2** [IT-13.2]: Treatment preference Improvement Target: Increase the percentage of patients with chart documentation of preferences for life sustaining treatments by TBD% over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $72,439
Year 2 Estimated Outcome Amount: $15,151	Year 3 Estimated Outcome Amount: $18,525	Year 4 Estimated Outcome Amount: $30,096	Year 5 Estimated Outcome Amount: $72,439
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $136,211			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

Unique RHP outcome identification number(s): New: 121792903.3.23; Old: 121792903.3.11

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

OD-13 Palliative Care

IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 –Establish baseline rate for each non-standalone measure
    - IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.5 Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline
- DY5:

- IT-13.5 Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline

Rationale:

Process milestones P-1 and P-3 were chosen in order to identify the current services available in the region, and monitor additional resources available as a palliative care program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports currently available to measure and monitor information related to the palliative care project. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for the three non-standalone measures with P-2 and also continue to develop and test the data systems to ensure accurate baselines and further data will be measured effectively.

Improvement targets were chosen for all three non-standalone measures based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program.

The Category 3 outcome measures will reflect patient centered care delivery and the attention provided to the patient quality of life. The three chosen non-standalone measures for palliative care encompass an assessment for the nature of care we expect to accomplish by providing a Palliative Care Program to our patients. Due to the relatively smaller scope of this project in comparison to our other projects, these Category 3 outcomes are most reflective of the desired achievement for quality patient care and appropriate care transitions with the Palliative Care Program.

Outcome Measure Valuation:

This outcome measure has been valued at $136,211. The valuation process for the outcome measures considers multiple factors. This outcome achieves the waiver goals by ensuring that high-quality and patient-centered care is being delivered in the most cost effective ways. It also ensures that we are focused on improving patient outcomes and quality of life. The associated Category 2 project is designed to improve the health care infrastructure to better serve the patients of Hamilton General Hospital to provide appropriate and quality end-of-life care.

New: 121792903.3.23 *Old: 121792903.3.11*	*IT-13.5*	*Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*New: 121792903.2.9* *Old: 121792903.2.4*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, EHR reports Process Milestone 1 Estimated Incentive Payment: $7,525.50 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 2 Estimated Incentive Payment: $7,525.50	**Process Milestone 3** [P-2]: Establish baseline rate for each non-standalone measure Data Source: EHR reports, program records Process Milestone 3 Estimated Incentive Payment: $9,262.50 **Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR reports Process Milestone 4 Estimated Incentive Payment: $9,262.50	**Outcome Improvement Target 1** [IT-13.5]: Improvement Target: Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,096	**Outcome Improvement Target 2** [IT-13.5]: Improvement Target: Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss by TBD% over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $72,439
Year 2 Estimated Outcome Amount: $15,151	Year 3 Estimated Outcome Amount: $18,525	Year 4 Estimated Outcome Amount: $30,096	Year 5 Estimated Outcome Amount: $72,439
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $136,211			

Pass 3B

Title of Outcome Measure (Improvement Target): IT-1.10 – Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): New: 121792903.3.24; Old: 121792903.3.12

Performing Provider: Hamilton General Hospital / TPI 121792903

Outcome Measure Description:

IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rate for HbA1c
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - Reduce the percentage of patients with HbA1c >9.0%, %TBD below baseline
- DY5:
  - Reduce the percentage of patients with HbA1c >9.0%, %TBD below baseline

Rationale:

Process milestone P-1 was selected due to the lack of current Regional Diabetes Management. The project will require the collaboration of Hamilton General Hospital and Providence Healthcare Network in the project planning and implementation. P-3 is needed in DY2 to establish the mechanism for data collection, particularly due to a need to institute valid and reliable data collection regionally and among the diabetes care team.

In DY3, testing of data systems will continue to ensure validity and P-2 will allow for establishing a baseline rate for HbA1c testing.

Improvement target 1.10 was chosen to measure the percentage of patients considered to have poor glycemic control with a HbA1c >9.0%. The implementation of the Diabetes Management project is meant to provide clinically significant results to impact diabetes outcomes. The longitudinal study, Diabetes Control and Complications Trial (DCCT) of 1993, related that the best diabetes management is tight glycemic control. Improving A1C values will decrease long-term complications of diabetes such as cardiovascular disease, retinopathy, neuropathy, nephropathy, and amputation.

"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." (Regional Healthcare Partnership Planning Protocol)

PDSA cycles will be used to evaluate and improve intervention activities of the project and data collection. PDSA will be valuable in the carrying out of this project regionally. Continuous quality improvement is important for identifying project impacts and opportunities. Findings, lessons learned, and sharing of best practices will be used to improve the project and promote regional involvement. Learning collaboratives will host opportunities for sharing of information between providers. The use of best practice across the region will lend to achieving the improvement target for reducing A1c values.

Outcome Measure Valuation:

Valuation for the outcome measure of reducing patients with poorly controlled HbA1c considers multiple factors. Included in the valuation assessment is the achievement of waiver goals. The associated Category 2 project for Diabetes Management and its Category 3 outcome for reducing the percentage of patients with poorly controlled HbA1c values achieves the goals of the waiver as identified in the planning protocol. The project assures that patients receive high quality and patient-centered care in the most cost effective ways. The outcome target demonstrates improved clinical outcomes from a better coordinated care delivery system.

Project investment will include time for organization, development, and implementation as well as ongoing resources for sustained implementation and continued growth of the project. Cost avoidance from decreased rates of diabetes complications, potentially preventable hospitalizations, and non-urgent ED utilization may be impacts of increasing access to care through diabetes management. The measured clinical indicator for HbA1c values is significant in demonstrating that the risk for long-term complications is decreased as HbA1c values decrease. The quality of life for diabetic patients with improved glycemic control is intangible.

A weighted tool was used for assigning a project valuation. The project weight was then used in a projection valuation worksheet as a standardized means for determining project and outcome valuation. Outcome valuation for the five year period totals $1,838,849. With this project offered regionally, RHP 16 data supports that there is great opportunity for cost avoidance with better diabetes management. Total potentially preventable hospitalization hospital charges for all seven counties in the region related to long-term complications of diabetes from 2005-2010 was $43,955,711. Short-term complications made up another $15,570,148 in charges.

The choice of a clinical measure specific to diabetes care is important to this project because of the research and evidence to support that improved glycemic control will impact diabetes complications. As Hamilton and Providence partner to deliver the Diabetes Management project, it will allow for a strong presence in the region that will work to transform care delivery.

New: 121792903.3.24 *Old: 121792903.3.12*	*OD-1.IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*	
Hamilton General Hospital			*121792903*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier – New: 121792903.2.10* *Old: 121792903.2.5*		
Starting Point/Baseline:	*To be developed in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation plan Process Milestone 1 Estimated Incentive Payment*:* $102,270 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Process Milestone 2 Estimated Incentive Payment: $102,270	**Process Milestone 3** [P-3]: Develop and test data systems Data Source: Process Milestone 4 Estimated Incentive Payment: $125,042 **Process Milestone 4** [P-2]: Establish baseline rate for poorly controlled HbA1c (>9.0%) Data Source: Lab data Process Milestone 2 Estimated Incentive Payment: $125,042	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9%) Improvement Target: Reduce the percentage of patients with HbA1c >9.0%, %TBD below baseline Data Source: Lab data Outcome Improvement Target 1 Estimated Incentive Payment*:* $406,290	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9%) Improvement Target: Reduce the percentage of patients with HbA1c >9.0%, %TBD below baseline Data Source: Lab data Outcome Improvement Target 2 Estimated Incentive Payment*:* $977,934
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $204,542	Year 3 Estimated Outcome Amount: $250,083	Year 4 Estimated Outcome Amount: $406,290	Year 5 Estimated Outcome Amount: $977,934
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,838,849			

Identifying Outcome Measure and Provider Information: Outcome measure OD-6. Patient Satisfaction. Child and Adolescent Behavioral Health Service Expansion. 084859002.3.1 - HOTRMHMR/084859002.

Outcome Measure Description: The Category 3 Outcome Measure selected is OD – 6; Patient Satisfaction. This measure was selected as a way of determining the satisfaction of parents relating to their child's improvement in functioning. That improved functioning leads to better outcomes in a variety of areas. The need for intensive services and supports for children has been identified as a significant priority for the region. In Year 2 Process milestones P-1 will be used to plan the project and get community input. In YR3, Process Milestone P-2 will be used to determine baseline data needed to achieve stated outcomes. In YR 4 & 5, IT -6.1 will be used to identify success in meeting outcomes.

Rationale: The use of Process milestones P-1 & P-2 are building blocks to establish positive outcomes with children experiencing behavioral health issues. The resulting patient satisfaction is an indicator that the newly established services are meeting the goal of better clinical outcomes with the child. The outcome measure OD-6 Patient Satisfaction will be measured using IT-6.1- Percent improvement over baseline of patient satisfaction. 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:

(5) patient's overall health status/functional status. ***(Standalone measure)***

a Numerator: Percent improvement in targeted patient satisfaction domain

b Data Source: Patient survey

c Denominator: Number of patients who were administered the survey

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

Outcome Measure Valuation: The valuation of this project was based on current cost of serving individuals in the HOTRMHMR Center combined with savings achieved by reducing inpatient hospitalizations, juvenile justice involvement, out of home placements and emergency department visits. The project addresses a significant community need in that behavioral health services for children are under serving the number of children in need of services. The project size was determined utilizing waiting list numbers, state and local need assessments and underserved populations in rural communities. Improved outcomes in all these areas financially impact the community due to more costly residential and inpatient services used.

[Unique Category 3 outcome measure identifier(s), ***OD-6***	*[Outcome Measure (Improvement Target)* ***IT-6.1***	***Patient Satisfaction***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.1.1		
Starting Point/Baseline:.	**Program will be designed and services begun in YR 2. Expansion and children will be served in Yr-2-5**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1 – P-1.1** **Baseline/Goal:** Develop project plan. **Data Source:** Project plan. **Milestone 1 - Incentive Payment *(maximum amount):*** 0	**Milestone 2 – P-2** **Metric 2** P-2.1 **Baseline/Goal:** Establish baseline data. **Data Source:** HOTRMHMR Clinical records. **Milestone 2 Estimated Incentive Payment:** $30,710	**Outcome Improvement Target 1** [IT-6.1 Improvement Target: A 25% improvement on CAHPS - (5) patient's overall health status/functional status. ***(Standalone measure)*** **Data Source:** Clinical Records **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $ 36,852	**Outcome Improvement Target 2** [IT-6.1 Improvement Target: A 50% improvement on CAHPS - (5) patient's overall health status/functional status. ***(Standalone measure)*** **Data Source:** Clinical Records **Outcome Improvement Target2 Estimated Incentive Payment*:*** $ 85,987
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 30,710	Year 4 Estimated Outcome Amount: $ 36,852	Year 5 Estimated Outcome Amount: $ 85,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 153,549			

Identified Outcome Measure and Provider Information: Outcome measure OD-1. Primary Care and Chronic Disease Management. Integrated Health Clinic. 084859002.3.2- HOTRMHMR/084859002

Outcome Measure Description: The Category 3 outcome measure is OD-1 – Primary Care and Chronic Disease Management. Utilizing specific health metrics to show overall project effectiveness gives concrete data to verify progress and ties into the regional goal of better health outcomes. Process milestones in YR 2- will be P-1. This will include program planning and community input. YR 3 will include P-2, to establish baseline data to measure progress. These milestones were selected to establish integrated health care services and to ensure practices are in place to meet Category 3 outcomes, of reducing hypertension in those participating.

Rationale: The use of process milestones P-1 & P-2 are needed steps to establish an integrated physical and behavioral health clinic. Once the project is established Category 3 outcomes can be expected. The outcome measure of OD-1 will be measured utilizing IT-7.- Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)228 *(Standalone measure)*

a Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year

b Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

c Data Source: EHR, Registry

d Rationale/Evidence: 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 hypertensives, 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 a14 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.

Outcome Measure Valuation: The project was valued utilizing Maeng's assessment of cost savings in a collaborative care model combined with data on health related issues within the SMI population. It addresses a significant community need in that it provides integrated health care to those who often do not follow through with needed physical health care due to their mental health condition. The size and scope of the project was based on capacity to deliver services to those targeted as needing specialized assistance. It was determined that identifying those at the greatest risk and then tailoring an integrated health service delivery system to meet their needs would be the most effective way of combating the issue. The project investment is minimal when compared to the cost of potentially avoidable hospitalizations and the cost to treat medical conditions left untreated over extended periods of time.

[Unique Category 3 outcome measure identifier(s), ***OD-1***	*[Outcome Measure (Improvement Target)* ***IT-1.7***	**Controlling high blood pressure**	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:			
Starting Point/Baseline: The project will be starting new. YRs 2&3 will prepare the program to meet Category 3 outcomes in Yrs 4&5.	*084859002.2.1*		
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: P- 1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1: – P-1.1** **Baseline/Goal:** Develop Project Plan. **Data Source:** Project plan. **Milestone 1 - Incentive Payment** ***(maximum amount):*** 0	**Milestone 2** – P-2 Establish baseline data. **Metric 2 :** P-2.2 Establish baseline data using CQI. **Data Source:** Demonstrate CQI in clinical records. **Milestone 2 - Incentive Payment** ***(maximum amount):*** 69,144	**Outcome Improvement Target 1** [IT-1.7]: Improvement Target: A 10% reduction in the number of individuals previously diagnosed with hypertension whose blood pressure is within acceptable limits. **Data Source**: Clinical records. **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $ 82,973	**Outcome Improvement Target 1** [IT-1.7]: Improvement Target: A 20% reduction in the number of individuals previously diagnosed with hypertension whose blood pressure is within acceptable limits. **Data Source:** Clinical records. **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $ 193,602
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 69,144	Year 4 Estimated Outcome Amount: $ 82,973	Year 5 Estimated Outcome Amount: $ 193,602
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 345,719			

Identifying Outcome Measure and Provider Information: OD-10 – Quality of Life / Functional Status. FACT Team. 084859002.3.3- HOTRMHMR/084859002

Outcome Measure Description: The Category 3 outcome measure is OD-10 – Quality of Life/Functional Status. The measurement of functioning directly relates to all areas of concern such as admission / readmissions to the criminal justice system, inpatient hospital utilization, emergency department contacts, and other health related provider healthcare services. The project ties into the regional goal of providing the appropriate services to individuals in special categories that are historically high utilizers of other health care services. In YR 2 process milestones will include P-1, will be used to develop the project and receive community input into the plan. In YR 3 Process milestone P-2, will be used to establish baseline data for the project. These milestones will lead towards preparedness to met category 3 outcome measures. The improvement in activities of daily living is an indicator that the individual is functioning at a higher level and therefore will be less inclined to utilize other more costly community interventions.

Rationale: The use of process milestones P-1 & P-2 will create a project that can improve the functioning of participants and assist in reaching Category 3 outcome measure OD-10. The outcome measure of OD-10 will be measured using IT-10.2 Activities of Daily Living *(Standalone measure)*

a. Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population.

b. Data source: Provider may select a validated assessment tool for activities of daily living. Some examples include the Katz ADL Scale, Lawton IADL Scale278, Barthal Index of Activities of Daily Living279 and Bristol Activities of Daily Living Scale (for dementia patients).

c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improved symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient
outcomes.

Outcome Measure Valuation: The project accomplishes the waiver goal of providing the supports needed to keep at-risk populations from utilizing more costly community services. This also addresses the community need of providing services to those individuals who regularly interface with law enforcement, emergency departments and inpatient hospitals in a more efficient and cost effective manner. The scope and size of the project was determined by analyzing the sub-population of individuals who repeatedly interface these systems. Utilizing cost analysis methodology (CAM) data from the HOTRMHMR Center and including additional costs for Court related expenses the average cost to serve each individual in an FACT model with Court support would be $14,425 per participant. Based on data provided from the Bluebonnet MHMR Center Jail Diversion Project the potential cost to the community for

this type of individual is $37,500 per year. The project reflects a substantial savings over current cost associated with serving this population.

[Unique Category 3 outcome measure identifier(s), ***OD-10***	*[Outcome Measure (Improvement Target)* ***IT-10.2***	***Quality of Life / Functional Status***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.3.3		
Starting Point/Baseline: The project will be starting new. Yrs 2&3 will prepare the program to reach Category 3 outcomes in YR 4&5.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1 – P-1.1** **Baseline/Goal:** Develop plan **Data Source:** Project plan is evidence based. **Milestone 1 Estimated Incentive Payment –** $0	**Milestone 2 – P-2** **Metric 1** P-2.1 **Baseline/Goal:** Establish baseline data. **Data Source:** HOTRMHMR Clinical records. **Milestone 1 Estimated Incentive Payment:** $ 50,000	**Outcome Improvement Target 1** IT-10.2: **Improvement Target:** 15% improvement from baseline on AQol assessment tool. **Data Source:** Clinical records **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $50,000	**Outcome Improvement Target 2** IT-10.2: **Improvement Target:** 30% improvement from baseline on AQol assessment tool. **Data Source:** Clinical records **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $125,000

[Unique Category 3 outcome measure identifier(s), ***OD-10***	*[Outcome Measure (Improvement Target)* ***IT-10.2***	***Quality of Life / Functional Status***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.3.3		
Starting Point/Baseline: The project will be starting new. Yrs 2&3 will prepare the program to reach Category 3 outcomes in YR 4&5.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 50,000	Year 4 Estimated Outcome Amount: $ 50,000	Year 5 Estimated Outcome Amount: $ 125,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 225,000			

Identifying Outcome Measure and Provider Information: OD-10 –Quality of Life / Functional Status. Recruit, train, and support consumers of mental health services to provide peer support services. 084859002.3.4 - HOTRMHMR/084859002

Outcome Measure Description: The Category 3 outcome measure is OD-10 – Quality of Life/Functional Status. The measurement of functioning directly relates to the success of a variety of community initiatives designed to educate and support individuals with SMI and their families. The project ties into the regional goal of providing the appropriate services to individuals with behavioral health needs. In YR 2 process milestones P-1 will be used to establish the project plan and to receive community input In YR 3 Process milestone P-2 will be used to establish baseline data needed to measure success of the project. These milestones will lead towards preparedness to met category 3 outcome measures.

Rationale: The use of process milestones P-1 & P-2 will create an innovative project that can improve the functioning of participants and assist in reaching Category 3 outcome measure OD-10. The outcome measure of OD-10 will be measured using IT-10.1 Quality of Life. *(Standalone measure)*

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

b. Data source: Provider may select a validated assessment tool for quality of life. Some examples include AQoL, SF-36, 20 or 12, PedsQL

c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Outcome Measure Valuation: The project achieves the waiver goal of providing greater support to individuals experiencing behavioral health issues. The community need of serving this underserved population is also addressed by the project. The project scope and size was determined by looking at the underserved population in need and establishing an intervention that could reach the greatest number of individuals in all areas of the region. The project investment is minimal in comparison to the significant costs associated with not providing serving and supports for those in need. These individuals utilize much more expensive services such as emergency departments, inpatient hospitalizations and crisis center services.

*[Unique Category 3 outcome measure identifier(s), **OD-10***	*[Outcome Measure (Improvement Target) **IT-10.1***	***Quality of Life/Functional Status***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:P-1,P-2,P-3,P-4,P-5,P-6, P-7, P-9, and It-17	084859002.3.4		
Starting Point/Baseline: Only 10% of individuals with a SMI are in services with the community center. These individuals need supports to ensure positive functioning.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1 – P-1.1** **Baseline/Goal:** Develop project **Data Source:** Submission of a strategic plan. **Milestone 1 Estimated Incentive Payment** – $ 0	**Milestone 2 – P-2** **Metric** 2 – P-1.1 **Baseline/Goal:** Establish baseline data. **Data Source:** HOTRMHMR Clinical records. **Milestone 2 Estimated Incentive Payment:** $ 20,000	**Outcome Improvement Target 1** [IT-10.1 **Improvement Target:** 20% improvement of AQoL scores from pre service baseline. **Data Source:** Clinical record. **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $ 20,000	**Outcome Improvement Target 2** [IT-10.1 **Improvement Target:** 20% improvement of AQoL scores from pre service baseline. **Data Source:** Clinical record. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $ 40,000
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 20,000	Year 4 Estimated Outcome Amount: $ 20,000	Year 5 Estimated Outcome Amount: $40,000

[Unique Category 3 outcome measure identifier(s), ***OD-10***	*[Outcome Measure (Improvement Target)* ***IT-10.1***	***Quality of Life/Functional Status***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:P-1,P-2,P-3,P-4,P-5,P-6, P-7, P-9, and It-17	084859002.3.4		
Starting Point/Baseline: Only 10% of individuals with a SMI are in services with the community center. These individuals need supports to ensure positive functioning.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 80,000			

Identifying Outcome Measure and Provider Information: OD-6 – Patient Satisfaction. Community-Based Interventions for Children and Individuals with Challenging Behaviors. 084859002.3.5- HOTRMHMR/084859002

Outcome Measure Description: The Category 3 Outcome Measure selected is OD – 6; Patient Satisfaction. This measure was selected as a way of determining the satisfaction of parents, providers and participants related the participant's improvement in functioning. That improved functioning leads to better outcomes in a variety of areas. The need for intensive services and supports for individuals with challenging behaviors has been identified as a significant priority for the region. In Year 2 Process milestone P-1 will be used to design the project and to receive community input. In YR 3, Process Milestone P-2 will be used to establish baseline data. These milestones will be used to establish a program that can met the Category 3 outcomes. The use of a patient/provider satisfaction tool will measure participant progress in establishing more adaptive skills therefore reducing the risk of future challenging behaviors which lead to more costly community interventions.

Rationale: The use of Process milestones P-1 & P-2 are building blocks to establish positive outcomes with individuals experiencing behavioral health issues. The resulting patient satisfaction is an indicator that the newly established services are meeting the goal of better clinical outcomes. The outcome measure OD-6 Patient Satisfaction will be measured using IT-6.1- Percent improvement over baseline of patient satisfaction. Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

a Numerator: Percent improvement in targeted patient satisfaction domain
b Data Source: Patient survey
c Denominator: Number of patients who were administered the survey
d Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided inreturn for the public investment.

Outcome Measure Valuation: The project achieves the waiver goal of providing services to at-risk populations that would otherwise utilize more costly services. The project also meets the community goal of serving individuals who would otherwise interface with law

enforcement, emergency departments, inpatient and residential treatment facilities. The size and scope of the project was determined by analyzing the number of individuals with challenging behaviors that are not currently able to be served. The Project investment is minimal compared to the costs associated with not serving this at-risk population and having them interface with other more costly community services.

084859002.3.5	*[Outcome Measure (Improvement Target)* ***IT-6.1***	***Patient Satisfaction***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.3.5		
Starting Point/Baseline: Due to funding reductions from the State, many individuals with challenging behaviors are not getting services they need to be successful.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 : P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1 – P-1.1** **Baseline/Goal:** Develop project plan **Data Source:** Project plan that is evidence based. **Milestone 1 Estimated Incentive Payment:** $ 0	**Milestone 2 – P-2** **Metric** 2 – P-2.1 **Baseline/Goal:** Establish baseline data. **Data Source:** HOTRMHMR Clinical records. **Milestone 2 Estimated Incentive Payment:** $ 40,000	**Outcome Improvement Target 1** IT – 6.1 Improvement Target: 15% improvement of patient / provider satisfaction on (e) of the HCAHPS assessment tool. **Data Source:** Clinical record. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $ 50,000	**Outcome Improvement Target 2** IT – 6.1 Improvement Target: 30% improvement of patient / provider satisfaction on (e) of the HCAHPS assessment tool. **Data Source:** Clinical record. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $ 125,000

084859002.3.5	*[Outcome Measure (Improvement Target)* ***IT-6.1***	***Patient Satisfaction***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.3.5		
Starting Point/Baseline: Due to funding reductions from the State, many individuals with challenging behaviors are not getting services they need to be successful.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 40,000	Year 4 Estimated Outcome Amount: $ 50,000	Year 5 Estimated Outcome Amount: $ 125,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 215,000			

Identifying Outcome Measure and Provider Information: OD-1Primary Care and Chronic Disease Management. Integrated Geriatric Services. 084859002.3.6 - HOTRMHMR/084859002

Outcome Measure Description: The Category 3 outcome measure is OD-1 – Primary Care and Chronic Disease Management. Utilizing specific health metrics to show overall project effectiveness gives concrete data to verify progress and ties into the regional goal of better health outcomes. The process milestone in YR 2- will be P-1. This will be used for project design and to receive community input. In YR 3 –P-2 would be used to establish baseline data needed to measure progress towards accomplishing Category 3 outcomes. These milestones were selected to establish an integrated physical and behavioral health model working with the geriatric population in a manner that can manage chronic health conditions. With better management of their chronic conditions participants will be able to achieve Category 3 outcomes.

Rationale: The use of process milestones P-1 & P-2 are needed steps to establish an integrated physical and behavioral health clinic. Once the project is established Category 3 outcomes can be expected. The OD -1 outcome measure will be assessed based on IT-1.9 – Depression Management. Depression Remission at Twelve Months (NQF# 0710)232 *(Standalone measure)*

a Numerator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.

b Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine. Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder is excluded.

c Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records

232http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251

232 http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=55#k=0710 Category 1 Infrastructure Development 9/21/12

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d Rationale/Evidence: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.

Outcome Measure Valuation: The project achieves the waiver goal of serving individuals with chronic conditions in a more assertive manner thereby keeping them from accessing more costly medical services. It meets the community need of serving individuals at-risk of more intensive services by aggressively managing their chronic conditions. The size and scope of the project was determined by reviewing the number of consumers in HOTRMHMR Center services that have chronic medical conditions and

designing an intervention that would best suit their needs. The project was valued utilizing Maeng's assessment of cost savings in a collaborative care model combined with data on health related issues within the SMI population to determine the size and scope of the project. It was determined that identifying those at the greatest risk and then tailoring an integrated health service delivery system to meet their needs would be the most effective way of combating the issue.

084859002.3.6	*[Outcome Measure (Improvement Target)* ***IT-1.9***	***Depression Management***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects: P-3, P-9, P11 & I-21.2	084859002.3.6		
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)**
Milestone 1 – P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1** – P-1.1 Develop a comprehensive plan. **Baseline/Goal:** Completion of plan. **Data Source:** Documentation of care management plan. **Milestone 1 Estimated Incentive Payment:** $ 0	**Milestone 2** – P-2 **Metric** 2 P-2.1 **Baseline/Goal:** Establish baseline data. **Data Source:** HOTRMHMR Clinical system. **Milestone 2Payment:** $ 55,000	**Outcome Improvement Target 1** IT-1.9 **Improvement Target:** Reduction of 15% in adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five. **Data Source:** Clinical Record **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $ 65,000	**Outcome Improvement Target 1** IT-1.9 **Improvement Target:** Reduction of 30% in adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five. **Data Source:** Clinical Record **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $ 158,000

084859002.3.6	*[Outcome Measure (Improvement Target)* ***IT-1.9***	***Depression Management***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects: P-3, P-9, P11 & I-21.2	084859002.3.6		
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): $ 0	Year 3 Estimated Outcome Amount: $ 55,000	Year 4 Estimated Outcome Amount: $ 65,000	Year 5 Estimated Outcome Amount: $ 158,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 278,000			

Identifying Outcome Measure and Provider Information: OD-9 – Right Care / Right Setting. COPSD Program. 084859002.3.7 - HOTRMHMR/084859002

Outcome Measure Description: The Category 3 Outcome Measure selected is OD – 9; Right Care / Right Setting. This measure was selected as a way of determining the effect of working with the targeted population in a project design established to keep at-risk patients out of the criminal justice system. The need for intensive services and supports for individuals with COPSD issues has been identified as a significant priority for the region. In Year 2 Process milestone will be used to develop the project and gain community input. In YR 3, Process Milestone P-2 will be used to establish baseline data needed to measure success in reaching Category 3 outcomes.

Rationale: The use of process milestones P-1 & P-2 are needed steps to establish a project design that can improve functioning of this at-risk population. These milestones establish the framework for the project meeting category 3 outcomes. The OD -9 outcome measures will be assessed based on IT-9.1 – decreases in mental health admissions and readmissions to criminal justice settings such as jails or prisons. IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons *(Standalone measure)*

a 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.

b Denominator: The number of individuals receiving project intervention(s)

c Data Sources: Claims/ encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records

d Rationale/Evidence: Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of 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, reduce long term medical costs and improve functioning. The reduction of individuals participating in the project that are arrested or incarcerated is a clear indicator that the project has been successful. This reduction shows interventions impacted the participants in a positive manner and led to outcomes that saved the community money by reducing the use of more costly interventions.

Outcome Measure Valuation: The project achieves the waiver goal of serving at-risk populations that would otherwise utilize more costly community services. It meets the community need of serving individuals who are treatment resistant and who otherwise would interface with law enforcement, emergency departments, inpatient and residential facilities. The size and scope of the project was determined by reviewing those individuals currently in HOTRMHMR center services who have COPSD and who would benefit from a specialized intervention. Utilizing data from the Bluebonnet Trails Jail Diversion Study, the baseline community cost of serving this population in the project model would be a significantly less than current community costs

084859002.3.7	*[Outcome Measure (Improvement Target)* ***IT-9.1***	***Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.3.7		
Starting Point/Baseline: Individuals with COPSD have a higher utilization of more costly services such as ED visits, homelessness, criminal justice involvement and inpatient hospital 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 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1 – P-1.1** **Baseline/Goal:** Develop a comprehensive plan. **Data Source:** Documentation of care management plan. **Milestone 1 Estimated Incentive Payment:** $ 0	**Milestone 2 –** P-2 Establish baseline data. **Metric 1 –** P-2. **Baseline/Goal:** 1Establish baseline data. **Data Source:** HOTRMHMR Clinical system. **Milestone 2 Payment:** $25,000$25,000	**Outcome Improvement Target 1** IT-9.1 **Improvement Target:** reduce the number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period by 15% ***Data Source:*** Clinical records. **Outcome Improvement Target 1Estimated Incentive Payment*:*** $ 25,000	**Outcome Improvement Target 2** IT-9.1 **Improvement Target:** reduce the number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period by 25% **Data Source:** Clinical records. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $ 68,000

084859002.3.7	*[Outcome Measure (Improvement Target)* ***IT-9.1***	***Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects:	084859002.3.7		
Starting Point/Baseline: Individuals with COPSD have a higher utilization of more costly services such as ED visits, homelessness, criminal justice involvement and inpatient hospital care.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 25,000	Year 4 Estimated Outcome Amount: $ 25,000	Year 5 Estimated Outcome Amount: $ 68,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 118,000			

Identifying Outcome Measure and Provider Information: OD-9 – Right Care / Right Setting. Community Clinic for Outpatient Services. 084859002.3.8 - HOTRMHMR/084859002

Outcome Measure Description: The Category 3 Outcome Measure selected is OD – 9; Right Care / Right Setting. This measure was selected as a way of determining the effect of working with the targeted population in a project design established to keep at-risk patients out of the local emergency departments. The need for services and supports for individuals with Axis II issues has been identified as a significant priority for the region. In Year 2 Process milestones P-1 will be used to plan and develop the project and to establish the framework for serving individuals with Axis II diagnoses in a community clinic model. In YR 3, Process Milestone P-2 will be used to establish baseline data. YR4 & 5 will measure the effectiveness of the project in keeping the targeted population from utilizing more costly emergency department services.

Rationale: The use of process milestones P-1& P-2 are needed steps to establish a project design that can improve functioning of this at-risk population. These milestones establish the framework for the project meeting Category 3 outcomes. The OD -9 outcome measures will be assessed based on IT-9.2 – ED appropriate utilization (standalone measure); reduce emergency department visits for targeted conditions of behavioral health / substance abuse.

a Numerator: The number of individuals receiving project intervention(s) that had an emergency department admission/readmission within the measurement period.

b Denominator: The number of individuals receiving project intervention(s)

c Data Sources: Claims/ encounter and clinical record data; anchor hospital and other hospital records, emergency department system records, local MH authority and state MH data system records

d Rationale/Evidence: Admission and readmission to emergency department setting. Interventions which can prevent individuals from cycling through the emergency departments can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

Outcome Measure Valuation: The project achieves the waiver goal of serving at-risk populations that would otherwise utilize more costly community services. It meets the community need of serving individuals with complex issues that do not qualify for traditional community center services, but that regularly interface with law enforcement, emergency departments, inpatient and residential facilities. The size and scope of the project was determined by reviewing those individuals currently being referred out of HOTRMHMR Center services based on not meeting target population diagnosis for services as established by the Texas Department of State Health Services. Additionally, clinic services would be available for individuals who meet the target population for project services that receive referrals from emergency departments, law enforcement, private practitioners, managed care organizations, hospitals inpatient psychiatric facilities and other community social service agencies who would benefit from a specialized

intervention. Utilizing data from local emergency departments, inpatient psychiatric facilities and other social service organizations, the baseline community cost of serving this population in the project model would be a significantly less than current community costs.

084859002.3.8	*[Outcome Measure (Improvement Target)* ***IT-9.2***	***ED appropriate utilization; reduce ED visits for targeted population of behavioral health and substance abuse.***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects: P-1 & P-2	084859002.3.8		
Starting Point/Baseline: Untreated individuals with Axis II diagnoses have a higher utilization of more costly services such as ED visits, homelessness, criminal justice involvement and inpatient hospital 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 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric 1 – P-1.1** **Baseline/Goal:** Develop a comprehensive plan. **Data Source:** Documentation of care management plan. **Milestone 1 Estimated Incentive Payment:** $ 0	**Milestone 2 –** P-2 Establish baseline data. **Metric 1 –** P-2. **Baseline/Goal:** 1 Establish baseline data. **Data Source:** HOTRMHMR Clinical system. **Milestone 2 Payment:** $ 142,001	**Outcome Improvement Target 1** IT-9.2 **Improvement Target:** reduce the number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to an emergency department within the measurement period by 15% **Data Source:** Clinical records. **Outcome Improvement Target 1Estimated Incentive Payment*:*** $ 134,210	**Outcome Improvement Target 2** IT-9.2 **Improvement Target:** reduce the number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a emergency department within the measurement period by 25% **Data Source:** Clinical records. **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $ 215,562

084859002.3.8	*[Outcome Measure (Improvement Target)* ***IT-9.2***	***ED appropriate utilization; reduce ED visits for targeted population of behavioral health and substance abuse.***	
Heart of Texas Region MHMR Center			*084859002*
Related Category 1 or 2 Projects: P-1 & P-2	084859002.3.8		
Starting Point/Baseline: Untreated individuals with Axis II diagnoses have a higher utilization of more costly services such as ED visits, homelessness, criminal justice involvement and inpatient hospital care.			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $ 142,001	Year 4 Estimated Outcome Amount: $ 134,210	Year 5 Estimated Outcome Amount: $ 215,562
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 491,773			

Category 3 Outcomes
Hillcrest Baptist Medical Center [138962907]
OD-13: Palliative Care

- **Identifying Outcome Measure and Provider Information:** Outcome Domain 13: Palliative Care; Improvement Target 13.1: Pain assessment (NQF-1637); [138962907.3.1]; Hillcrest Baptist Medical Center (138962907).

- **Outcome Measure Description:** Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. To achieve improvement under this metric, Hillcrest will engage in project planning during DY 2. In DY 3, Hillcrest will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Hillcrest intends to improve its proportion screened for pain within 24 hours but the goal is currently TBD. In DY 5, Hillcrest intends to improve its proportion of patients in the Palliative Care program who receive pain assessment in the first 24 hours with the additional improvement goal TBD.
- **Rationale:** Hillcrest used an approximation of 5% (334 patients) of discharges in order to identify the potential number of palliative care patients. Mature palliative care programs expect 30-40% of appropriate patients to be referred to a palliative care program. Using a conservative 20% calculation based on previous patient data yields a cost to Hillcrest Baptist Medical Center of approximately $28 million due to LOS and advanced acute care expenses over a one year timeframe. Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. Poor pain assessment can lead to improper treatment, longer lengths of stay, and higher costs due to readmission. In order to record this reduction, Hillcrest must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

- **Outcome Measure Valuation:** $608,334. In determining the value of this outcome measure, Hillcrest considered the extent to which a reduction in the proportion of patients properly assessed for pain will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this outcome measure also takes into account the challenges that Hillcrest will face in realizing this improvement in the hospital setting.

138962907.3.1	*13.IT-13.1*	*Palliative Care*	
Hillcrest Baptist Medical Center			*138962907*
Related Category 1 or 2 Projects:	138962907.2.1		
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)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $_125,000	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $__83,333	**Outcome Improvement Target 1** [IT-13.1]: Pain assessment: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Improvement Target: TBD. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $__125,000__	**Outcome Improvement Target 2** [IT-13.1]: Pain assessment: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Improvement Target: TBD . Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $_275,000_
Year 2 Estimated Outcome Amount: $_125,000	Year 3 Estimated Outcome Amount: $__83,333_____	Year 4 Estimated Outcome Amount: $_125,000_	Year 5 Estimated Outcome Amount: $_275,000_
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $_608,333_			

Category 3 Outcomes
Hillcrest Baptist Medical Center [138962907]
OD-13: Palliative Care

- **Identifying Outcome Measure and Provider Information:** Outcome Domain 13: Palliative Care; Improvement Target 13.2: Treatment preferences (NQF-1641); [138962907.3.2]; Hillcrest Baptist Medical Center (138962907).

- **Outcome Measure Description:** Percentage of hospice or palliative care patients who have documented preferences for life sustaining measures. To achieve improvement under this metric, Hillcrest will engage in project planning during DY 2. In DY 3, Hillcrest will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Hillcrest intends to improve its percentage of palliative care patients who have documented preferences for life-sustaining treatments, but the goal is currently TBD. In DY 5, Hillcrest intends to improve upon this percentage even further over baseline but the additional improvements are still TBD.
- **Rationale:** Hillcrest used an approximation of 5% (334 patients) of discharges in order to identify the potential number of palliative care patients. Mature palliative care programs expect 30-40% of appropriate patients to be referred to a palliative care program. Using a conservative 20% calculation based on previous patient data yields a cost to Hillcrest Baptist Medical Center of approximately $28 million due to LOS and advanced acute care expenses over a one year timeframe. Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. Unnecessary use of life-sustaining medical interventions can be extremely costly, unpleasant, and ultimately against the patient's true wishes. A reduction in the use of these types of interventions could provide greater patient satisfaction, while helping to reduce the massive costs that often occur in the last portion of a person's life. In order to record this reduction, Hillcrest must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

- **Outcome Measure Valuation:** $608,334. In determining the value of this outcome measure, Hillcrest considered the extent to which a reduction in the use of expensive and invasive life-sustaining treatments will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this outcome measure also takes into account the challenges that Hillcrest will face in realizing this improvement in the hospital setting.

138962907.3.2	*13.IT-13.2*	*Palliative Care*	
Hillcrest Baptist Medical Center			*138962907*
Related Category 1 or 2 Projects:	138962907.2.1		
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)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $_125,000	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $__83,333	**Outcome Improvement Target 1** [IT-13.2]: Treatment Preferences: Percentage of patients with chart documentation of preferences for life sustaining treatments. Improvement Target: TBD. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $__125,000__	**Outcome Improvement Target 2** [IT-13.2]: Treatment Preferences: Percentage of patients with chart documentation of preferences for life sustaining treatments. Improvement Target: TBD . Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $_275,000_
Year 2 Estimated Outcome Amount: $_125,000	Year 3 Estimated Outcome Amount: $__83,333_____	Year 4 Estimated Outcome Amount: $_125,000_	Year 5 Estimated Outcome Amount: $_275,000_
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $_608,333_			

Category 3 Outcomes
Hillcrest Baptist Medical Center [138962907]
OD-13: Palliative Care

Identifying Outcome Measure and Provider Information: Outcome Domain 13: Palliative Care; Improvement Target 13.5: Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified); [138962907.3.3]; Hillcrest Baptist Medical Center (138962907).

- **Outcome Measure Description:** Percentage of hospice or palliative care patients who have documented religious/spiritual preferences or a notation that they did not want to discuss such things. To achieve improvement under this metric, Hillcrest will engage in project planning during DY 2. In DY 3, Hillcrest will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Hillcrest intends to improve its proportion admitted to the ICU in the last 30 days of life but goal is currently TBD. In DY 5, Hillcrest intends to improve its proportion of patients admitted to the ICU in the last 30 days of life with the additional improvements TBD.
- **Rationale:** Hillcrest used an approximation of 5% (334 patients) of discharges in order to identify the potential number of palliative care patients. Mature palliative care programs expect 30-40% of appropriate patients to be referred to a palliative care program. Using a conservative 20% calculation based on previous patient data yields a cost to Hillcrest Baptist Medical Center of approximately $28 million due to LOS and advanced acute care expenses over a one year timeframe. Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. Acute care settings may not align with the spiritual/religious goals of the patient, so it is important to proactively attempt to address these issues with each individual. Hillcrest will seek to capture the patient wishes and satisfaction expectation in order to avoid costly and unnecessary care. In order to record this reduction, Hillcrest must first engage in planning and baseline measurement in DYs 2 and 3, respectively.
- **Outcome Measure Valuation:** $608,334. In determining the value of this outcome measure, Hillcrest considered the extent to which a reduction in the use of unnecessary acute care resources will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this outcome measure also takes into account the challenges that Hillcrest will face in realizing this improvement in the hospital setting.

138962907.3.3	*13.IT-13.5*	*Palliative Care*	
Hillcrest Baptist Medical Center			*138962907*
Related Category 1 or 2 Projects:	138962907.2.1		
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)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $_125,000	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $__83,333	**Outcome Improvement Target 1** [IT-13.5]: Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. Improvement Target: TBD. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $__125,000__	**Outcome Improvement Target 2** [IT-13.5]: Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. Improvement Target: TBD . Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $_275,000_
Year 2 Estimated Outcome Amount: $_125,000	Year 3 Estimated Outcome Amount: $__83,334_____	Year 4 Estimated Outcome Amount: $_125,000_	Year 5 Estimated Outcome Amount: $_275,000_
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $_608,334_			

Title of Outcome Measure (Improvement Target): **IT-3.1 All Cause 30 Day Readmission Rate**

Unique RHP outcome identification number: **138962907.3.4 (Hillcrest Baptist Medical Center)**

- **Outcome Measure Description:** To achieve improvement under this metric, Hillcrest will engage in project planning during DY 2. In DY 3, Hillcrest will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Hillcrest intends to determine the goal for improving its all-cause 30-day readmission rate over the baseline recorded in DY 3. In DY 5, Hillcrest intends to improve its all-cause 30-day readmission rate by an additional amount TBD over the baseline.

- **Rationale:** According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving access to specialty care and follow up. Patients must currently drive over 40 miles to receive follow up care or assessments from a specialist provider. There is some limited local availability, but this plan will expand specialty coverage in the communities where the patients actually live. This follows the triple aim of right care, right place, and right time. There are over 800 inpatient admissions per year from Limestone County at HBMC, so the reduction in the all cause 30 day readmission rate would show a broad approach to meeting the specialty needs of the outlying community. There are also significant costs involved with unplanned readmissions, so there could be significant financial benefits in lowering these rates as well as improving the overall health of the chronically ill in Limestone County. In order to achieve this reduction, Hillcrest must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

- **Outcome Measure Valuation:** $847,930. In determining the value of this outcome measure, Hillcrest considered the extent to which a reduction in the all cause 30 day readmission rate will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this outcome measure also takes into account the challenges that Hillcrest will face in realizing this improvement in the hospital setting.

138962907.3.4	*3.IT-3.1*	*All Cause 30 Day Readmission Rate*	
Hillcrest Baptist Medical Center			*138962907*
Related Category 1 or 2 Projects:	138962907.1.1		
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)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $_134,037	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $_109,254	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: TBD improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $__177,497__	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate. Improvement Target: TBD improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $_427,142_
Year 2 Estimated Outcome Amount: $_134,037	Year 3 Estimated Outcome Amount: $__109,254__	Year 4 Estimated Outcome Amount: $_177,497_	Year 5 Estimated Outcome Amount: $_427,142_
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $_847,930_			

Patient Satisfaction –RHP Project 140714001.3.1

South Limestone Hospital District/140714001

- **Outcome Measure Description:** -- South Limestone Hospital District(SLHD) will survey patient in the wound care clinic to determine patient satisfaction. We will be using the HCAHPS Survey. The target of this project is to improve patient satisfaction by 3% at the end of the project (DY5).

- **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:** Measuring Patient Satisfaction is addressed with the accomplishment of this project. This project is directly related to the category 2 project 140714001.2.1 The measures for the project include the following questions:

    1. Are getting timely care, appointments, and information
    2. Patients overall health status/functional status

The HCAHPS Survey will provide the data for determining percent improvement in targeted patient satisfaction domain (numerator) and number of patients who were administered the survey (denominator). DY2 will be an implementation year and a process measure will be used to gauge successful implementation of surveys. DY2 will serve as the baseline. DY3-5 will have the goal of improving the baseline by 3%.

140714001.3.1	*IT-6.1*	*Patient Satisfaction*	
South Limestone Hospital District			130089906
Related Category 1 or 2 Projects::	140714001.2.1		
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 *IT-6.1*: HCAHPS Survey Data Source: HCAHPS Survey Process Milestone 1 Estimated Incentive Payment *(maximum amount): 45,515*	**Outcome Improvement Target 1** *IT-6.1*: 1 % improvement over baseline satisfaction scores (1) are getting timely care, appointments, and information Data Source: : HCAHPS Survey Outcome Improvement 1 Estimated Incentive Payment: $26,379 **Outcome Improvement Target 2** *IT-6.1*: 1 % improvement over baseline satisfaction scores (5) patient's overall health status/functional status Data Source: : Patient survey HCAHPS Survey Outcome Improvement 2 Estimated Incentive Payment: $26,379	**Outcome Improvement Target 1** *IT-6.1*: 2 % improvement over baseline satisfaction scores (1) are getting timely care, appointments, and information Data Source: : HCAHPS Survey Outcome Improvement 1 Estimated Incentive Payment: $42,329 **Outcome Improvement Target 2** *IT-6.1*: 2 % improvement over baseline satisfaction scores (5)patient's overall health status/functional status Data Source: : HCAHPS Survey Outcome Improvement 2 Estimated Incentive Payment: $43,329	**Outcome Improvement Target 1** *IT-6.1*: 3 % improvement over baseline satisfaction scores (1) are getting timely care, appointments, and information Data Source: : HCAHPS Survey Outcome Improvement 1 Estimated Incentive Payment: $101,222.50 **Outcome Improvement Target 2** *IT-6.1*: 3 % improvement over baseline satisfaction scores (5)patient's overall health status/functional status Data Source: HCAHPS Survey Outcome Improvement 2 Estimated Incentive Payment: $101,222.50

Year 2 Estimated Outcome Amount: $45,515	Year 3 Estimated Outcome Amount: $52,758	Year 4 Estimated Outcome Amount $84,658	Year 5 Estimated Outcome Amount: $202,445
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ $385,376			

Providence Healthcare Network
111829102

- **Title of Outcome Measure (Improvement Target):** IT-6.1 - Percent improvement over baseline of patient satisfaction scores
- **Unique RHP outcome identification number(s):** 111829102.3.1
- **Outcome Measure Description:**
    - IT-6.1 - Percent improvement over baseline of patient satisfaction scores
        - Rate 1: are getting timely care, appointments, and information

Process Milestones:

- DY2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-2 – Establish baseline rates for Rate 1

Outcome Improvement Targets for each year:

- DY4: IT-6.1 Rate 1: Percent improvement over baseline of patient satisfaction scores: are patients getting timely care, appointments and information by 5% above baseline
- DY5: IT-6.1 Rate 1: Percent improvement over baseline of patient satisfaction scores: are patients getting timely care, appointments and information by 5% above DY4 baseline

Rationale:

- Process milestones – P-1 and P-2 were chosen in order to test the current resources available in the region, and monitor resources as the telemedicine program is implemented in the region. As a result of the impending new program, these milestones will address the lack of accurate reports and resources currently available to measure and monitor patient satisfaction related to the regional telemedicine system. In order to report accurate data and establish baselines, P-1 must be accomplished in DY2. In DY3 we will establish baselines for Rate 1 with P-2.
- Improvement targets were chosen for Rate 1 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a new program. The outcome measures addressed by this project are largely affected by social determinants other than increased access to services. For

instance, transportation issues, cultural and behavioral issues, and childcare issues will affect a patient's perception of service received.

Outcome Measure Valuation:

- $1,962,025. In determining the value of this outcome measure, Providence considered the extent to which an improvement in patient satisfaction scores will address the community's needs, the population which this improvement will serve, the resources and cost necessary to realize the improvement, and the improvement's conformity to the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, the valuation of this outcome measure takes into account the fact that patient satisfaction scores in the identified areas will be a good indicator of whether Providence's related Category 1 project are successful in their goals. The valuation of this outcome measure also takes into account the challenges Providence will face in maintaining a telemedicine program appropriate to the patient populations served.

- **Starting Point/Baseline (if applicable):**
  Telemedicine services are currently not offered in Region 16, so no baseline has been established. Beginning in DY4, we expect to begin seeing improvement in patient satisfaction scores established in DY3 that will continue in DY5 and future years.

111829102.3.1	*6.IT-6.1*	*Patient Satisfaction*	
Providence Health Center			*111829102*
Related Category 1 or 2 Projects:	*111829102.1.1*		
Starting Point/Baseline:	*Will be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation showing engagement of stakeholders Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $231,727	**Process Milestone 2 [P-2] :** Establish baseline rates Data Source: Patient Surveys Process Milestone 2 Estimated Incentive Payment: $268,602	**Outcome Improvement Target 1** [IT-6.1]: Improvement Target: Are getting timely care, appointments, and information? Data Source: HCAHPS **Goal:** 5% over baseline Outcome Improvement Target 1 Estimated Incentive Payment*:* $431,013	**Outcome Improvement Target 2** [IT-6.1]: Improvement Target: Are getting timely care, appointments, and information? Data Source: HCAHPS **Goal:** 5% over baseline Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,030,683
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $231,727	Year 3 Estimated Outcome Amount: $268,602	Year 4 Estimated Outcome Amount: $431,013	Year 5 Estimated Outcome Amount: $1,030,683
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,962,025			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Category 4

Category 4: Population-Focused Improvements

Coryell Memorial Hospital/134772611

134772611.4.1-4.6

- Coryell Memorial Hospital (CMH) will report on five 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)
  - Domain 6 – N/A

CMH has identified the following DSRIP projects:

134772611.1.4 1.1.2 - Expand Existing Primary Care Capacity	Expansion of existing space to accommodate additional providers; expand clinic hours to provide primary care services in order to increase access at times convenient to patients.	134772611.3.13 134772611.3.14 134772611.3.15 134772611.3.16 OD 12-IT-12.1, IT-12.2, IT-12.3; OD 1-IT-1.7 Primary Care and Primary Prevention, Primary Care and Chronic Disease Mgt
134772611.1.5 1.9.2 Improve Access to Specialty Care	Lead a specialty care expansion in a rural county to increase access.	134772611.3.17 OD-3-IT-3.1 Potentially Preventable Readmission – All Cause 30 day readmission rate
134772611.1.3 1.7 - Introduce, Expand, or Enhance Telemedicine/Telehealth	Implement a telepsych program in the emergency room to expedite care for the patient and others seeking care in the emergency room and ensure patients receive appropriate evaluations.	134772611.3.9 OD-1 IT-1.20 Primary Care and Chronic Disease Management
134772611.2.5	Improve access for patients and better	134772611.3.18

2.1.3 Implement Medical Home in Rural Area	coordination of preventive and chronic care.	OD-9-IT-9.2 Right Care, Right Setting
134772611.2.6 2.6.3 Regional Health Promotion Program	Regionally address health literacy for RHP 16 using community health workers.	134772611.3.19 134772611.3.20 134772611.3.21 OD-11-IT-11.3 Increase Preventive Screenings for high blood pressure, lipid disorders and type 2 diabetes mellitus
134772611.2.7 Regional Disease Prevention Program Obesity	Regionally address childhood obesity	134772611.3.22 OD-10-IT-10.1 Quality of Life
134772611.2.4 2.10 - Use of Palliative Care Programs	Regional project that enables local caregivers and providers to introduce and implement a palliative care program for the Medicaid and Indigent population as well as coordinated transitions for patients in a palliative care program from an acute care facility to the local rural facilities.	134772611.3.10 134772611.3.11 134772611.3.12 OD-13 IT-13.1, 13.2, 13.5

Below is a listing of Category 4 domains and how our projects could impact these reports.

Domain	Description
Domain 1 – Potentially Preventable Admissions	134772611.1.4, 134772611.2.5, 134772611.2.6 CMH is initiating two projects that will increase access to primary care. One project will increase the number of available primary care physicians and another will implement the medical home model within the rural health clinic(s) to improve care coordination and available services. Both projects will reduce the number of PPAs. The health literacy program will also address preventive screenings that can prevent PPAs.
Domain 2 – Potentially Preventable Readmissions	134772611.1.5

	CMH has proposed an expansion of specialty services in the rural health clinic to better manage chronic conditions which will ultimately improve the PPR rate.
Domain 3 – Potentially Preventable Complications	CMH will report on this measure although we do not have a project with an identified outcome specifically related to PPCs.
Domain 4 – Patient-Centered Healthcare	134772611.2.6, 134772611.2.7 CMH is implementing a regional disease prevention project for childhood obesity and measuring pediatric quality of life which will improve patient satisfaction. A regional health literacy program will also assist patients with access to preventive screenings and improved self-management skills.
Domain 5 – Emergency Department	134772611.1.3 A new ER telepsych program in partnership with Providence Medical Center will greatly reduce the decision time to transfer patients
Domain 6 – N/A	

- $3,806,343. Domain Valuation: Valuations were estimated at 9% of funds available over DY 2-5 and divided equally across the reporting domains. This will enable us to make the necessary technological improvements to generate the reports related to all the projects in our DSRIP menu. Utilizing this information between projects and total population change during the next 4 years will enable CMH to more efficiently determine how to reduce overall healthcare costs and increase community value for RHP 16.

Category 4: Population-Focused Measures *Coryell Memorial Hospital 134772611*				
	Year 2 (10/1/2012 – 9/30/2013)	**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 ,	$441,343	$207,572		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$207,572	$222,808	$242,620
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$207,572	$222,808	$242,620
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$222,808	$242,620
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
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
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		$207,572	$222,808	$242,620
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		$207,572	$222,808	$242,620
<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$441,343	$1,037,860	$1,114,040	$1,213,100

Performing Provider Name/TPI: Hillcrest Baptist Medical Center (138962907)

Domain Description

Hillcrest Baptist Medical Center will report on the five required domains. These domains are:

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)

Hillcrest Baptist Medical Center (HBMC) will provide a report on what changes were made in order to measure and report the required domains in DY3. The results of these metrics will actually be monitored and reported for DY4 and DY5. The domains are related to the goals of the Palliative Care project (138962907.2.1) and Specialty Care Expansion project (138962907.1.1) being proposed by HBMC.

Domain Descriptions:

Domain 1: Potentially Preventable Admissions

Both projects being proposed should help to reduce the number of potentially preventable admissions. The category 2 Palliative Care project should help to more appropriately diagnose the right setting and right level of care for patients, which can help to reduce admissions to the acute care setting. The category 1 Expansion of Specialty Care also helps to address under-served patients where they live. This proactive approach should help to reduce the number of complications that tend to fester and lead to a higher number of acute care admissions. These projects both have the ability to improve outcomes for patients across RHP 16, with the category 1 project hyper-focusing on Limestone County.

Domain 2: Potentially Preventable Readmissions – 30 days

The projects being proposed should help to reduce the number of potentially preventable readmissions within 30 days. The category 2 Palliative Care project should help to more appropriately diagnose the right setting and right level of care for patients, which can help to reduce readmissions to the acute care setting. The category 1 Expansion of Specialty Care also helps to address under-served patients where they live. This proactive approach should help to reduce the number of complications that may arise from poor follow-up care or a lack of follow-up care all together. These projects both have the ability to improve outcomes for patients across RHP 16, with the category 1 project hyper-focusing on Limestone County.

Domain 3: Potentially Preventable Complications

The category 2 Palliative Care project will include inpatient consults, which can help to direct care in a more appropriate manner based on the patients' wishes and beliefs. This project hopes to reduce the length and severity of inpatient acute care stays, which should help to reduce several PPC's that have a higher risk associated with longer hospital stays. The other project focused on specialty care expansion is not expected to impact inpatient PPC's.

Domain 4: Patient-Centered Healthcare

Our category 2 Palliative Care project is primarily meant to address patient needs, wishes, and beliefs in a manner that best maximizes their quality of life. This project will include inpatients that are initially enrolled into the program or on-going patients that will have a palliative care team to help address patient satisfaction expectations as well as medication reconciliation both in the hospital and upon discharge. Our other specialty care expansion project is not likely to impact RD-4.

Domain 5: Emergency Department

The two proposed projects are not likely to have any direct impact on ED times.

Domain Valuation

The Domains were equally valued at the 10% level based on the overall project size and scope. Between the Category 1 and 2 projects, a large number of patients in RHP 16 will be served. HBMC serves as the safety net hospital and is the only Level 2 trauma center in RHP 16. For these reasons, a large number of people in the indigent and Medicaid populations stand to benefit from these two projects. The projects both address the triple aim of right care, right place, and right time. The populations being served in this region generally have higher rates of poverty and poorer health than the state averages, which contributes to higher case mix indexes being seen in the hospital. All of these domains should help to measure, assess, and then address the challenges and opportunities that are consistent with the goals of the 1115 waiver transformation process.

Category 4: Population-Focused Measures *[Hillcrest Baptist Medical Center/138962907]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$0	$71,854		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$71,850	$73,666	$75,495
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$71,850	$73,666	$75,495
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	
Domain 3 - Estimated Maximum Incentive Amount			$73,666	$75,495
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
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
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		$71,850	$73,666	$75,495
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		$71,850	$73,666	$75,495
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$	$359,254	$368,331	$377,477

Category 4: Population-Focused Improvements (Hospitals only)

Providence Healthcare Network
111829102
11829102.4.1

- **Domain Descriptions:**
  Providence Healthcare Network will be the Performing Provider for the following DSRIP project.

111829102.1.1 - Expand Telemedicine Capacity Providence Healthcare Network - 111829102	Regionally lead Telemedicine expansion in order to increase access to needed behavioral health care.	111829102.3.1 OD-6 Patient Satisfaction IT 6.1 Percent improvement over baseline patient satisfaction scores

- Category 4 domains and measures will be impacted by telemedicine capabilities targeting patients who present to the ED for behavioral health needs. Providence Health Center currently does not offer these but will develop a program that will benefit both McLennan County as well as Region 16. At this point we have chosen to not participate in the optional domain due to the lack of data currently utilized in a statistically significant way. Below is a listing of Category 4 domains and how our projects could impact these reports.
-

Domain	Description
Potentially Preventable Admissions	Providence Health Center's telemedicine project will be designed to get patients with behavioral health needs to the appropriate setting of care that can address both their psychological needs as well as other health problems.
Potentially Preventable Readmissions – 30 days	Providence Health Center will work with our regional partners to evaluate patients for behavioral patterns that can be addressed through outpatient counseling our inpatient psychiatric care.
Potentially Preventable Complications	Though we will report this measure, we do not have a DSRIP project directly related to PPCs.

Patient-Centered Healthcare	Patient Satisfaction is expected to be impacted as patients are more engaged in their treatment plans through the behavioral health telemedicine project as well as patients indirectly impacted by behavioral health patients being treated in the ED.
Emergency Department	Providence Health Center's telemedicine project will be designed to get patients with behavioral health needs to the appropriate setting of care that can address both their psychological needs as well as other health problems.
Children and Adult Core Measures (OPTIONAL)	N/A

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- **$984,128. Domain Valuation**: Valuations were estimated based on estimated expenses to report on Domain's 1-6 as well as estimated value generated by data obtained. Utilizing this information will enable Providence Health Center to reduce overall healthcare costs and increase community value for RHP 16. Using guidelines set forth in the DSRIP Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally.

Category 4: Population-Focused Measures *Providence Health Center/111829102*				
111829102.4.1	**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)**
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	$115,863	$53,720		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$53,720	$57,468	$62,465
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$53,720	$57,468	$62,465
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			$57,468	$62,465
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
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
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		$53,720	$57,468	$62,465
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		$53,729	$57,468	$62,465
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$115,863	$268,600	$287,340	$312,325

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 the best of my knowledge and belief.

Signature	Name	Organization
See Addendum with Signatures	**David Byrom**	**Coryell Memorial Hospital, Anchor**
	Eldon Tietje	**Central Counties MHMR**
	Julie Stimmel	**Falls Community Hospital and Clinic**
	Adam Willmann	**Goodall Witcher**
	Michele Cathey	**Hamilton General Hospital**
	Steven Dorris	**Hill Regional Hospital**
	Richard Perkins	**Hillcrest Baptist Medical Center**
	Barbara Tate	**HOT MHMR**
	Larry Price	**Limestone Medical Center**
	Karen Richardson	**Providence Health Center**

Section VII. Addendums

- *Collaboration Letters: Pass 1 & Pass 2*
- *Private hospital certifications –*
    - *Hillcrest Baptist Medical Center*
- *Letters of Support*
- *RHP 16 Newsletter*
- *Revised Pass 1 workbook for Hillcrest Baptist Medical Center*
- *Revised Pass 1 workbook for Falls Community Hospital and Clinic*