Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

March 2013

RHP 19

RHP Lead Contact: *Jan Reed, CEO*
Electra Hospital District
PO Box 1112
Electra, TX 76360
Jan.reed@electrahospital.com
940-495-3981

Table of Contents

Section I. RHP Organization 1

Section II. Executive Overview of RHP Plan 11

Section III. Community Needs Assessment 26

INTRODUCTION 28

Section IV. Stakeholder Engagement 44

- RHP Participants Engagement 44
- Public Engagement 45

Section V. DSRIP Projects 48

- RHP Plan Development 48
- Project Valuation 50
- Section V. Category 1 Projects 51
- Section V. Category 2 224
- Section V. Category 3 371
- Section V. Category 4 526

Section VI. RHP Participation Certifications 549

Section VII. Addendums 551

Instructions

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

Timeline:

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

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

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

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

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

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

Please mail RHP Plan packets to:

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

11209 Metric Blvd.
Austin, Texas 78758

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

Section I. RHP Organization

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

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

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Anchoring Entity						
Public Hospital District	135034009	1756219138 1 002	Non-State-owned public entity	Electra Hospital District	Jan Reed	P.O. Box 1112 1207 S. Bailey Street Electra, TX, 76360 jan.reed@electrahospital.com 940-495-3981
IGT Entities						
Public Hospital District	138353107	1752299922 0 501	Non-State-owned public entity	Baylor County Hospital District	Leslie Hardin	200 Stadium Drive, Seymour, TX, 76380 940-889-5572

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)
						lhardin@seymourtexas.net
Public Hospital Authority	127305405	1751220799 8 002	Non-State-owned public entity	Bowie Memorial Hospital	T. Kim Lee	705 E Greenwood Avenue, Bowie, TX, 76230 klee@bowiememorial.com 940-872-9374
City Owned Hospital	130613604	1751919268 0 501	Non-State-owned public entity	City of Graham d/b/a Graham Regional Medical Center	Steve Hartgraves	1301 Montgomery Road, Graham, TX, 76450 shartgraves@grahamrmc.com 940-521-5303
County Owned Hospital	094138703	1756000727 4 001	Non-State-owned public entity	Clay County d/b/a Clay County Memorial Hospital	Jeff Huskey	310 West South Street Henrietta, TX, 76365, jhuskey@ccmhospital.com 940-538-5621
Public Hospital District	135034009	1756219138 1 002	Non-State-owned public entity	Electra Hospital District	Jan Reed	1207 S. Bailey Street Electra, TX, 76360 jan.reed@electrahospital.com 940-495-3981
Public Hospital District	121777003	1751091664 0 501	Non-State-owned public	Gainesville Hospital	Randy Bacus	1900 Hospital Blvd. Gainesville, TX, 76240

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)
			entity	District		940-665-1751 randy.bacus@ntmconline.net
Public	121692107	1756002047 5 000	Non-State-owned public entity	Hardeman County Memorial Hospital	Carol Lively	402 Mercer Street Quanah, TX 79252 carol.lively@hcmhosp.com 940-663-2795
Public Hospital District	119874904	1756004585 2 001	Non-State-owned public entity	Jack County Hospital District	Frank Beaman	717 Magnolia Street, Jacksboro, TX, 76458 fbeaman@fchtexas.com 940-567-6633 x236
Public Hospital	120745806	1751244289 2 501	Non-State-owned public entity	Muenster Memorial Hospital	Michael Kent	605 North Maple Muenster, TX 76252 mkent@trhta.net (940) 759-2271
Public Hospital District	127310404	1751368648 9 001	Non-State-owned public entity	Nocona General Hospital District	Lance Meekins	100 Park Road Nocona, TX, 76255 lmeekins@naconageneral.com 940-825-3235
Public Hospital District	110856504	1756001727 3 001	Non-State-owned public	Olney-Hamilton	Michael Huff	901 West Hamilton, Olney, TX, 76374

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)
			entity	Hospital District		mhuff@olneyhh.com 940-564-5521
County Owned Hospital	088189803	1756003473 2 001	Non-State-owned public entity	Throckmorton County Memorial Hospital	Bob Carruthers	802 North Minter St, Throckmorton, TX, 76483
Public Hospital District	112707803	1756047638 8 000	Non-State-owned public entity	Wilbarger General Hospital District	Jonathon Voelkel	920 Hillcrest Drive Vernon, TX, 76384 jvoelkel@wghospital.com 940-553-2882
Public Hospital District	154632701	1756002948 4 000	Non-State-owned public entity	Chillicothe Hospital District	Linda Hall	303 Avenue I, P.O. Box 370, Chillicothe, TX, 79225 linda@chillhd.org 940-852-5131
CMHC	127373205	1751241976 7 000	CMHC	Helen Farabee Centers	Roddy Atkins	P.O. Box 8266, Wichita Falls, TX 76307-8266 Atkinsr@helenfarabee.org (940)397-3101
CMHC	084434201	1 751452360-8014	CMHC	Texoma Community Center	Tony Maddox	315 W McLain Dr, Sherman, TX 75092 tmaddox@mhmrst.org 903-957-4700

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)
Performing Providers						
Not For Profit Hospital	135237906	1751912147 3 003	Private	United Regional Health Care System	Phyllis Cowling	1600 Eleventh Street Wichita Falls, TX, 76301, pcowling@unitedregional.org 940-764-3023
Public Hospital District	138353107	1752299922 0 501	Non-State-owned public entity	Baylor County Hospital District	Leslie Hardin	200 Stadium Drive, Seymour, TX, 76380 940-889-5572 lhardin@seymourtexas.net
Public Hospital Authority	127305405	1751220799 8 002	Non-State-owned public entity	Bowie Memorial Hospital	T. Kim Lee	705 E Greenwood Avenue, Bowie, TX, 76230 klee@bowiememorial.com 940-872-9374
City Owned Hospital	130613604	1751919268 0 501	Non-State-owned public entity	City of Graham d/b/a Graham Regional	Steve Hartgraves	1301 Montgomery Road, Graham, TX, 76450

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)
				Medical Center		shartgraves@grahamrmc.com 940-521-5303
County Owned Hospital	094138703	1756000727 4 001	Non-State-owned public entity	Clay County d/b/a Clay County Memorial Hospital	Jeff Huskey	310 West South Street Henrietta, TX, 76365 jhuskey@ccmhospital.com 940-538-5621
Public Hospital District	135034009	1756219138 1 002	Non-State-owned public entity	Electra Hospital District	Jan Reed	1207 S. Bailey Street Electra, TX, 76360 jan.reed@electrahospital.com 940-495-3981
Public Hospital District	121777003	1751091664 0 501	Non-State-owned public entity	Gainesville Hospital District	Randy Bacus	1900 Hospital Blvd. Gainesville, TX, 76240 940-665-1751 randy.bacus@ntmconline.net
Public	121692107	1756002047 5 000	Non-State-owned public entity	Hardeman County Memorial Hospital	Carol Lively	402 Mercer Street Quanah, TX 79252 carol.lively@hcmhosp.com 940-663-2795
Public Hospital	119874904	1756004585 2	Non-State-	Jack County	Frank Beaman	717 Magnolia Street,

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
District		001	owned public entity	Hospital District		Jacksboro, TX 76458 fbeaman@faithcommunityhospital.com 940-567-6633 x236
Public Hospital	120745806	1751244289 2 501	Non-State-owned public entity	Muenster Memorial Hospital	Michael Kent	605 North Maple Muenster, TX 76252 mkent@trhta.net (940) 759-2271
Public Hospital District	127310404	1751368648 9 001	Non-State-owned public entity	Nocona General Hospital District	Lance Meekins	100 Park Road Nocona, TX, 76255 lmeekins@naconagen eral.com 940-825-3235
Public Hospital District	110856504	1756001727 3 001	Non-State-owned public entity	Olney-Hamilton Hospital District	Michael Huff	901 West Hamilton, Olney, TX, 76374 mhuff@olneyhh.com 940-564-5521
County Owned Hospital	088189803	1756003473 2 001	Non-State-owned public entity	Throckmorton County Memorial Hospital	Bob Carruthers	802 North Minter St, Throckmorton, TX, 76483 bob.carruthers@yahoo.com
Public Hospital District	112707803	1756047638 8 000	Non-State-owned public entity	Wilbarger General Hospital District	Jonathon Voelkel	920 Hillcrest Drive Vernon, TX, 76384 jvoelkel@wghospital.com

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)
						940-553-2882
CMHC	127373205	1751241976 7 000	CMHC	Helen Farabee Centers	Roddy Atkins	P.O. Box 8266, Wichita Falls, TX 76307-8266 Atkinsr@helenfarabee.org (940)397-3101
CMHC	084434201	1 751452360-8014	CMHC	Texoma Community Center	Tony Maddox	315 W McLain Dr, Sherman, TX 75092 tmaddox@mhmrst.org 903-957-4700
UC-only Hospitals						
Public Hospital District	154632701	1756002948 4 000	Non-State-owned public entity	Chillicothe Hospital	Linda Hall	303 Avenue I, P.O. Box 370, Chillicothe, TX, 79225 linda@chillhd.org 940-852-5131

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)
Other Stakeholders						
			Non-State Public	Wichita Falls Wichita County Health District	Lou Kreidler	1700 3rd St. Wichita Falls, TX 76301 Lou.kreidler@wichitafallstx.gov 940-716-8535
			Non-State Public	Archer County	Gary Beesinger	P.O. Box 458 Archer City, TX 76351 Gary.beesinger@co.archer.tx.us 940-574-4811
			Private	Red River Hospital	Rob Marsh	1505 8th St. Wichita Falls, TX 76301 Rob.marsh@acadiahealthcare.com 940-322-3171

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)
			Non-State Public	Wichita county Indigent Health Care	Tonya Gideon	600 Scott Street Wichita Falls, TX 76301 Tonya.gideon@co.wichita.tx.us 940-716-8535
			State	North Texas State Hospital	Lauren Parsons, M.D.	6515 Kemp Blvd. Wichita Falls, TX 76308 Lauren.parson@dshs.state.tx.us 940-692-1220
			Private	North Central Texas Community Health Center	Phyllis Hiraki	P.O. Box 720 Wichita Falls, TX 76301 phiraki@chcwf.com 940-766-6306
			Non-State Public	Young County Indigent Health Care	Marsha Sumpter	516 4th St. Rm. 108 Graham, TX 76450 mreed@wf.net 940-549-7911

Section II. Executive Overview of RHP Plan

RHP 19 is located in north central Texas, just west of Fort Worth, north of Abilene, and southeast of the Panhandle. Of the 12 counties which constitute this region, 11 are Medically Underserved Areas (MUAs) as noted by Health Resources and Services Administration (HRSA) and all have some type of Health Professional Shortage Area (HPSA) designation, including Primary Care, Mental Health and/or Dental Providers. This limitation in access extends to other specialties as well, which the plan addresses. 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 six 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. As noted in Medicaid and other long term care services budgets, 20 percent of patients typically 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. Patient centered health and wellness initiatives, complemented by increased access to needed specialty care, give patients the tools necessary to better manage their chronic health conditions as they age. Regionally we aim to improve patients' ability to seek and to access primary and preventive services, like vaccinations and wellness plans, and specialty care to prevent more costly and acute admissions into the inpatient hospital setting. In our rural region we also find a great opportunity for care transition coordination when patients discharge from tertiary centers and seek to return home.

RHP 19 has proposed Delivery System Reform Incentive Payment (DSRIP) plans from twelve acute care hospitals and two Community Mental Health Centers (CMHC). At least one hospital in the region will be participating in the Uncompensated Care (UC) pool only. There has been wide provider participation. The hospitals and centers have all actively participated in stakeholder meetings, brainstorming sessions, webinars, and conference calls and are now in the submission phase.

With the various statistical data uncovering quantifiable limitations on patient access to appropriate care professionals and settings, RHP 19 has developed a plan to stop the bleeding with regard to access for patients and residents across the region. Additionally, as the healthcare environment is shifting, the region also developed strategic paths to implement targeted transformational projects as well. RHP 19 goals are to:

- Increase access to the primary care, specialty 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 health promotion and wellness activities and patient satisfaction outcomes which engages patients to take ownership of their health and treatment protocols through patient centered healthcare.

RHP 19 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, more efficient models to deliver quality health care. Our environment and our plans push the needle. Across our region, hospitals have patients seeking non-emergent care in the Emergency Department. Many factors contribute to why a mother, for example, might need to bring a child with lice into the ED for treatment including her surprise that morning when the school wouldn't allow her child to attend due to the presence of lice and her inability to then go to work. This is an example of an urgent need for this family. 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. This example of urgent and/or crisis care needs is not limited to physical health. The same can be true for mental health emergencies. (Non-emergent treatment of lice in the Emergency Department was discovered through investigations of claims data by the Texas Medicaid Program in 2010.)

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.

Other transformational 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, or 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 conditions will further initiatives related to value-based purchasing. As evidence is being uncovered, value-based purchasing and payment variances which reward providers who reduce potentially preventable events, further improves clinical outcomes for patients who might otherwise have encountered 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-Outcomes 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 19 seeks to increase primary and specialty care capacity, increase appropriate care in appropriate settings, better engage patients with diabetes and heart disease in disease management and ongoing preventive and primary care treatments, and expand services and care for persons with Severe and Persistent Mental Illness (SPMI) through the Healthcare Transformation Waiver.

RHP 19 has two state owned psychiatric hospitals in our region. Per guidance from HHSC and the state these hospitals will be included in UC and workbooks accompany the March 2013 plan submission to HHSC. Representatives participated in initial meetings, and we welcome them to the plan.

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			
127305405.1.1, 1.1 Expand Primary Care Capacity Bowie Memorial Hospital 127305405	Expand Primary Care Capacity in Bowie, Texas.	127305405.3.1 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$991,777
Pass 3B *NEW 094138703.1.2 OLD 094138703.1.1*, 1.1 Expand Primary Care Capacity Clay County Memorial Hospital 094138703	Expand Primary Care Capacity in Clay County through additional family practice physicians.	*094138703.3.3 (094138703.3.1)* OD-6 Patient Satisfaction IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$758,431
Pass 3B *New Pass 3B Project 135034009.1.4 (Old Pass 1 Project 135034009.1.1)* 135034009.1.1, 1.1 Expand Primary Care Capacity Electra Memorial Hospital 135034009	Expansion of current clinic space to accommodate additional providers; extend clinic hours to provide primary care services at times convenient to patients in order to reduce emergency department utilization.	135034009.3.5 (135034009.3.1) OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$2,231,365

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 *New Pass 3B Project 135034009.1.5* *(Old Pass 1 Project 135034009.1.2)*, 1.9 - Expand Specialty Care Capacity Electra Memorial Hospital 135034009	Regionally lead a Specialty Care Capacity expansion in order to increase access to needed specialty care.	135034009.3.6 (135034009.3.2) OD-3 Potentially Preventable Re-Admissions - 30 day readmission rates IT 3.2 Congestive Heart Failure 30 day readmission rate	$12,272,513
Pass 3 135034009.1.3., 1.1 Expand primary care capacity/Establish more primary care clinics Electra Memorial Hospital 135034009	1.1.1 Expand primary care capacity/Establish more primary care clinics -Iowa Park	135034009.3.4 OD- 1 Primary Care and Chronic Disease Management IT-1.7 Controlling high blood pressure (Standalone measure)	$2,083,891
Pass 3B *New Pass 3B Project 130613604.1.2* *(Old Pass 2 Project 130613604.1.1)*, 1.1 Expand Primary Care Capacity Graham Regional Medical Center/13613604	Expand capacity in response to growing community need to primary care services.	130613604.3.2 *(130613604.3.1)* OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$4,436,824

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**
110856504.1.1, 1.1 Expand Primary Care Capacity Hamilton Hospital/110856504	Establish More Primary Care Clinics	110856504.3.1. OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$1,303,740
Removed from Section V. ~~121692107.1.1, 1.1 - Expand Primary Care Capacity~~ ~~Hardeman County Memorial Hospital 121692107~~	~~New Primary Care Clinic with dedicated area for education, behavioral health and wellness initiatives.~~ -	~~121692107.3.1~~ ~~OD-9 Right Care, Right Setting~~ ~~IT-9.2 ED appropriate utilization~~	~~$648.420.00~~ -
127373205.1.1, 1.12 - Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care Helen Farabee Center 127373205	Expand the number of community based settings where behavioral health services.	127373205.3.1 OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$2,535,404
127373205.1.2, 1.9 - Expand Specialty Care Capacity Helen Farabee Center 127373205	This project expands the hours for psychiatric evaluation.	127373205.3.2 OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$2,209,380

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**
127373205.1.3, 1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization. Helen Farabee Center 127373205	Develop and Implement crisis stabilization services to address the identified gaps in the current community crisis system	127373205.3.3 OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$2,941,950
Pass 3B *120745806.1.2* *(120745806.1.1)* , 1.11 Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health service Muenster Memorial Hospital 120745806	Improve patient safety through improving pharmacist oversight of prescriber orders	120745806.3.2 (120745806.3.1) OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions IT-4.5 Patient Fall Rate- NQF 0141255 (Standalone measure)	$821,636
Pass 3B *Old Project 121777003.1.1* *Pass 3B New Project #121777003.1.2* 1, 1.1 - Expand Primary Care Capacity North Texas Medical Center 121777003	Expand Primary Care Capacity in Cooke County.	*OLD 121777003.3.1* *NEW 121777003.3.3* OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$5,857,336

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 *New ID: 138353107.1.3* *Old ID: 138353107.1.1*, 1.9 Expand Specialty Care Capacity Seymour Hospital 138353107	Expand OB initiatives to prevent low birth weight babies.	138353107.3.4 (Old ID: 138353107.3.1) OD-8 Perinatal Outcomes IT-8.2 Low Birth Weight	$944,881
Pass 3 138353107.1.2, 1.1 Expand Primary Care Capacity Seymour Hospital 138353107	Increased Access to Primary Care through an Urgent Care Clinic	138353107.3.3 OD-9 OD-9 Right Care, Right Setting IT-9.2, ED Appropriate Utilization	$1,061,876
084434201.1.1, 1.11 - Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services Texoma Community Center 084434201	Expand the number of patients served by scaling up an existing telemedicine system into broader, more comprehensive telehealth services	084434201.3.1 OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$294,813

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084434201.1.2, 1.12 - Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care Texoma Community Center 084434201	Develop Substance Abuse Services	OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$246,449
084434201.1.3, 1.12 - Enhance service availability (i.e., hours, locations, transportation, mobile clinics) to appropriate levels of behavioral health care Texoma Community Center 084434201	Expand Counseling Services To Non-Priority Populations	084434201.3.3 OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$391,951
084434201.1.4, 1.10 - Enhance Performance Improvement and Reporting Capacity Texoma Community Center 084434201	Expand Quality Improvement Capacity Through People, Processes and Technology So That The Resources Are In Place To Conduct, Report, Drive and Measure Quality Improvement	084434201.3.4 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$119,366

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**
135237906.1.1, 1.1 - Expand Primary Care Capacity United Regional Health Care System 135237906	Expand Primary Care Capacity in Wichita Falls.	135237906.3.1 OD-3 Potentially Preventable Re-Admissions - 30 day readmission rates IT 3.5, AMI 30 day readmission	$10,292,852
112707803.1.1, 1.1 Expand Primary Care Capacity Wilbarger General Hospital 112707803	The Walk In Clinic	112707803.3.1 OD-1- Primary Care and Chronic Disease Management IT-1.10 Diabetes care: HbA1c	$647,633
Category 2: Program Innovation and Redesign			
Pass 3B *New 127305405.2.2* *Old 127305405.2.1*, 2.2 Expand Chronic Care Management Models Bowie Memorial Hospital 127305405	Chronic disease management initiatives, such as patient education, self-management support, and improved patient-provider communication techniques.	*127305405.3.3* *(127305405.3.2)* OD-3 Potentially Preventable Re-Admissions-30 day Readmission Rates IT-3.1 All cause 30 day readmission rate	$671,869
Pass 3B Project 094138703.2.2 *Old Project 094138703.2.1* , 2.3 Redesign Primary Care	Redesign Primary Care	**094138703.3.4.** **((094138703.3.2)87** OD-9 Right Care, Right Setting	$474,025

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**
Clay County Memorial Hospital 094138703		IT-9.2 ED appropriate utilization	
Pass 3B Project 135034009.2.2 (Old Pass 1 Project 135034009.2.1), 2.12 - Implement/Expand Care Transitions Programs Electra Memorial Hospital 135034009	Implement Care Transitions	**135034009.3.7 (135034009.3.3)** OD-3 Potentially Preventable Re-Admissions - 30 day readmission rates IT 3.1 All cause 30 day readmission rate	$8,925,464
Pass 3B: *New ID: 119874904.2.3* *Old ID: 119874904.2.1* 1, 2.6 - Implement Evidence-based Health Promotion Programs Faith Community Hospital 119874904	Wellness by Faith	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3* OD-12 Primary Care and Primary Prevention IT 12.1 Breast Cancer Screening IT 12.2 Cervical Cancer Screening IT 12.4 Pneumonia Vaccination	$2,464,929

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 3 119874904.2.2., 2.12 Care Transitions Category Faith Community Hospital 119874904	ED Care Transitions	119874904.3.4 OD-9 Right Care, Right Setting IT 9.2 Appropropriate ED Utilization	$1,135,108
Pass 3B, New: 110856504.2.2 (Old:110856504.2.1), 2.6 - Implement Evidence-based Health Promotion Programs Hamilton Hospital/110856504	Establish Self-Management Programs and Wellness Using Evidence-Based Designs	110856504.3.2 OD-11 Addressing Health Disparities in Minority Populations IT-11.1 Improvement in Clinical Indicator in identified disparity groups	$526,795
Pass 3 127373205.2.1, 2.18 - Recruit, train and support consumers of mental health services to provide peer support services Helen Farabee Center 127373205	Expand the Peer Provider Staffing	127373205.3.4 OD-10 IT-10.1 Quality of Life	$1,940,914
127310404.2.1, 2.4 Redesign to improve patient experience	Improve Patient Experience	1273104043.1 OD-6 Patient Satisfaction	$409,190

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**
Nocona General Hospital 127310404		IT-6.1 Percent improvement over baseline of patient satisfaction scores	
Pass 3 121777003.2.1, 2.12.1 : Implement Care Transitions Program North Texas Medical Center 121777003	Care Transitions Program Targeting Patients with a High Risk of Readmission.	121777003.3.2 OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.2 Congestive Heart Failure 30 day readmission rate	$1,794,205
Pass 3B Project 138353107.2.2 (Old Pass 1 Project 138353107.2.1), 2.6 Implement Evidence Based Health Promotion Programs Seymour Hospital 138353107	Seymour Hospital plans to implement a Community Wellness Program	138353107.3.5 (138353107.3.2) OD-1 Primary Care and Chronic Disease Management IT-1.7, Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018))	$944,879
084434201.2.1, 2.19 - Develop Care Management Function that integrates primary and behavioral health needs of individuals Texoma Community Center 084434201	Combine Primary And Behavioral Healthcare	084434201.3.5 OD-10 Quality of Life/Functional Status IT-10.1 Quality of Life	$367,694

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 3 084434201.2.2, 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.). Texoma Community Center 084434201	Project Option: 2.13.1 -- Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	084434201.3.6 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$705,787
Pass 2---PROVIDER IS REVIEWING NEW PROJECT SUBMISSION BASED ON HHSC GUIDANCE. **088189803.2.1, 2.5 - Redesign for Cost Containment** **Throckmorton County Memorial Hosptital 088189803**	**Cost Containment with CT-Scan and Mobile X-Ray Imaging System**	**088189803.3.1** **OD-5 Cost of Care** **IT-5.1 Improved Cost Savings: Demonstrate Cost Savings in Care Delivery**	**$832,429**
135237906.2.1, 2.5 - Redesign for Cost Containment United Regional Health Care System 135237906	Cost Containment-Transformation	135237906.3.2 OD -5 Cost of Care IT-5.2 Per Episode Cost of Care	$511,423

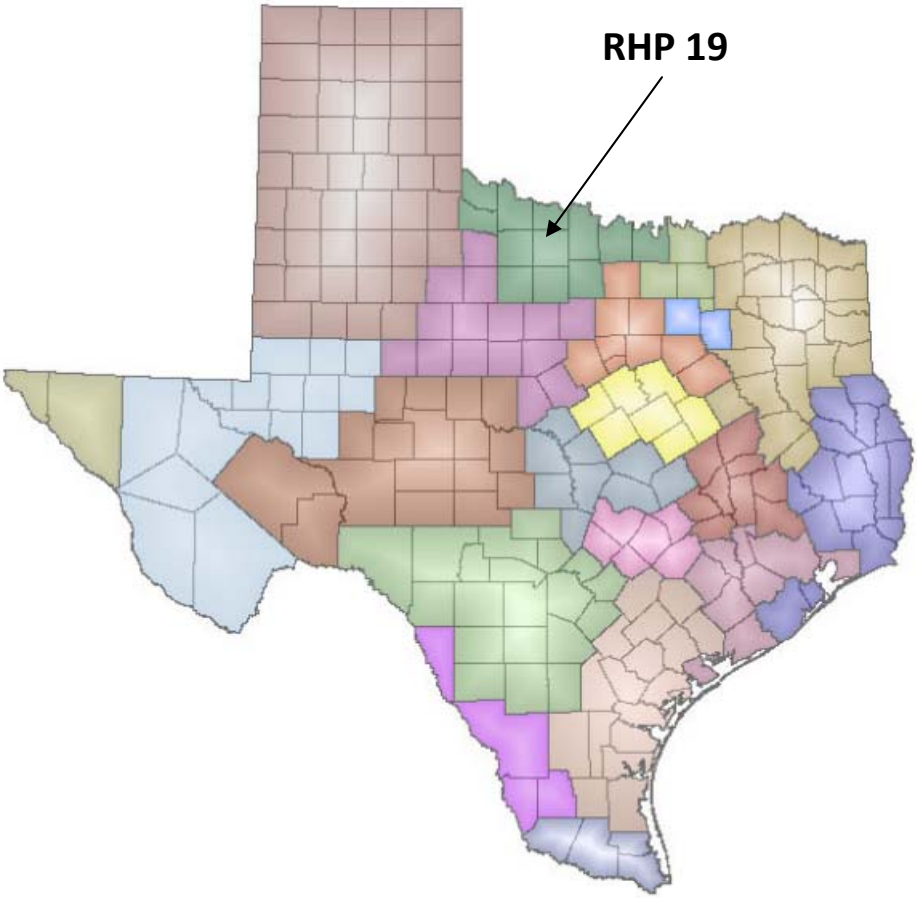
Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
135237906.2.2, 2.10 - Use of Palliative Care Programs United Regional Health Care System 135237906	Palliative Care Unit	135237906.3.3 135237906.3.4 135237906.3.5 OD-13 Palliative Care IT 13.1 Pain Assessment IT 13.2 Treatment Preferences IT 13.5 Spiritual/Religious Counseling	$1,204,052
Pass 3B ***NEW: 135237906.2.4 OLD:*** 135237906.2.3, 2.11 - Conduct Medication Management United Regional Health Care System 135237906	Medication Management	NEW: 135237906.3.7 OLD: 135237906.3.6 OD -6 Patient Satisfaction 6.1- Percent improvement over baseline of patient satisfaction scores	$1,714,673

Section III. Community Needs Assessment

Regional Healthcare Partnership 19

Community Needs Assessment

October 2012



Summary of Community Needs, RHP 19		
	Description	Data Sources
CN.1	High rates of chronic disease, including cancer, diabetes, heart disease, respiratory diseases, and obesity.	•County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation •Texas Department of Health and Human Services
CN.2	High costs associated with preventable hospitalization admissions and readmissions.	•Texas Department of State Health Services, Center for Health Statistics
CN.3	Shortages of health care professionals, including mental health care providers.	•Texas Center for Public Policy Priorities •Texas Department of State Health Services, Center for Health Statistics •Texas Medical Board •US Department of Health and Human Services, Health Resources and Services Administration
CN.4	Low utilization of preventative care services, including sigmoidoscopy, colonoscopy, and immunizations.	•Texas Behavioral Risk Factors Surveillance System
CN.5	Need to overcome patient access to care barriers.	•Texas Behavioral Risk Factors Surveillance System •US Census Bureau
CN.6	Need for improvement in fertility and natality care.	•County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation •Texas Department of Health and Human Services
CN.7	High rate of teen pregnancy.	•Texas Department of State Health Services, Center for Health Statistics
CN.8	High emergency department utilization.	•CDC/NCHS, National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey

INTRODUCTION

A community needs assessment often focuses on barriers to accessing care. It can also describe the primary service area of a hospital, a hospital's patients and its services, other healthcare providers in the area, and demand for services. Community needs assessments also aid in planning and improving access to and quality of care. This assessment concerns Regional Healthcare Partnership (RHP) 19 in Texas, which includes the following 12 counties: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, and Young. The assessment's purpose is to assist RHP 19 as it plans its proposal for the HHSC 1115 Waiver. The Delivery System Reform Incentive Pool (DSRIP) section of the waiver includes the following four categories:

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

This assessment contributes supporting data for Categories 1 & 2. Categories 3 & 4 require data supporting high burden areas in particular, some of which are provided with this document, but again, should be strengthened with data from providers in the region. This assessment includes several supporting data tables and figures, most of which can be found in the appendix. Appendix tables are ordered by letter and are noted in parentheses beside section subtitles.

DATA SUPPORTING INFRASTRUCTURE AND ACCESS DEVELOPMENT

A. Primary Service Area and Potential Patients

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

Population and Counties (Table A in the Appendix supplements information below)
Total population grew by less than 1% from 2000 to 2010. (See Table 1 below.) All but two counties (Clay, Wichita) in RHP 19 are considered rural by the U.S. Census. Population density per square mile for the region is 25.0. Four counties (Baylor, Foard, Hardeman, Throckmorton) in RHP 19 are considered Frontier Counties because they have less than seven people per square mile.

Almost 90% of RHP 19 residents identify as white, while 16% of all people, regardless of race, identify as Hispanic. Eighty-eight percent speak English only. The region's percentage of the population 65 and older (15%) is greater than Texas' percentage (10%).

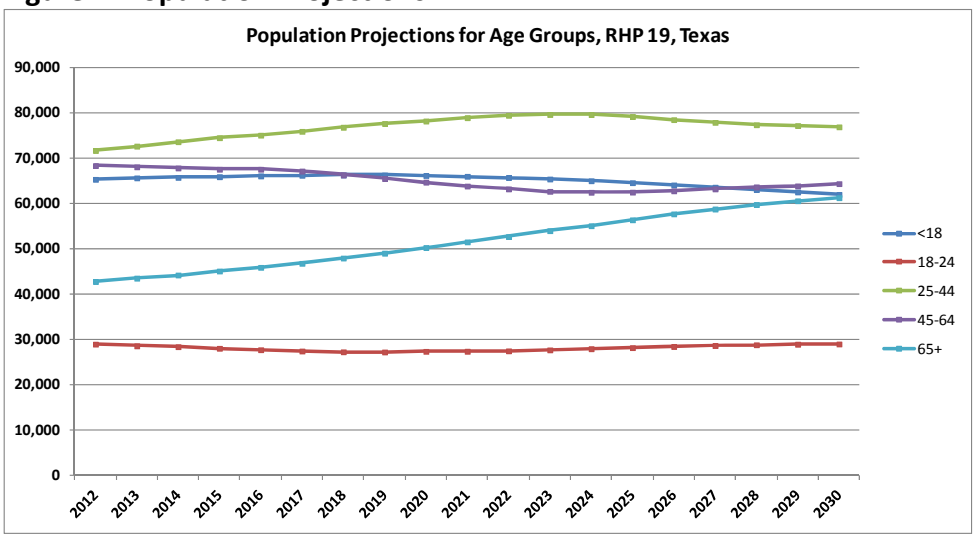
Population Projections

Population growth in RHP 19 is expected to increase 6% from 2012 to 2030, growing from 276,705 to 293,137. People aged 65 and older will continue to account for a larger percentage of the population. (See Figure 1 below.)

Table 1. Population Density

Population and Size, RHP 19, Texas	
Population	
2000	260,675
2010	261,433
2011	260,157
Population of RHP's counties (2011)	
Archer	8,842
Baylor	3,741
Clay	10,721
Cooke	38,396
Foard	1,341
Hardeman	4,176
Jack	9,035
Montague	19,710
Throckmorton	1,609
Wichita	130,698
Wilbarger	13,404
Young	18,484
Size in square miles	
Land area	10,401
Water area	161
Total area	10,562
Population density per square mile (2011)	25.0

Figure 1. Population Projections



Socioeconomic Profile of Residents (Tables B-D)
Eighteen percent of adults 25 years or older in RHP 19 do not graduate from high school. About 24% have some kind of college degree. Almost 16% of all people in the RHP fall below the poverty line. The percentage of children living in poverty is 23%. The percentages of high school dropouts and poor people are expected to increase in Texas. According to demographer Dr. Steve Murdock, "The state's public schools have more and more low-income kids and persistently high dropout rates, and unless that changes, the future of Texas will contain more long-term unemployment and poverty, and more folks depending on food stamps, Medicaid and CHIP."[1]

Median household income and per capita income in the RHP are similar to the median in Texas and the U.S. The average wage per job has increased slightly since 2006. However, the unemployment rate has also increased over the last five years. (Table D in the appendix displays the major employers in RHP 19.)

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

RHP 19 has eight hospitals in the Metropolitan Statistical Area (MSA) of Wichita Falls and eleven hospitals outside the MSA. Fourteen of the hospitals are public, and four are for-profit. In 2009, there were 914 acute beds and 682 psychiatric beds among all of the region's hospitals. As of 2011, none of the hospitals in RHP 19 had Teaching Facilities, Burn Care, Intermediate Nursing Care, Other Long Term Care, Neonatal Intensive Care, Pediatric Intensive Care, Skilled Nursing Care, or Other Intensive Care.

Health Professional Shortage Areas
Texas ranks 42nd in the nation for the ratio of physicians to population, and 47th for the ratio of nurses to population. There is a shortage of every kind of health professional in Texas except Licensed Vocational Nurses. Physicians, registered nurses, physical therapists, clinical laboratory scientists, occupational therapists, pharmacists, dentists, audiologists, and other health care professionals all number less (per 100,000 population) than the national averages.[2]

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[1] Scharrer, Gary. "Poverty, dropout rates threaten Texas' future," Austin Bureau. Available: http://www.chron.com/news/houston-texas/article/Report-Poverty-dropout-rates-threaten-Texas-1698327.php. June 2012.
[2] Dunkelberg, Anne. 2011. Texas *Health Care 2011: What Has Happened and the Work that Remains*, Center for Public Policy Priorities. 2011. Available: http://www.cppp.org/files/2011_11_TexasHealthCare.pdf. June 2012.

The 2012-2013 Texas legislative budget allows for some growth in support for health-related institutions of higher education, but many programs sustained significant cuts. State support for Graduate Medical Education has been reduced by almost a third, from $79 million to $54 million. Funds for the Professional Nursing Shortage Reduction Program have been cut by 40%, and about three-fourths of funding for both the Family Practice Residency Program and the Physician Education Loan Repayment Program has been eliminated. Other primary care training programs have also been completely eliminated, including the Children's Medicaid Loan Repayment Program. It is important for Texas to build its healthcare workforce in order to (1) reduce the current shortages and (2) prepare for large increases in demand when more Texans become insured in 2014 through the Affordable Care Act. Over $250 million in new federal medical education training funds have been allocated since the Affordable Care Act passed in 2010. The Texas legislature did not build on this investment in 2011, but instead made cuts to key health care professional training.[3]

Health Professional Shortage Areas (HPSAs) are designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental, or mental health providers and may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, federally qualified health center or other public facility). As of 2011, every county but one (Archer) in RHP 19 is considered a Mental Health Professional Shortage Area and three counties are considered Primary Care Health Professional Shortage Areas. (See Table 2 below.) Five counties in the region have special populations with unmet needs (i.e., limited access) for primary care health professionals. Special populations include: Medicaid eligibles, low-income populations, migrant and seasonal farm workers, homeless, American Indians, Alaska Natives, and other populations isolated by linguistic or cultural barriers. The majority of counties in the region are also shortage areas for dental health professionals.

Medically Underserved Areas

Medically Underserved Areas designated by HRSA are those with too few primary care providers, high infant mortality, high poverty, or high elderly population. All but one county (Wichita) are designated as Medically Underserved Areas; Wichita has an area within it that is designated as a Medically Underserved Area.

Supply of Physicians and Specialists (Tables H-M)

Medicaid funding has a large impact on the supply of physicians. For health professionals, Texas Medicaid fees fall well below commercial insurance or Medicare, and sometimes do not even cover the costs of services. The failure of Texas Medicaid rates to keep up with inflation—even before the recent rate cuts made by the legislature—discourages providers from agreeing to take Medicaid patients. For example, the Texas Medical Association's biennial poll of doctors shows the percentage of doctors taking on new Medicaid patients has dropped steeply over the last decade.[4] Rate cuts during the 82nd Legislature were the largest healthcare budget cuts the

[3] Ibid.
[4] Ibid.

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

Table 2. HPSAs and MUAs

X" Denotes "Entire County" as Health Professional Shortage Area or Medically Underserved Area, RHP 19, Texas, September 2011				
	Primary Care	Mental	Dental	Medically Underserved Area
Archer	X			Partial county
Baylor	Facility	X		X
Clay	Low-income			X
Cooke		X		X
Foard	X	X		X
Hardeman		X		X
Jack	Low-income	X		X
Montague		X		X
Throckmorton	Low-income, facility	X	X	X
Wichita	Low-income, facility	Facility	Low-income, Facility	Partial county
Wilbarger		X		X
Young	Low-income, facility	X	Facility	X

"Direct Patient Care" (DPC) physicians are those who work directly with patients and do not include researchers, administrators, or teachers. For the region as a whole, the rate of DPCs per 100,000 population ranged from 138.6 in 2007 to 145.4 in 2011. Rates of DPCs in the state of Texas are higher than those of RHP 19. Wichita County has the highest rate of Direct Patient Care physicians, while Foard County has the lowest.

"Primary Care" (PC) physicians are those who indicate that they have a primary specialty of General Practice, Family Practice/Medicine, Internal Medicine, Pediatrics, Obstetrics and/or Gynecology, or Geriatrics, and are a sub-set of DPC physicians. For the region as a whole, the rate of PC physicians per 100,000 people varied from 64.9 to 69.1 from 2007 to 2011. Rates of PC physicians in the state of Texas are similar to those in RHP 19. Wichita County has the highest rate of PC physicians per 100,000 people, while Foard County has the lowest.

Over the last five years, family practitioners have accounted for 45-50% of all primary care specialists. Percentages of each specialization have remained stable since 2007. The percentage of family practitioners in RHP 19 (45%) is higher than that of Texas (29%).

Healthcare Coverage (Tables N-P)

About half the people living in RHP 19 have commercial insurance. Twenty percent are uninsured, and the remainder relies on Medicare, Medicaid, or CHIP.

People without healthcare coverage are less likely to have a usual source of care, to use preventive or specialty services, to obtain needed prescription medications, or to receive high-quality services. As a result, they are at increased risk of poor health outcomes and death. The latest data from the U.S. Census Bureau show that in 2010, Texas remained the state with the highest uninsured rate in the nation at 24.6%. The total number of uninsured Texans is 6.2 million—roughly 250,000 fewer than in 2009. Working-age adults saw a small increase in coverage through job-based insurance, which was a slight reverse in the long-term trend in loss of job-based coverage, made even worse by the recession. Despite the modest up-tick, Texas' working-age adults are still nearly twice as likely as children to be uninsured. Compared to Texas as a whole, RHP 19 has similar percentages of people who lack healthcare coverage. Compared to the U.S., the region and Texas have higher percentages of uninsured adults.

Medicaid is the foundation of Texas' health care safety net, providing health care benefits for over 3.3 million low-income Texans in September 2011. Children make up the greatest number of enrollees, but adults with disabilities, low-income seniors, pregnant women, and a small number of parents in poverty also rely on the program for critical medical care and community services and supports. About seven in 10 Texas nursing home residents rely on Medicaid for their care. Approximately 12% of RHP 19 residents are enrolled in Medicaid.

Disparities in Accessing Healthcare (Tables Q-S)

In recent decades, the U.S. has made much progress in improving health among its residents and in reducing health disparities, yet health disparities by race/ethnicity, income and education, and other characteristics still exist.

Public Health Administrative Region 2/3, which includes RHP 19 and the state of Texas have similar percentages of adults who could not access healthcare due to cost. RHP 19 and Texas have slightly higher percentages than the U.S. In the region, the following groups were more likely than their counterparts to report that they could not access healthcare due to cost in the past 12 months: women, blacks and Hispanics, younger adults, those with no high school diploma, and people with low incomes.

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

Screenings and the utilization of other preventative services are other access to care measures. RHP 19, Texas, and the U.S. have similar percentages of adults who did not access these specific aspects of preventative care. In the region, women aged 50 and older are less likely than their male counterparts to have had a sigmoidoscopy, colonoscopy, or a flu vaccination. Hispanics are less likely than whites and blacks to receive preventative services. Older blacks are less likely than older whites to get a flu vaccine. Those with lower levels of education and income are less likely than adults with higher education and income levels to receive preventative services.

Limited Access and High Emergency Department Utilization

Emergency department (ED) utilization has increased in hospitals across the nation over the last decade. According to the CDC, the national number of ED visits increased by 28% between 1995 and 2008.[5] As a matter of fact, there is greater demand for health care services in general. For example, during the same time period (1995-2008), physician office visits across the U.S. increased by 37%.[6]

A noted reason for the increase in ED utilization is the limited access patients have to usual health care services. The majority of all ED visits nationwide occur outside of normal business hours.[7] In areas such as RHP 19, where physician offices are not open after hours or on weekends, patients seeking care often resort to the ED. As seen in Table 3, nearly a third of all 2010 outpatient visits in RHP 19 acute care hospitals were ED visits.

Table 3. Emergency Department Utilization

Emergency and Outpatient Utilization Data for Texas Acute Care Hospitals by County, 2010		
	Number of ER Visits	% of All Outpt Visits
Archer	n/a	n/a
Baylor	2154	6.9%
Clay	2713	31.3%
Cooke	18688	44.4%

[5] Cunningham, P. "Nonurgent Use of Hospital Emergency Departments." Statement before the U.S. Senate Health, Education, Labor and Pensions Committee Subcommittee on Primary Health Aging. May 11, 2011. Available at: http://www.hschange.org/CONTENT/1204/?PRINT=1. Source for Table 1: CDC/NCHS, National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey, as reported in Health, United States, 2010.

[6] Cunningham, P. "Nonurgent Use of Hospital Emergency Departments." Statement before the U.S. Senate Health, Education, Labor and Pensions Committee Subcommittee on Primary Health Aging. May 11, 2011. Available at: http://www.hschange.org/CONTENT/1204/?PRINT=1.

[7] Ibid.

Foard	n/a	n/a
Hardeman	2113	5.9%
Jack	2585	16.2%
Montague	8703	19.1%
Throckmorton	610	64.3%
Wichita	87934	47.7%
Wilbarger	7072	33.2%
Young	14285	17.9%
Total	**146857**	**31.5%**

Source for Table 3: 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database. Available at: http://www.hhsc.state.tx.us/1115-docs/10ER-reportx.pdf

High ED utilization is often accompanied by inappropriate ED utilization. It is estimated that only 55% of national ED visits in 2008 were for immediate or urgent needs.[8] With high ED utilization in several counties in RHP 19, the region should work toward increasing access to health care for patients with non-emergency needs.

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

C. Mental Health and Substance Abuse

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

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

- The number of children receiving community mental health services in 2012-2013 is projected to be the same as in 2011, though lower than in 2010. The 2012-2013

[8] Cunningham, P. "Nonurgent Use of Hospital Emergency Departments." Statement before the U.S. Senate Health, Education, Labor and Pensions Committee Subcommittee on Primary Health Aging. May 11, 2011. Available at: http://www.hschange.org/CONTENT/1204/?PRINT=1. Source for Table 2: CDC/NCHS. National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables.

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

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

number represents a 6% gain over children served in 2003, though not enough to keep up with population growth.

- The number of adults receiving community mental health services has been flat since 2009 and remains at essentially the same number served in 2003. However, the population in Texas has grown by 3.3 million (15%), and the number of uninsured Texans has grown by nearly 1 million.
- The Legislature expressed an intent to maintain state and community mental health hospital bed capacity, contingent on DSHS implementing $15 million in cost-containment policy changes in the state facilities.
- The number of adults and youth receiving substance abuse treatment is held at the 2010 level.[11]

D. **Mortality** (Table T)

RHP 19 has higher "all-cause" death rates than Texas. Its rates for all-cancer, heart disease, and respiratory/lung are also higher than the rates for Texas.

E. **Fertility and Natality** (Table U)

Like every state, Texas funds family planning through both federal block grants and Medicaid coverage. These programs provide not only birth control, but also preventive care and basic check-ups to low-income and largely uninsured women (one-third of Texas' working age adults are uninsured). The 82nd Texas Legislature passed deep cuts in block-grant-funded family planning care that will reduce the total number of Texas women served with birth control by at least 70% in 2012-2013. The appropriations act for 2012-13 says that the Department of State Health Services (DSHS) Family Planning programs will serve 61,135 Texas women in each year of the budget; this is down from the actual 211,980 served in 2010—a 71% reduction (150,845 less) in clients served by DSHS programs. The Texas Legislative Budget Board estimated the 2010-2011 DSHS Family Planning spending at over $111 million, compared to appropriations for 2012-2013 of $37.9 million for the biennium. This results in a 66% reduction ($73.2 million) from 2010-2011—a two-thirds cut.[12]

Access is critical to reducing several Texas challenges: high and growing rates of pre-term births, births too close together causing medical risks for the newborn, and births to unmarried teen mothers. More than half of all Texas births are reported unplanned, and maintaining access to family planning services is essential to reducing unplanned pregnancies. Most of the fertility and natality-related rates are similar for the region and Texas. The region has a higher rate than Texas of women getting prenatal care in the first trimester.

Teen Pregnancy and Births

The Texas pregnancy rate per 1000 female teenagers between 13 and 17 years was 21.4 in 2010.[13] The overall rate in RHP 19 was slightly lower (19.3/1000) than the Texas rate. Table 4

[11] Ibid.
[12] Ibid.
[13] http://www.dshs.state.tx.us/chs/vstat/vs10/t14b.shtm

below displays the pregnancy rate among this population by county. Five of the 12 counties in RHP 19 have higher pregnancy rates among 13 to 17 year olds than Texas' overall rate. Foard County had the highest rate at 61.2 per 1000, while Throckmorton County had no reported pregnancies in this age group in 2010.

In 2010, 4.3% of births in Texas were to mothers less than 18 years of age.[14] The rate in RHP 19 was slightly higher than in Texas (4.4%). Table 5 below shows the percent of births to these young mothers by county. One-third of the counties in RHP 19 have higher birth rates to young mothers than Texas' overall rate. Hardeman and Jack Counties have birth rates to mothers less than 18 years above 8%. The birth rate to white, black, and Hispanic teen mothers in Texas was 1.8%, 5.0%, and 6.2%, respectively, in 2010.[15] The majority of counties in RHP 19 showed higher rates in white mothers less than 18 years of age than overall Texas rates.

Table 4. Pregnancy Rates, Ages 13 – 17

Reported Pregnancy Rate Per 1000 Women Age 13-17 by County, RHP 19, 2010	
	Rate per 1000
Archer	6.4
Baylor	10.9
Clay	5.2
Cooke	16.1
Foard	61.2
Hardeman	27.8
Jack	29.8
Montague	15.6
Throckmorton	0.0
Wichita	22.1
Wilbarger	22.7
Young	17.3

Table 5. Births to Mothers Less than 18 Years of Age

Births to Mothers ≤ 17 Years by County and Ethnicity, RHP 19, 2010				
	Total %	**White %**	**Black %**	**Hispanic %**
Archer	1.4%	1.5%	0.0%	0.0%
Baylor	2.5%	0.0%	0.0%	n/a
Clay	2.1%	2.2%	0.0%	0.0%
Cooke	3.9%	2.0%	0.0%	8.8%
Foard	n/a	n/a	0.0%	0.0%

[14] http://www.dshs.state.tx.us/chs/vstat/vs10/t11.shtm
[15] Ibid.

Hardeman	8.7%	4.5%	n/a	n/a
Jack	8.5%	11.0%	0.0%	0.0%
Montague	3.7%	3.9%	0.0%	2.1%
Throckmorton	0.0%	0.0%	0.0%	0.0%
Wichita	4.3%	2.4%	7.7%	8.9%
Wilbarger	6.1%	4.0%	n/a	6.0%
Young	4.4%	3.6%	0.0%	6.6%

F. **Communicable Diseases** (Table V)

The Varicella rate is much higher in RHP 19 than in Texas; the rate for Pertussis is lower in the region.

G. Health Rankings

Health Factors (Table W)

There are many different variables that measure health behaviors and other factors related to health. We have chosen obesity, excessive drinking, motor vehicle crash death rate, Chlamydia rate, and teen birth rate for illustrative comparison. Obesity is a risk factor for adult-onset diabetes, coronary heart disease, and several other serious medical conditions that can lead to poor health and premature death. Chlamydia is the most common bacterial sexually transmitted infection (STI) in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death. RHP 19 has a lower excessive drinking rate than Texas and a motor vehicle crash death higher rate than Texas.

Health Outcomes (Table X)

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

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

among adults are similar for the region and Texas. The region has a higher rate of premature death than Texas.

Counties in RHP 19 Ranked

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

Our Community Needs Assessment examined data for the counties in RHP 19. Using the percentile rank for each county, we determined the quartile in which the counties fell. Comparing the counties in RHP 19 to 223 Texas counties, the lower quartile (up to 24%) represents the highest, or relatively better, scores for health factors and outcomes. The upper quartile (75% to 100%) represents the lowest, or relatively worse, scores for factors and outcomes. Looking at the rankings for health factors, 60% of RHP 19 counties ranked relatively well in health behaviors; 40% ranked relatively poorly. (See Figures 2 and 3.) There is great opportunity for improvement in health behaviors, clinical care, and especially the physical environment, where about 70% of the counties were relatively worse off than other Texas counties. Forty-three percent of RHP 19's counties ranked relatively well in health outcomes.

Looking at the rankings for health outcomes, half of the counties in RHP 19 scored in the better quartiles for mortality and morbidity rates. The other half scored relatively poorly compared to other Texas counties for mortality and morbidity.

Figure 2. Percentage of RHP 19 Rankings for Health Factors

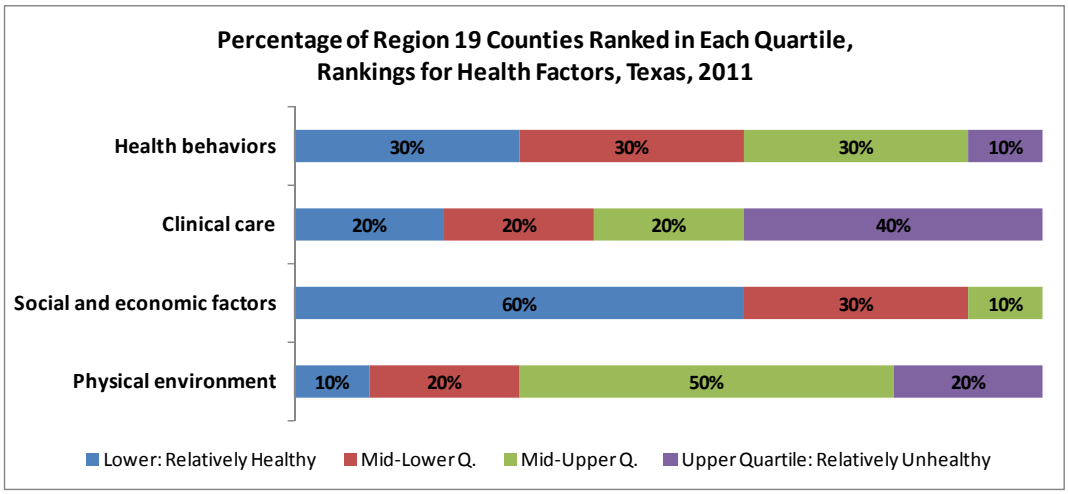
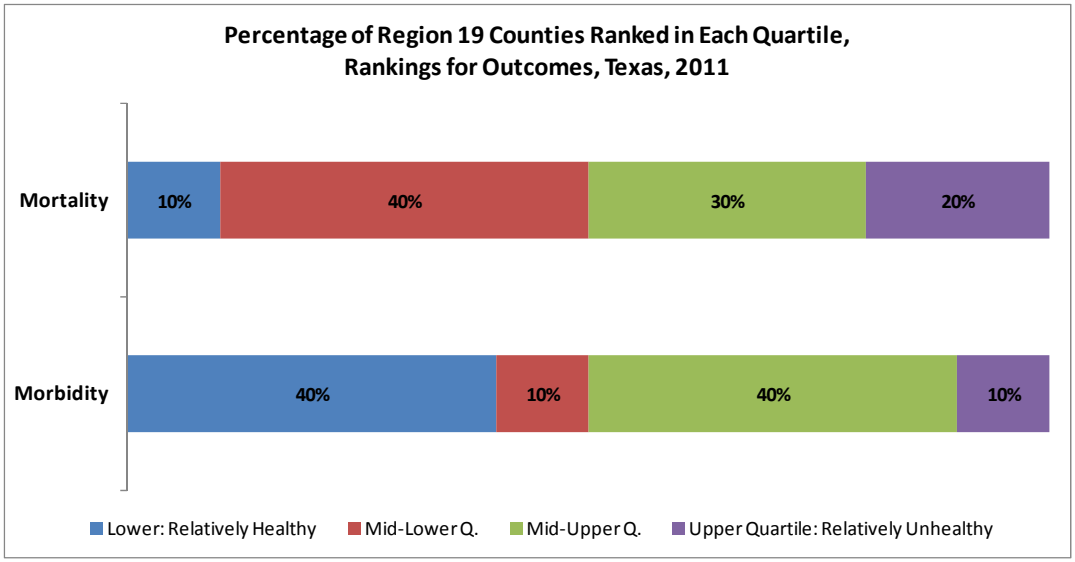


Figure 3. Percentage of RHP 19 Rankings by Quartile



H. **Preventable Hospitalizations** (Table Y)

Hospital admissions increased across Texas by 7.8% between 2001 and 2010, and inpatient days increased by 6.9%. Also across Texas, emergency room visits increased by 28.6%, and inpatient surgical operations increased by 11%. RHP 19, which is included partially by Public Health Region 2, had higher hospital utilization than the state average of 546 inpatient days per 1,000 population, with 571 inpatient days per 1,000. In Public Health Region 2, bad debt charges totaled $9.6 million and charity charges totaled $1.7 million, for total uncompensated care charges of $11.2 million. As a percent of gross patient revenue, uncompensated care was 9.6% in PHR 2 in 2010, lower than the state average of 14%.[16]

According to a recent analysis of THCIC data, RHP 19 received $376,846,440 between 2006 and 2010 for hospitalizations that may have been preventable. The two most costly hospitalizations per county resident were pneumonia ($555 per adult resident) and CHF ($507 per adult resident). These conditions in particular may be focus areas for quality improvement. Provider-specific data regarding volume and other burden to the current healthcare infrastructure may be supplemented here to drive initiatives in these two high-burden conditions.

SUMMARY: DEMAND AND NEED FOR SERVICES

Regional Healthcare Partnership 19, compared to Texas as a whole, has a greater percentage of Whites and people 65 years or older. This older population means that expansion of services for chronic conditions related to coronary and cerebrovascular disease may be as cost-beneficial as if not more so as those related to pre-natal and infant care, diabetes, and acute illnesses. Conditions of focus to reduce potentially avoidable hospitalizations, with both

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

inpatient and outpatient efforts, may be bacterial pneumonia and congestive heart failure. These two conditions have the highest rate of reimbursement per county resident from 2006 to 2010.

The median household income and per capita income of RHP 19 residents are similar to those of Texas. Twenty-nine percent of the county's adults are uninsured, and 17% of its children are uninsured. An analysis of ED overutilization may reveal an opportunity to shift ED visits among the poor to community based care. Additionally, with market reforms underway and expanded coverage in 2014 under the Affordable Care Act, the percentage of uninsured is expected to decrease.

The population in much of the region is inadequate to support full-time specialty physicians, so the community must rely on satellite clinics, telemedicine, and travel to secure specialty care. As of 2011, all counties in the region are considered Medically Underserved Areas. Medically Underserved Areas are areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty, or high elderly population. All but one of the RHP 19 counties are also designated as Mental Health Professional Shortage Areas. Most counties have special populations that are considered shortage areas for primary care health professionals. Throckmorton County is a Dental Health Professional Shortage Area. These shortages are expected to worsen in the short-term future.

Texas' health challenges have also been made more severe by a deep revenue shortfall from the global recession and the 82nd Texas Legislature's Budget for 2012-2013, which made deep cuts in health care investment. Cost-effective healthcare is a priority for RHP 19.

DATA SOURCES

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

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

Prepared by Terri Conner, Ph.D.
Independent Healthcare Consultant

Section IV. Stakeholder Engagement

RHP Participants Engagement

In May 2012, the Health and Human Service Commission finalized our North Texas region with 12 counties included in Regional Healthcare Partnership 19. Meetings of RHP 19 were held in Wichita Falls and the following entities were represented and participated in the discussions: United Regional Health Care System, Electra Hospital District/Electra Memorial Hospital, Jack County Hospital District/Faith Community Hospital, Red River Hospital, Young County Indigent Health Care, Olney-Hamilton Hospital District/Hamilton Hospital, Hardeman County Memorial Hospital, Helen Farabee Centers, Clay County Memorial Hospital, Bowie Memorial Hospital, Wilbarger Hospital District/Wilbarger General Hospital , Wichita County Indigent Health Care, Baylor County Hospital District/Seymour Hospital, Throckmorton County Memorial Hospital, Gainesville Hospital District/North Texas Medical Center, Chillicothe Hospital District/Chillicothe Hospital, Muenster Hospital District/Muenster Memorial Hospital, Graham Regional Medical Center, North Central Texas Community Health Care Center, Inc., Archer County, Texoma Community Center, Nocona Hospital District/Nocona General Hospital, Wichita Falls-Wichita County Health District, and North Texas State Hospital.

Electra Hospital District was designated as the RHP 19 anchor and began engaging stakeholders. All hospitals and providers within RHP 19 were invited to participate. Stakeholder forums were hosted in the central, suburban center of Wichita Falls, Texas throughout the summer. Hospitals, Community Mental Health Centers and health departments all participated in meetings. As the protocols were developed by HHSC and approved by CMS, entities began to identify their IGT sources in order to participate with DSRIP projects.

Once Pass 1 allocations were released by HHSC and IGT sources were secured, performing providers were more clearly delineated and took leadership roles in researching and publishing projects to meet the needs for access to care and delivery reform in RHP 19. Participating providers have engaged one-on-one within RHP 19 in order to finalize plans, workbooks and projects. Chillicothe Hospital District/ Chillicothe Hospital, a critical access hospital in Hardeman County, declined to participate in DSRIP due to the lack of staff to coordinate, implement and manage a project. In addition, their allocation was not significant enough to warrant hiring additional staff or developing a project. Red River Hospital, a mental health hospital in Wichita Falls/Wichita County, declined to participate in DSRIP due to the lack of an IGT source. Though Chillicothe and Red River are not performing providers in DSRIP, representatives from these hospitals attended all or most of the meetings, and we have been having continued conversations with them about participation in DSRIP. Hardeman County Memorial Hospital has recently withdrawn their project submission and will only be participating in UC. They have stated that they do not

anticipate meeting the milestones they had established and did not want to risk their funding.

In addition to face-to-face meetings, RHP 19 utilized webinars, conference calls and email distribution to quickly and effectively communicate with providers across the region. We expect to continue all forms of communication in order to ensure all providers have the appropriate information regarding their participation in the RHP 19 plan. Additionally, there are regional projects, such as Specialty Care, which will also facilitate a learning collaborative and share evidence based protocols to engage providers across the region.

Providers locally reached out to their medical societies and other interested parties in plan development. RHP 19 will continue to work to inform stakeholders of opportunities to engage. We will continue to welcome non-provider stakeholders.

Public Engagement

RHP 19 Meetings

The formation meeting of the North Texas Regional Health Partnership (now RHP 19) was held on March 29, 2012 at United Regional Health System in Wichita Falls, TX. It was determined at that meeting that the Electra Hospital District would serve as the anchor for the RHP. The group reviewed the HHSC Draft RHP Plan and discussed IGT potential for the region. It was determined to set up a meeting with Stanley Stewart to discuss the boundaries of the RHP.

April 26, 2012 met with Stanley Stewart with HHSC in Wichita Falls to discuss the 1115 Waiver requirements, timelines and size and boundaries of the RHPs.

May 1, 2012 met in Wichita Falls, TX to discuss membership, governance and committee structure of the RHP. Also discussed was the engagement of consulting groups to facilitate development of the RHP Plan.

May 31, 2012 met in Wichita Falls, TX to approve membership agreements, bylaws and elect officers. Also there was discussion of the proposed 1115 Waiver Program Funding and Mechanics Protocol and consulting firms.

July 3, 2012 met in Wichita Falls, TX to discuss Program Funding & Mechanics Protocol and the DSRIP menu. The Community Needs Assessment was discussed and it was announced that the RHP 19 website was posted on the internet.

July 11, 2012 met in Wichita Falls, TX to discuss RHP Planning Protocol and information from HHSC regarding the implementation of the Waiver. Also discussed draft DSRIP plans and the upcoming Summit in Austin.

August 7 – 8, 2012 met in Austin for the Waiver Summit hosted by HHSC.

August 21, 2012 hosted a conference call.

Medical providers and patients were engaged as stakeholders across the region. Medical societies provided information along the way and have included a letter of support for projects in RHP 19. RHP 19 distributed a newsletter to providers and stakeholders shortly after the HHSC Waiver Summit in August 2012. We also held a webinar for providers and stakeholders to provide step by step instructions on how to fill out the workbook and complete the plan template. Throughout the process the anchor has updated providers via email and the website to keep providers up to speed. At each new juncture, RHP 19 provided communication using tools that would best communicate important information to participants.

Throughout the stakeholder process and plan development phase, the 13 public hospitals and two Community Mental Health Providers have had public board meetings where discussions of the waiver, IGT and financing were discussed. The public hospitals are located in 10 of the 12 counties in RHP 19. Foard and Archer counties do not have hospitals located in their counties, but Hamilton Hospital includes Archer County in their Primary Care Expansion project to meet the needs in that community.

On November 5, 2012, the plan was officially posted for 5 business days on the RHP 19 website. www.texasrhp19.com. A copy remained on the website until December 2012. A public comment form was imbedded in the website for stakeholders to easily provide feedback on the projects identified under Pass 1 allocations. No comments were submitted.

On December 3, 2012 the RHP 19 Final Draft Plan was posted to the RHP 19 website for public comments. A public comment form was imbedded in the website for stakeholders to easily provide feedback on the projects. The plan was officially posted for 5 days, but a copy remained on the website longer in order to allow for public comment. There were no comments submitted through the online form.

Once the RHP 19 feedback plan is finalized, it will be posted to the RHP 19 website as well.

Ongoing RHP activities will include conference calls, webinars, face-to-face meetings, telephone calls, and emails depending on the need facing RHP 19. We have met together as a group and plan to further coordinate on projects once projects get underway, but currently there is a need for quick responses to plan development. Our focus will shift from

planning to implementation, and we will adjust. Continuous quality initiatives will be hosted in RHP 19 to facilitate ways to improve and learn from others.

Section V. DSRIP Projects

RHP Plan Development

RHP 19 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. Pass 2 projects were offered similarly to Pass 1. Once Pass 2 was complete remaining funds were summed. The anchor requested providers who had a project for Pass 3 to request an allocation. Electra, the Anchor, worked with provider requests and priorities to allocate funds across the region and across projects under Pass 3. PFM valuation principles were used as guidelines in the distribution. Providers didn't all receive the highest valuation requested, but the region ensured all providers with projects and with IGT had funding.

Projects not included in the RHP Plan:

1. Clay County d/b/a Clay County Memorial Hospital -Hospice/Palliative Care Expansion in Henrietta, Texas
2. Faith Community Hospital-Patient Care Navigator Program
3. Faith Community Hospital-Expanding Access to OB Services
4. Faith Community Hospital-Expanding Access to EMS Services (when an option)
5. Faith Community Hospital-Implement Technology-Assisted Services
6. Hamilton Hospital (Olney Hamilton)- Expand Access to Specialty Care
7. Hardeman County Memorial Hospital-Wellness Center
8. Helen Farabee Center-Integrated Health Care
9. Muenster Memorial Hospital-Expand Access to Primary Care
10. North Texas Medical Center- Expanding Behavioral Health Care Capacity & Integrating Behavioral Health Care by adding a midlevel practitioner with behavioral health specialization to our primary care clinic.
11. North Texas Medical Center- Redesign to improve patient experience – we considered expanding NCR picker surveys to our outpatient clinics
12. North Texas Medical Center- Improve Access to specialty care – We would recruit a full time cardiologist and open a CHF clinic.
13. North Texas Medical Center- Establish/Expand primary care training programs – we would serve as a rotation site for a rural family medicine residency.
14. North Texas Medical Center- Expand Access to preventative care – we considered a flu/pneumonia vaccine program for nursing home patients
15. North Texas Medical Center- Implement Medical Homes in our primary care clinics
16. North Texas Medical Center- Implement Evidence based health promotions via a wellness center
17. Texoma Community Center-ECI Services Expansion
18. Texoma Community Center-Behavioral Interventionist Specialist

19. Throckmorton County Memorial Hospital-Diabetes Management Program to Promote Wellness and Population Change
20. United Regional Health System Care System-Population Health Oriented Projects
21. Wilbarger General Hospital-Patient Navigator
22. Wilbarger General Hospital-Mobile Dental Van

Based on the Community Needs Assessment, RHP 19 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 19 providers concentrated on the number one issue facing local communities, access to primary care. In order to impact the cost curve, providers see the need for taking care outside the hospital and back into the clinic and or the home. RHP 19 projects show this commitment and lead our communities back to this delivery model. This extends to specialty care with a growing elderly and often dual eligible population in our region. To address this, the anchor, Electra Hospital District, will coordinate a regional approach to access to specialty care, and the Community Mental Health Centers will expand their reach for individuals in need of specialty care for behavioral health services. Transformational projects, such as patient experience, have also been deployed to build on the primary care infrastructure of access. These projects engage patients to take ownership of their own health and hold providers accountable.

Providers Exempt from Category 4:

Reporting Status	Provider Name	Hospital County	RHP
Exempt	Bowie Memorial Hospital	Montague	19
Exempt	Chillicothe Hospital	Hardeman	19
Exempt	North Texas Medical Center	Cooke	19
Exempt	Graham Regional Medical Center	Young	19
Exempt	Clay County Memorial Hospital	Clay	19
Exempt	Faith Community Hospital	Jack	19
Exempt	Muenster Memorial Hospital	Cooke	19
Exempt	Nocona General Hospital	Montague	19
Exempt	Hamilton Hospital	Young	19
Exempt	Hardeman County Memorial Hospital	Hardeman	19
Exempt	Seymour Hospital	Baylor	19
Exempt	Throckmorton County Memorial Hospital	Throckmorton	19

Project Valuation

RHP 19 established valuation of projects based on the investments which providers will 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. The regional instructions with regard to valuation based on the PFM's criteria of project size, provider size, project scope, populations served, community benefit, cost avoidance, and addressing priority community needs was to maximize opportunities for health outcomes for as many patients as possible. However, often the project size and scope is limited by the dollars available.

Using valuation principles, RHP 19 collectively tried to stretch dollars and invest DSRIP funds where transformation was most needed and most likely. Specialty care and care transitions when patients return to their home community, were priority needs for the entire region, with much opportunity to impact the patient groups.

Pass 3B

Per HHSC guidance issued January 2013, certain collaboration projects were removed from Pass 1 or Pass 2. Once the projects were removed, Pass 3B funds, totaling $54.3 million, were rebid to providers in RHP 19. The email announcing the rebid of the funds in Pass 3B is included in the appendix. Providers wanting to participate in Pass 3B were required to submit project ideas and request sum certain valuations for their projects under the new Pass 3B. Once compiled by the anchor Pass 3B DSRIP allocations were made to providers requesting it.

Section V. Category 1 Projects

Summary Information: Bowie Memorial Hospital

Pass 1 Project 127305405.1.1

- Provider: Bowie Memorial Hospital is a 49-bed community hospital in Bowie, Texas, serving a rural population of approximately 20,000, in a 930 square mile area.

- Intervention(s): This project will expand our existing primary care services to accommodate additional providers and extended hours.

- Need for the project: There is a primary care clinic, in the Bowie community that provides 3 primary care physicians services, and two extenders, with availability approximately 4 days a week by each provider and hours of 8 am to 5 pm. Hospital admissions are received from this clinic and when providers aren't available, patients present to the emergency room for primary care. Another clinic, with limited physician availability, is also closed at 5pm. Therefore, there is essentially no medical care available in the community, except the emergency room, after 5pm and none on weekends. There are currently insufficient appointments available in the community to provide for the numbers of patients asking to be seen.

- Medicaid and Uninsured Target population: The target population is the county of Montague, seeking primary care appointments and who may be relying on the emergency services for that care. We will have the only providers accessible for the evening and weekend hours, through this project. Approximately 53% of our patients are either Medicaid eligible, uninsured or county indigent, and we expect they, along with other county residents, will benefit from the availability of primary care services outside normal operating hours.

- Category 1 or 2 expected patient benefits: The project seeks to provide increased primary care accessibility, each year to Medicaid and uninsured patients, as well as other individuals in the county, by increasing the numbers of providers and extending the hours. The goal will be to reduce the number of Level I and II ED visits by 320 encounters in DY 4 (705 remaining) thus increasing the number of primary care visits/encounters and in DY 5 demonstrate a 10% (70) improvement in reduction of Level I and II ED visits from the prior reporting period. A baseline of 1025 Level I and II patient visits to the ED is utilized for determination of patient impact. This change of venue of care should provide a decrease in cost of patient care per visit, as well as a formal structure for continued follow up for the patients.

- Category 3 outcomes: IT-9.2 Our goal is to decrease encounters in the emergency department for inappropriate emergency visits and demonstrate improvement over the prior reporting period, by the end of DY 5.

Category 1: Infrastructure Development

Narrative for each Category 1 Project shall include:

- **Identifying Project and Provider Information:**
  - **1.1 Expand Primary Care Capacity,**
  - **Unique RHP project ID= 127305405.1.1,**
  - **Performing Provider- Bowie Memorial Hospital/ TPI 127305405.**

- **Project Description:**
  - **1.1.2 Expand existing primary care capacity,**
    - **1.1.2 a) Expand primary care clinic space**
    - **1.1.2 b) Expand primary care clinic hours**
    - **1.1.2 c) Expand primary care clinic staffing.**

The Geriatric population group is a large consumer of primary care. The County of Montague, a medically underserved area (MUA) has over 19% of the population over 65, which increases the likelihood of patients with comorbidities and chronic conditions. The state average is 10% of a geriatric population in the typical county. The county has ratios of 1403 patients to 1 primary care provider which result in delayed appointments for the entire population and long wait times for basic primary care. Because access is so limited often time low income and patients with comorbid conditions seek non-emergent, urgent care in the Emergency Department. The goals of this project will be to provide increased primary care access and decrease episodic care visits to the emergency room of the acute care facility. Key challenges consist of a lack of primary care physicians (difficult recruitments), increased wait for appointments, and episodic reliance on emergency systems for managing chronic diseases. Providing increased clinic space, increased hours for appointments, and expanding primary care staffing will provide more access and timely appointments, allowing for improved availability to chronic care management. Over a 5 year period there should be an increase in primary care providers, clinic hours expanded to allow for increased volume, and increased space to accommodate the increased patient flow. On a regional perspective, increasing primary care access in Montague County, will provide for improved chronic care and lessen acute care complications. Decreasing complications will result in less tertiary acute care hospital transfers, thus providing cost savings to both local and regional facilities, as well as CMS. RHP 19 goals are to transform health care in the total population and to advance the goals of right care, right place, and right time. Focusing on increasing capacity of primary care in the region, increases strategies related to disease prevention and promotion of general health improvement. Care costs in the region are impacted when there is availability of primary care, creating decreased non urgent emergency room visits, as well as complication prevention.

Starting Point/Baseline:

Currently this level of primary care has not been available in our community**.**

Therefore the improvement rate is expected in the change of care for 320 visits from Level I and II ED visits (approximately 1025 patient visits/annually), to a primary care site in DY 4.

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. 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. Our reasons for choosing the option of expand existing primary care capacity (1.1.2) and thus enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity is the belief that patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services. The components of the above option consist of 1.1.2.a expanding primary care clinic space; 1.1.2.b expanding primary care clinic hours; and 1.1.2.c expanding primary care clinic staffing. These components will be achieved through redesign of concurrent spaces, addition of newly hired staff and providers, as well as reassignment of current staff members, and by provision of more open hours and accessibility enabled by securing additional staff.
The unique community need number CN.3 delineates the shortages of health care professionals in RHP 19. Additionally, Montague County is a designated medically underserved area. The county serves a higher percentage of geriatric population, known to have increased health problems and be frequent utilizers of the health care systems.

Related Category 3 Outcome Measure(s):

127305405.3.1, OD- 9 Right Care, Right Setting was chosen because limited access to primary care results in overall poorer health outcomes in the community. ; Individuals who have difficulty accessing primary care services are often seen in inappropriate setting, such as the emergency room. Therefore the improvement measure chosen was IT-9.2 ED Appropriate Utilization (standalone). There are many reasons why the emergency setting is limited for comprehensive care for those with chronic conditions and continuity of care. Physicians rotate through these settings and every visit traditionally focuses on the reason for that episodic visit, there is no long range planning for patient self-management and guidance. This becomes a disadvantage in care management, as well as more costly approach to overall health management. The National Association for Community Health Centers estimated in 2006 that more than $18 billion annually is spent on ED visits that are non-urgent or could be treated in a physician office or health clinic. (J. Greene, Trustee Magazine, Oct. 2012).

Relationship to other Projects:

In the RHP 19 region, while several entities are expanding primary care capacity, in Montague County the need for these services will be provided by Bowie Memorial Hospital's project. Expanding primary care in Montague County reinforces support for prevention of complications and less transport to tertiary facilities. There is another hospital facility in the county; however they are not planning for a Primary Care Provider project. Therefore, there is no expected overlap of service for the county population.

Relationship to Other Performing Providers' Projects in the RHP:

There is essentially no overlap in Bowie Memorial Hospital Category 1 project with those of the surrounding counties and facilities. The impact of RHP 19 Category 1 projects is to provide a strong network of primary care resources and to provide adequate support for the safety net hospital of the region.

Project Valuation:

The project 1.1 Expanding Primary Care has significant value for the community, from decreasing the cost of health care for the patients and for providing a more constant continuum in the treatment of ongoing health issues. While the community population is smaller, the cost avoidance to a facility providing care to those individuals on a local area cannot be overlooked. The valuation of this project gave consideration to several influencing factors: redesign plans and projects; personnel recruitment and procurement of both primary care providers and support staffing; technology; alleviation of expense burdens; various types of payer sources; and the overall project management. At present there is no local funding provided to this facility for improvements in this area. Each of the Demonstration Years was included in the valuation process, based upon the planning process: DY2 came to an estimated value of $370,000 (obtaining resources for planning for expansion of services, site and personnel, and utilization of expert consultations); DY3 estimated to be a value of $425,000 (securing services of care providers and training of support staff members); DY4 was $440,000, (decreasing the cost of more expensive 320 ED visits) and finally DY5 estimated at $710,000 (influenced by decreasing the more expensive health care venue for another 70 patients, plus increasing afterhours access to public not visiting the ED), (for a total valuation estimated at $1,945,000). Respectively, the distribution of available funding ($1,204, 347) will be under the project value to the facility and the community; however it is felt that this is a viable project with a potentially great positive impact for this community, and will be necessary for promoting the future health of residents of this county.

PROJECT 127305405.1.1	PROJECT OPTION 1.1.2	PROJECT COMPONENTS 1.1.2.A, 1.1.2.B, 1.1.2.C	EXPAND PRIMARY CARE CAPACITY	
Bowie Memorial Hospital				TPI 127305405
Related Category 3 Outcome Measure(s):	I.T. 9.2	127305405.3.1	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)**
Process Milestone 1 P-1 Expand existing primary care clinic. Metric 1 P-1.1 Develop a plan for expansion of primary care clinic. Baseline/Goal: Plan for expansion of primary care Data Source: Documentation of plans. Milestone 1 Estimated Incentive Payment (maximum amount): $228,856	**Process Milestone 2** P-5 Train/hire additional primary care providers and staff. Metric 1 P-5. 1 Documentation of increased number of providers and staff. Baseline/Goal: Number of staff prepared/trained for the expansion of primary care. Data Source: HR records. Milestone 2 Estimated Incentive Payment: $265,274		**Improvement Milestone 3** I-12 Increase primary care volume of visits and improved access for patients seeking services. Metric 1: I-12.1 Documentation of primary care clinic volume of visits. Demonstrate improvement over prior reporting year. Baseline/Goal: Change of venue of care for 320 Level I and II visits to a primary care site, from a baseline of 1025 visits by the end of DY 4. Data Source: Appointment scheduling, Billing records Milestone 4 Estimated incentive payment: $ 268,016	**Improvement Milestone 4** I-12 Increase primary care volume of visits and improved access for patients seeking services. Metric 1: I-12.1 Documentation of primary care clinic volume of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Decrease number of Level I and II ED visits from prior reporting year (approximately700 visits) by 10% (70) by the end of DY 5. Data Source: Appointment scheduling, Billing records Milestone 4 Estimated Incentive Payment: $229,630

PROJECT 127305405.1.1	PROJECT OPTION 1.1.2	PROJECT COMPONENTS 1.1.2.A, 1.1.2.B, 1.1.2.C	EXPAND PRIMARY CARE CAPACITY
Bowie Memorial Hospital			TPI 127305405
Related Category 3 Outcome Measure(s):	I.T. 9.2	127305405.3.1	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)
Year 2 Estimated Milestone Bundle Amount: $228,856	Year 3 Estimated Milestone Bundle Amount: $265,275	Year 4 Estimated Milestone Bundle Amount: $268,016	Year 5 Estimated Milestone Bundle Amount: $229,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $991,777			

Summary Information: Clay County Memorial Hospital

Pass 3B Project NEW 094138703.1.2
OLD094138703.1.1

- Provider: Clay County Memorial Hospital is a 25-bed Critical Access Hospital in Henrietta serving a 1,000 square mile area and a population of over 11,000.

- Intervention(s): This project will recruit and keep one family practice physician in Clay County to expand existing primary care capacity by 200 patients

- Need for the project: We currently have four family practice physicians in Henrietta, but none of the four are accepting new patients.

- Medicaid and Uninsured Target population: The target population is our patients that don't have insurance or have Medicare/Medicaid. Over 75% of our patients are either Medicare or Medicaid or uninsured.

- Category 1 or 2 expected patient benefits: The project seeks to recruit one new family practice physician over the next three years. Care capacity will expand by 200 patients over four years.

- Category 3 outcomes: IT-6.1 Our goal is to increase patient satisfaction scores. We will reduce patient wait time for appointments and patient wait time while in the office.

Overview

Identifying Project and Provider Information
1.1 Expand Primary Care 1.1.2 Expand Existing Primary Care Capacity
New Project Identifier 094138703.1.2
Old Project Identifier 094138703.1.1
Clay County Memorial Hospital TPI 094138703

Project Description
Clay County Memorial Hospital is a general acute care hospital serving an area of 11,000 residents. We have been designated by Medicare as Critical Access since March 2005. Our hospital is county-owned and operated. We provide high quality health care for the residents of Clay County and surrounding counties, regardless of ability to pay or insurance status. Our payer mix is 72% Medicare, 2% Medicaid, 15% Other Insurance and 11% Self pay. Annually, the Hospital writes off approximately $800,000 to Bad Debt and $60,000 to Charity Care.

Our project is to recruit one family practice physician to Clay County. We desperately need more family practice physicians to reduce the drain on the Hospital Emergency Department. With another physician available, residents will be able to see a doctor in their office rather than using our ED. The five year goal is to recruit and keep one new/additional physician in the community.
The starting point for this project is zero. We do have four family practice doctors in town, but none of them are accepting new patients.
Previous experience has taught us that today's medical student has difference expectations than one from two generations ago. The medical student today expects to be assisted financially in getting their practice started. With the help of the DSRIP, Clay County Memorial Hospital will be able to give a physician the assistance they require to live and work in a small community.

Starting Point/Baseline
The starting point is zero available new patient appointments. We have four family practice physicians currently in practice in Clay County, but none are accepting new patients.

Rationale
The Community Needs Assessment for RHP 19 states in CN.3 that there is a critical shortage of health care professionals in our area. Additionally, Clay County is designated as a Medically Underserved Area. There are only four family practice physicians serving a population of over 11,000 residents.
Our goal is to recruit and keep one family practice physician in Clay County. The reasons for choosing this project are the following. We have four family practice physicians in our

community. One physician concentrates his clientele to diabetic patients and another physician practices half days in his office due to other professional commitments. The third physician is seventy three years old. That leaves one physician to handle the needs of over 11,000 residents. All four of the physicians have closed their practices to new patients. With the help of DSRIP, we will be able to recruit and keep one more physician in the community. This will enable residents of our county residents with over 75% eligible for Medicare and/or Medicaid or uninsured to access primary and preventative medical care close to home. The new physician will be able to increase the capacity by 200 patients.
Core components will be met as the new physician will (a) have his/her own clinic space, (b) an additional physician will be able to expand the available primary care hours to residents of this community and (c) an additional physician will expand our primary care clinic staffing. The community need identification number that supports this project is CN.3, shortage of health care professionals.

Related Category 3 Outcome Measure
OD-6 Patient Satisfaction
IT-6.1 Percent Improvement over baseline of patient satisfaction scores

The Community Needs Assessment for RHP 19 states in CN.3 that there is a critical shortage of health care professionals in our area. By recruiting an additional family practice physician to our community, patient satisfaction will tremendously increase. Patient time spent in the office will decrease due to innovative measures. This milestone will improve the overall status of the patient. Patient satisfaction is a priority for the RHP.

Relationship to other Projects

The category 1 project is indelibly linked with our Category 2 project, which is Redesigning Primary care project old number #094138703.2.1, new unique project identifier #094138703.2.2.
By recruiting another doctor and redesigning the delivery of primary care in Clay County, we will achieve improvements in efficiency, access, continuity of care and patient experiences. This will also accomplish the Triple Aim goals of the RHP in our county.

Project Valuation

Clay County Memorial Hospital is a County Hospital in need of primary and preventative care services for Medicaid and uninsured patients. The Clay County Commissioners and the Hospital Board of Managers have heard many times over the last two years from residents who cannot get in to see a local physician. From the provider side, the process to find a physician to work in a rural area is tedious and a grinding one. The physician will expect a bonus to relocate and a monthly guarantee to maintain their standard of living. Loan repayment programs often help in recruitment efforts for Medicaid focused providers. Valuation for the project is determined as follows. The first year we expect to recruit and hire a physician. In the second, third and fourth years will require payment of sign-on bonuses and monthly stipends, in addition to setting up

an office and staff. By accomplishing these things, an additional 200 patients over four years will be able to get clinic appointments. Our expectations are for this physician to focus and to open capacity and service for our Medicaid and Indigent patients in need of primary and preventative care. We value this project at $758,431.

NEW 094138703.1.2 ***OLD 094138703.1.1***	***1.1.2***	***1.1.2 A,B,C***	***EXPAND PRIMARY CARE CAPACITY***	
Clay County Memorial Hospital				*094138703*
OD-6	*IT-6.1*	*094138703.3.3* *(094138703.3.1)*	*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 Recruit additional primary care provider. <u>Metric 1</u> P-5.1: Documentation of increased number of providers and staff. Baseline/Goal: Four Family Practice physicians as of 09/30/2012. Contract with one new family practice physician. Data Source: Medical Staff listing on 09/30/2012 and 09/30/2013. Milestone 1 Estimated Incentive Payment $175,011	**Milestone 2** : I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Demonstrate improvement over prior reporting period. Data Source: Registry Goal: Increase primary care capacity by 50 patients to accommodate the needs of our residents Milestone 2 Estimated Incentive Payment: $202,860		**Milestone 3**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Data Source: Registry Goal: Increase primary care capacity by 100 patients to accommodate the needs of our residents. Milestone 3 Estimated Incentive Payment: $204,957	**Milestone 4**: I-12 Increase primary care clinic volume o f visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Data Source: Registry Goal: Increase primary care capacity by 200 patients to accommodate the needs of our residents. Milestone 4 Estimated Incentive Payment: $175,603
Year 2 Estimated Milestone Bundle Amount: $175,011	Year 3 Estimated Milestone Bundle Amount: $202,860		Year 4 Estimated Milestone Bundle Amount: $204,957	Year 5 Estimated Milestone Bundle Amount: $175,603
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $758,431				

Summary Information: Electra Memorial Hospital

New Pass 3B Project 135034009.1.4
(Old Pass 1 Project 135034009.1.1)

- Provider: Electra Memorial Hospital is a 19-bed critical access hospital in Electra, Texas on the western edge of Wichita County, serving a 25 square mile area and a population of approximately 8,000. The Hospital District owns Electra Medical Clinic, which is the only clinic located in Electra, which is considered to be a non-urbanized area of an urban county.

- Intervention(s): This project will expand our existing clinic capacity to accommodate additional providers and extended hours.

- Need for the project: We have 12 exam rooms for four providers, with limited providers available from 7 am – 7 pm. When providers aren't available, patients present to the emergency room for primary care.

- Medicaid and Uninsured Target population: The target population is our Medicaid and uninsured patients that seek primary care in the emergency department of the hospital. Approximately 47% of our hospital emergency department patients and 17% of our clinic patients are either Medicaid eligible or uninsured. We estimate that this represents approximately 600 patients and 825 emergency department visits.

- Category 1 or 2 expected patient benefits: The project seeks to reduce emergency department visits for non-emergent conditions from the current level by 150 visits over the 4 years of the waiver. Over 2,100 visits were made to the emergency department of the hospital in 2012. Of the total Medicaid and uninsured patients, approximately 30%, or 180 patients and almost 250 visits, were for non-emergent services. At the same time, we expect to provide approximately 100 additional primary care clinic visits each year, 50 of which would be to Medicaid and uninsured patients that would possibly have been treated in the emergency room. In the clinic, there were over 3,000 unique patients that had over 11,000 visits. Approximately 700 Medicaid and uninsured patients were seen for over 1,800 clinic visits. We expect they will benefit from the availability of primary care services outside normal operating hours, since 29% of ED visits to Medicaid and uninsured patients are for non-emergent conditions. We expect additional patients that would not have sought treatment at the onset of their illness to utilize the clinic setting at an earlier stage, which will result in fewer complications and reduced hospital admissions.

- Category 3 outcomes: IT-9.2. Our goal is to reduce ACSC encounters in the emergency department from the current level by 150 visits by the end of DY5.

Category 1: Infrastructure Development

Project Option: Project 1.1 Option 1.1.2 Expand primary care capacity

RHP Project Number: New ID: 135034009.1.4
(**Old ID:** 135034009.1.1)

RHP Performing Provider: Electra Memorial Hospital- 135034009

Project Description:

In order to meet the Triple Aim goals of RHP 19 of right care, right place, right time, and to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, Electra Memorial Hospital (EMH) plans to expand our existing clinic space, expand the hours of the clinic, and employ primary care providers and staff 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 addresses the current challenge almost all rural Texas hospitals face of patients presenting to the Emergency Department for primary care services and the limited number of providers available, as noted in CN.3 of the RHP 19 Needs Assessment, to provide those services. Patients have no access to primary care other than a hospital's emergency department after hours and on weekends. We know this is true at our hospital based on the number of Medicaid claims for emergency room visits that have had payment reductions due to non-emergent diagnoses. We suspect that this is true for all patients, including other low income and uninsured populations, but we have not been compiling that information. By expanding clinic space to accommodate additional providers and extended hours, patients will have greater access to primary care, which should reduce emergency department encounters for Medicaid and the uninsured, as well as all patients. Our 5-year goal is to increase clinic visits and clinic capacity and decrease non-emergent emergency department visits at Electra Memorial Hospital. Patients will be better served in the most appropriate setting for the care they need. Other projects in this region reflect similar needs, but do not address the Electra community.

Starting Point/Baseline:

Current clinic space allows for four practitioner offices but currently houses two primary care physicians and four hospital-employed nurse practitioners providing primary care. These same practitioners also provide emergency room coverage in the hospital's emergency department. Two of the nurse practitioners were added in early September, 2012, in anticipation of this project, using supply rooms as temporary offices. The clinic is open from 7 am until 7 pm, Monday through Friday, with walk-ins being seen from 7-8:30 am, 11 am – 2 pm, and 4-7 pm. The provider taking emergency room calls also takes walk-ins, which disrupts the patient flow in the clinic. We believe,

based on Medicaid claims history, that many of our emergency room encounters have a primary diagnosis that would indicate they could have been treated in a clinic setting. Baseline data will be established by gathering data from January through September of 2012 and annualizing those numbers in order to create comparatives.

Rationale:

As evidenced by the health statistics in our community needs assessment in CN.4 and CN.5, there is low utilization of preventive services in the region, as well as a need to overcome barriers to patient access. Wichita County, which includes the Electra Hospital District, is a low-income HPSA. Electra Memorial Hospital (EMH) has selected Project 1.1 Expand Primary Care Capacity due to the need for increased access to primary care in the local area and the entire RHP 19 region. Though we are in Wichita County, EMH is 27 miles from Wichita Falls and United Regional Health Care System (URHCS), our tertiary provider. Electra is considered to be in a non-urbanized area of an urban county by the US Census Bureau, with patients and local community similar to rural areas. Our current clinic space is occupied by 4 full-time primary care providers. Our limited provider capacity is exacerbated by the EMTALA requirement that patients be treated in the emergency department once they present themselves for treatment. Rural physicians wear many hats. In our community our primary clinic physicians are often called away from the clinic to see non-emergent cases in the ED. The costs associated with emergency department services far outweigh the costs of care in a clinic setting. With the confluence of factors facing our ED and the clinic, it is important that we expand primary care capacity so that when we begin educating patients on urgent care services available in the clinic, there is the capacity for them to be seen and/or make necessary appointments.

In order to accommodate the needs of the community and reform the delivery system in our area, we are proposing to expand our clinic to provide space for two additional providers. These providers would provide primary care in the clinic setting 12 hours per day, six days per week. After trying to recruit a physician for over a year with no success, two nurse practitioners were hired to fill the void, but they are sharing space with the other practitioners, which doesn't allow for additional volume since there are no additional exam rooms. In the event that a physician is successfully recruited, space will be an even bigger issue. Over the next 5 years, as identified in project option 1.1.2 Expand Existing Primary Care Capacity we expect to implement each core component as outlined below.

A. Expand our primary clinic space to include two additional provider offices and six additional exam rooms.

B. Expand primary care clinic hours to accommodate walk-ins 12 hours per day, 6 days per week.

C. We hired two additional nurse practitioners in September of 2012 that will allow the clinic to be staffed one additional day per week.

We further anticipate that this project will reduce the percentage of emergency room visits with primary care diagnoses. We expect that patients will recognize the value of

being treated in the appropriate setting and take advantage of the extended hours in the clinic. Additional providers and staff allow more patients to be seen and a greater choice of providers. By expanding our clinic, providing two additional practitioners and expanding hours, we would be meeting community needs in our area of the region. Approximately 10% of our patients are Medicaid clients, so we also plan to enroll and train our new providers in the Texas Health Steps program so that they can provide primary care services to the Medicaid population in the area. Project milestones will include expanding clinic space and expanding clinic hours. Metrics to measure these will be additional square footage in the clinic and additional clinic hours available to treat patients. Improvement milestones will be the increased volume of clinic visits and increased access to primary care capacity. These will be measured by the volume of visits and unique patients. This project would be a new initiative for us and enable us to reform our existing delivery system.

Related Category 3 Outcome Measure(s):

OD- 9 Right Care, Right Setting 135034009.3.5 (135034009.3.1)
IT-9.2 ED appropriate utilization (Standalone measure)
OD-9 Right Care, Right Setting and IT-9.2 ED appropriate utilization was selected because we believe a large number of our emergency department encounters have an Ambulatory Care Sensitive Condition (ACSC) as a primary diagnosis. As noted in CN.5, the region has access to care barriers, driving patients to the emergency department. No baseline data has been established, but we believe that these types of emergency room encounters are better served in a clinic setting, which can only be done by providing primary care services outside traditional clinic hours. By making primary and preventive care available at times that are convenient to patients, the health of the community we serve can be improved and emergency department visits reduced. By training additional providers in the Texas Health Steps program, Medicaid and low-income populations will be given greater access to preventive services.

Relationship to other Projects:

As noted above, this project relates to the Category 3 project, 135034009.3.5 (135034009.3.1) to improve appropriate ED utilization. 135034009.1.4 (135034009.1.1), Expanded Primary Care Capacity, is a common project throughout the region due to the rural nature of RHP 19. We are also addressing Expansion of Primary Care in 135034009.1.3 that will service the Iowa Park community, just 15 miles east of Electra. Iowa Park patients that have historically been treated in Electra Medical Clinic have been excluded from this project's calculations since they will be used for baseline data in project 135034009.1.3. Information gathered from electronic health records can be analyzed to evaluate PPAs for CHF, 135034009.3.6 (135034009.3.2) and Diabetes, Behavioral Health admission rates, COPD/Asthma admission rates, hypertension admission rates, pediatric asthma encounters, bacterial pneumonia immunizations, and influenza immunizations. 30-day readmissions for these as well as stroke can be tracked

and potentially reduced. Medication management reconciliations can be compiled, along with the number of patients or caregivers who receive a reconciled medication list at the time of discharge. Through this project, we expect the overall health of our local community to be improved, thereby improving the health of the entire region. Expanded Specialty Care, 135034009.1.5 (135034009.1.2), compliments this project by providing greater access to specialty care, which can also result in lowering ED visits, but also reduce potentially preventable readmissions. Together with the care transitions project, 135034009.2.2 (135034009.2.1), and the placement of ED case managers throughout the region, ED admissions as well as all types of potentially preventable admissions and readmissions, 135034009.3.7 (135034009.3.3) can be deterred.

Relationship to Other Performing Providers' Projects in the RHP:

Other Performing Providers in RHP 19 that are doing similar projects in their local areas, are:

Bowie Memorial Hospital 127305405.1.2 (127305405.1.1)
Clay County Memorial Hospital 094138703.1.2 (094138703.1.1)
Graham Regional Medical Center 130613604.1.2 (130613604.1.1)
Hamilton Hospital 110856504.1.2 (110856504.1.1)
Hardeman County Memorial Hospital 121692107.1.2 (121692107.1.1)
North Texas Medical Center 121777003.1.2 (121777003.1.1)
United Regional Health Care System 135237906.1.2 (135237906.1.1)
Wilbarger General Hospital 112707803.1.2 (112707803.1.1)

None of these address primary care in the Electra community. It is well known that the national supply of primary care does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHP 19 is in real need of expanding primary care capacity in the entire region in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

Project Valuation:

The value of this project was determined by considering investment, scope, community need, and local available funds. We considered the cost of employing two additional nurse practitioners and four additional support staff personnel to accommodate the expanded hours, the community benefit of expanding hours to serve our local population and thereby improving the patient experience. As noted above, we have faced ongoing barriers to recruiting needed physicians to our community. Rural providers must make significant investments to recruit physicians, nurse practitioners and other mid-levels to fill the void and address community needs. Electra Medical Clinic provided 11,000 clinic visits in 2012, of which approximately 1,800 were Medicaid or uninsured visits. We project that clinic visits will increase by 5% over the next 4 years to 11,500 total visits, 1,950 of which will be for Medicaid and the uninsured. 24% of all

unique patients seen, or approximately 700, in 2012 were Medicaid or uninsured patients, before considering Medicare patients that are dual eligible. We are projecting that we will move 150, Medicaid and uninsured visits from the ED to the clinic setting by the end of 2016, and establish physician/patient relationships that will continue that trend into the future. In addition, we expect to increase Medicaid unique patient encounters from approximately 700 in 2012 to 750 by the end of the waiver. Other factors considered were the value of the reduction in cost to Medicaid and other payers of providing primary care services in the appropriate clinic setting rather than in the emergency department of the hospital and the value of maintaining a healthy community for many years to come. Using the assumptions above, 1.4 (Old 1.1) Expand Primary Care Capacity is valued at $2,231,365 over DY 2 – DY 5. This includes the value of additional staff, space, and of providing additional clinic hours for primary care services. Each year we have at least one milestone, and in years with more than one, each is valued equally per the PFM Protocol. This project makes a significant investment into our low income population and provides additional access to primary care. This initiative is projected to reduced non-emergent ED utilizations, increase vaccination rates and disease screenings which would prevent hospitalizations. In addition to the project investments, we project savings to the public payer systems of at least $160,000 each year based on pilots by DSHS and other initiatives across the nation, as well as savings to other payers and to our local hospital district taxpayers for the burden they bear for uninsured patients.

NEW ID: 135034009.1.4 (OLD ID: 135034009.1.1)	1.1.2	1.1.2.A 1.1.2.B 1.1.2.C	EXPAND PRIMARY CARE CAPACITY
Electra Memorial Hospital			135034009
Related Category 3 Outcome Measure(s):	OD-9 IT-9.2	135034009.3.5 (135034009.3.1)	Right Care, Right Setting ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-4. Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1 P-4.1. Increased number of hours at primary care clinic over baseline. Baseline/Goal: In September 2012 clinic hours were expanded to 7 am – 7 pm Monday through Friday, with walk-ins only accepted 5 ½ hours each day. Our goal is to expand the hours to 7 am – 7 pm Monday through Saturday with walk-ins accepted 12 hours each day.	**Milestone 3** P-1. Expand existing primary care clinic space. Metric 1 P-1.1. Expanded clinic space. Baseline/Goal: In September 2012 our clinic design allowed for 4 providers in 4,320 square feet. Our goal is to expand the clinic to accommodate 2 additional providers that were hired in September in anticipation of this project. Data Source: Documentation of detailed expansion and construction plans.	**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 clinic visits in DY 3 over the base period. Goal: Increase in clinic visits by 400 over base period. Data Source: EHR reports indicating the total number of visits in DY 1 and DY 3. Metric 2 I-12.2: Documentation of increased number of unique patients	**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 clinic visits in DY 4 over the base period. Goal: Increase in clinic visits by 500 over base period. Data Source: EHR reports indicating the total number of visits in DYs 1and 4. Metric 2 I-12.2: Documentation of increased number of unique patients encountered in the

NEW ID: 135034009.1.4 (OLD ID: 135034009.1.1)	**1.1.2**	**1.1.2.A 1.1.2.B 1.1.2.C**	**EXPAND PRIMARY CARE CAPACITY**	
Electra Memorial Hospital				135034009
Related Category 3 Outcome Measure(s):	OD-9 IT-9.2	135034009.3.5 (135034009.3.1)	Right Care, Right Setting ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Clinic schedule showing availability of providers. Milestone 1 Estimated Incentive Payment: $272,856.50 **Milestone 2** P-X. Establish a baseline in order to measure improvement over self. Metric 1 P-X.1. Compilation of baseline data from DY 1. Baseline/Goal: Compile 9 months of DY 1 data	Milestone 3 Estimated Incentive Payment: $297,671.50 **Milestone 4** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Documentation of increased number of visits in DY 2 over base period. Goal: Increase clinic visits by 200 over base period. Data Source: EHR reports indicating the total number		encountered in the clinic in DY 3 over prior reporting period. Goal: Increase number of unique patients encountered from DY 1 to DY 3 by 40. Data Source: EHR reports indicating the total number of unique patient encounters in DY 2 and DY 3. Milestone 5 Estimated Incentive Payment: $597,074	clinic in DY 4 over prior reporting period. Goal: Increase number of unique patients encountered from DY 1 to DY 4 by 50. Data Source: EHR reports indicating the total number of unique patient encounters in DY 2 and DY 4. Milestone 6 Estimated Incentive Payment: $493,235

NEW ID: 135034009.1.4 (OLD ID: 135034009.1.1)	1.1.2	1.1.2.A 1.1.2.B 1.1.2.C	EXPAND PRIMARY CARE CAPACITY	
Electra Memorial Hospital				135034009
Related Category 3 Outcome Measure(s):	OD-9 IT-9.2	135034009.3.5 (135034009.3.1)	Right Care, Right Setting ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
(January 2012 – September 2012) to set baselines for clinic visits, unique patients and emergency department visits by diagnosis. Annualize to establish comparison data for subsequent years. Data Source: EHR reports indicating the number of clinic visits, unique patients and emergency department visits, annualized. Milestone 2 Estimated Incentive Payment: $272,856.50	of visits in DY 2 and in annualized base period. <u>Metric 2</u> I-12.2. Documentation of increased number of unique patients encountered in the clinic in DY 2 over base period. Goal: Increase in clinic unique patient encounters over base period by 20. Data Source: EHR reports indicating the total number of unique patient encounters in DY 2 and DY 1. Milestone 4 Estimated Incentive Payment: $297,671.50			

NEW ID: 135034009.1.4 (OLD ID: 135034009.1.1)	**1.1.2**	**1.1.2.A** **1.1.2.B** **1.1.2.C**	**EXPAND PRIMARY CARE CAPACITY**	
Electra Memorial Hospital				135034009
Related Category 3 Outcome Measure(s):	OD-9 IT-9.2	135034009.3.5 (135034009.3.1)	Right Care, Right Setting ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $545,713	Year 3 Estimated Milestone Bundle Amount: $595,343		Year 4 Estimated Milestone Bundle Amount: $597,074	Year 5 Estimated Milestone Bundle Amount: $493,235
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $2,231,365				

Summary Information: Electra Memorial Hospital
New Pass 3B Project 135034009.1.5
(Old Pass 1 Project 135034009.1.2)

- Provider: Electra Memorial Hospital is the anchor hospital for RHP 19, located in Electra, Texas on the western edge of Wichita County. As the anchor for RHP 19, Electra is coordinating this Regional Project for the entire region.

- Intervention(s): This is a regional project that focuses on specialty care in RHP 19, in cooperation with United Regional Health Care Center, the tertiary and safety net hospital, as well as the other hospitals in RHP 19. Specialists will be recruited to Wichita Falls and provided on an intermittent basis as demand requires, in the rural areas of the region.

- Need for the project: Specialists are difficult to recruit, even to Wichita Falls. With the shortage of specialists in the entire region, we plan to coordinate an effort with URHCS to recruit specialists to Wichita Falls where the demand is greater, and then have the specialists that are needed in the rural areas have monthly or semi-monthly clinics at the other hospitals throughout the region where the population is inadequate to support full-time specialty care.

- Medicaid and Uninsured Target population: The target population is the approximately 260,000 people that reside in RHP 19. Only 52% of the patients in RHP 19 have commercial insurance. 15% are Medicare recipients, and the remaining 33% are covered by either Medicaid, CHIP or are uninsured.

- Category 1 or 2 expected patient benefits: This project seeks to increase the number of specialty care providers by 4 as well as total clinic hours of availability; and increase the number of specialty care referrals and visits by 6%, or 250, by DY 4 and an additional 250 in DY 5. 85,000 Medicaid and uninsured patients will potentially be affected by this project. However, we have estimated that 5% of those will seek specialty care, which is approximately 4,250 Medicaid or uninsured patients. CHF patients will represent 600-700 of visits by those patients.

- Category 3 outcomes: IT-3.2. Our goal is to reduce the congestive heart failure 30-day readmission rate in RHP 19 by 4%.

Category 1: Infrastructure Development

Project Option: Project 1.9 Expand Specialty Care Capacity, Improve Access to Specialty Care

RHP Project Number: New ID : 135034009.1.5
(Old ID : 135034009.1.2)

RHP Performing Provider: Electra Memorial Hospital-135034009

Project Description:

The Community Needs Assessment for RHP 19 has identified a shortage of health care professionals (CN.3) and the need to overcome patient access to care barriers (CN.5) as needs of this region. Electra Memorial Hospital has selected Expand Specialty Care Capacity, 1.9.2, as a project that will provide additional specialty services to the Medicaid and uninsured populations, as well as all other patients, in RHP 19. Some of the challenges will include physician call coverage for specialties that need only one specialist based on the population needs assessment, resources needed to provide a physician employment model since this is the preferred model for physicians coming out of residencies, and resources needed to coordinate with outlying providers for scheduling of specialty physicians in their clinic locations. By identifying shortages of specific specialties throughout the region, gaps in care and care coordination can be overcome. Medicaid and low-income patients will have improved access to specialty care, reducing the amount of time before seeking that care due to transportation barriers and service availability, providing earlier interventions for more complicated diseases. Recruitment strategies for attracting high demand specialists will be developed and implemented. Existing physician office space will be expanded to provide additional office space to accommodate new specialty physicians. Current primary care physicians and residents in the region will be educated regarding available specialty services and physician specialists. We plan to conduct a physician needs assessment to measure outcomes of project goals and to provide ongoing direction for continuous recruitment of needed physician specialists. By providing specialty care throughout the region, we can address the challenges and work to improve specialty care access. By increasing specialty care access, the triple aim goals of right care, right time and right setting can be accomplished for specialty care services throughout the region. By the end of the 5-year waiver period, we expect to increase specialty care access to all patients in RHP 19.

Starting Point/Baseline:

A baseline will be established in DY 2 by compiling information from providers in RHP 19 that are in need of high impact/most impacted medical specialty care physicians. Statistics on current specialty providers and frequency, as well as what is needed will also be determined.

Rationale:

RHP 19's goals are to advance the Triple Aim: right care, right place, and right time. Providing specialty care throughout the region will further those goals. Additionally, Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions as evidenced by the Texas Department of State Health Services, Center for Health Statistics, seems to suggest that providing specialty care in rural areas encourages low income populations to seek specialty care on a more frequent basis than if they were required to travel outside their local area. By providing specialty services in all areas of RHP 19, admissions and readmission could be potentially prevented. CN.3, Shortages of health care professionals, shows that there is a shortage of specialty providers throughout the region.

United Regional Health Care System (URHCS) is the safety-net hospital for RHP 19 as well as the tertiary hub. Residents of the Region depend on URHCS to provide specialty care services, but often have barriers to seeking those services in Wichita Falls. Electra Memorial Hospital plans to work with URHCS and other providers in RHP 19 to provide increased service availability and convenient access to high-demand specialty care services so that a burden does not continue to be placed on area residents to seek care hours from their home unless they choose to do so. Inadequate access to specialty care has contributed to low income populations seeking emergency department care and being admitted/readmitted for conditions that could be managed properly through regular specialty provider visits. Through a coordination effort with URHCS and other providers in RHP 19, recruitment efforts of specialty physicians can be increased, additional office space provided, opportunities created within an employed physician model, and methods to support physician specialists' treatment and transfer protocols developed. A learning collaborative is planned to identify "lessons learned" and the impact of the project on the health of the population in RHP 19.

Over the next 5 years, as identified in project option 1.9.2 Expand Specialty Care Capacity, Improve Access to Specialty Care, we expect to implement each core component as outlined below.

1.9.2.a. Increase service availability and extended hours to residents of the region by providing high impact/high demand specialty physicians at the local level and priority scheduling in URHCS specialty clinics for patients located outside Wichita Falls zip codes.

1.9.2.b. Increase the number of specialty clinic locations throughout the region through construction, renovation or leasing/renting of existing space.

1.9.2.c. Coordinate and implement transparent, standardized referrals to URHCS within the region, as well as work with other regions as needed.

1.9.2.d. Consider conducting a learning collaborative for targeted specialty care services to identify the impact of the project and reflect on "lessons learned".

Related Category 3 Outcome Measure(s): 135034009.3.6 (135034009.3.2)
OD-3. Potentially Preventable Readmissions
IT-3.2, Congestive Heart Failure 30 day readmission rate.

Table Y in the Supporting Data for the Community Needs Assessment for RHP 19 indicates that congestive heart failure (CHF) is the second leading diagnosis related to potentially preventable admissions. This improvement target has been selected because of the importance of reducing admissions and readmissions in the entire RHP, resulting in higher quality of care, reduced costs to payers, improved access to care for low-income populations, and an overall improved patient experience. By providing specialty care to outlying providers and priority scheduling in URHCS specialty clinics for patients located outside Wichita Falls zip codes, barriers to care can be reduced, resulting in preventive treatments that will reduce admissions to other providers as well as the safety net hospital. Patients can access specialists in their own communities or receive priority scheduling in Wichita Falls, and take preventive measures rather than waiting until their disease has progressed to the point of requiring admission to the local hospital and possibly subsequent transfer and admission/readmission to URHCS.

Relationship to other Projects:

Specialty care is a need in RHP 19 as is Primary care, which is addressed in our Projects to Expand Primary Care Capacity, 135034009.1.4 (135034009.1.1) and 135034009.1.3. Primary care providers can be recruited at the local level, but the demand for specialty care is not great enough to support specialists in rural areas. Helen Farabee Center's 127373205.1.2 expands specialty care for psychiatric patients and Seymour Hospital's 138353107.1.1 addresses obstetrics. No obstetricians are being sought for specialty care expansion in this project. The shortage of providers and difficulty in recruiting physicians in this region has been a challenge for all providers for many years. Rural providers do not have the resources or demand to sustain specialty care on their own, but by developing a synergistic relationship with United Regional in Wichita Falls, specialty care could be provided on a regular intermittent basis to rural regional providers. By establishing priority scheduling protocols for patients outside Wichita Falls, access to care would be enhanced for rural patients. Local primary care providers could establish a rapport with targeted specialty care physicians, which would facilitate transfers between providers when necessary and provide familiarity for patients when they are referred by their primary care provider for specialty services. Referral of Medicaid and uninsured patients is often difficult, so a relationship between the rural physicians outside of Wichita Falls and the specialty care physicians practicing in Wichita Falls that is based on referrals of all payer types, will help facilitate those referrals. Additionally, our Category 2 Project 135034009.2.2 (135034009.2.1) Implement/Expand Care Transitions Programs is focused on returning patients to their primary care physician and reducing all 30-day readmissions, creating synergy among all projects.

Relationship to Other Performing Providers' Projects in the RHP:

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

project compliments all of those and creates a synchronized effort among all providers in RHP 19 to gain access to specialty care, including the safety net hospital, that could not be sustained at the local level. We believe that developing a project that provides services to the entire region, creates a cohesive environment for providers to build upon and compliments other projects within the RHP.

Plan for Learning Collaborative:

We expect to host learning collaboratives for CHF that will educate not only the specialists, but also the regional primary care providers, on the impact of the project, the lessons that are being learned from the implementation of this project, and opportunities to improve upon the project.

Project Valuation:

The value of this project was determined by estimating costs of recruiting specialty care physicians, physician employment costs, the cost of additional space to house the specialists, the cost of additional support staff for physician clinical operations, the community benefit to payers and taxpayers in the reduction of hospital admissions, and the cost avoidance benefit of maintaining a healthy community that will result from increased access to these providers. The scope of this project includes all 260,000 patients in RHP 19, which justifies a significant valuation based on the fact that it serves the population of the entire region rather than a single provider or community. Approximately 85,000 of the patients in RHP 19 are either uninsured or covered by Medicaid or CHIP. If 5% of those patients seek specialty care, that would approximate to 4,250 Medicaid or uninsured patients. We hope to recruit at least 4 new specialty care providers, increase the total clinic hours of availability, and increase the number of specialty care referrals by 6%, or 250 visits, in DY 4 and 5. Potential cost avoidance when patients don't have to delay necessary care for chronic conditions is also factored into the weight of this project. The community need and health disparity for patients with CHF related diagnoses supports this valuation. Using these assumptions and estimates, we have valued 1.2 at $12,272,513 over DY 2 – DY 5. This includes the value of additional staff, space, and of providing specialty care services. Each year we have at least one milestone, and in years with more than one, each is valued equally per the PFM Protocol.

NEW ID: 135034009.1.5 (OLD ID: 135034009.1.2)	PROJECT OPTION 1.9.2	PROJECT COMPONENTS 1.9.2.A, 1.9.2.B, 1.9.2.C, AND 1.9.2.D	EXPAND SPECIALTY CARE CAPACITY
Electra Memorial Hospital			135034009
Related Category 3 Outcome Measure(s):	IT-3.2	135034009.3.6 (135034009.3.2)	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 : P-1. Conduct specialty care gap assessment based on community need P-1.1. Metric: Documentation of gap assessment. Establish the baseline for subsequent year comparison. Baseline: Conduct Gap Assessment Data Source: Needs Assessment Milestone 1 Estimated Incentive Payment (maximum amount): $750,355.25	**Milestone 5: P-12.** Implement a specialty care access plan to include such components as statement of problem, background and methods, findings, implication of findings in short and long term, conclusions P-11.1 Metric: Documentation of specialty care access plan Goal: Implementation of plan for multiple specialties as determined by the gap analysis Data source: Documentation of Safety Net Hospital plan. Milestone 5 Estimated Incentive Payment: $818,597.50	**Milestone 9:** I-29. Increase the number of referrals of targeted patients to the Safety Net Hospital specialty care clinic I-29.1 Metric: Number of referrals of targeted patients Goal: 4500 referrals for specialty care from primary care physicians in RHP 19 to URPG Data Source: Registry or paper documentation of referrals from primary care physicians in the region. Milestone 9 Estimated Incentive Payment: $1,094,636	**Milestone 12:** I-29. Increase the number of referrals of targeted patients to the Safety Net Hospital specialty care clinic I-29.1 Metric: Number of referrals of targeted patients Goal: 4,750 referrals for specialty care from primary care physicians in RHP 19 to URPG Data Source: Registry or paper documentation of referrals from primary care physicians in the region Milestone 12 Estimated Incentive Payment: $904,264.66

NEW ID: 135034009.1.5 (OLD ID: 135034009.1.2)	PROJECT OPTION 1.9.2	PROJECT COMPONENTS 1.9.2.A, 1.9.2.B, 1.9.2.C, AND 1.9.2.D	EXPAND SPECIALTY CARE CAPACITY
Electra Memorial Hospital			135034009
Related Category 3 Outcome Measure(s):	IT-3.2	135034009.3.6 (135034009.3.2)	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2: P-15. Implement loan repayment program for Targeted Specialty Care (TSC) providers P-15.1 Metric: Loan Repayment program documentation Goal: Implement loan repayment program for Targeted Specialty Care (TSC) providers to Safety Net Hospital or their physician group Data Source: Program Materials Milestone 2 Estimated Incentive Payment: $750,355.25	**Milestone 6: P-13.** Complete planning and installation of new specialty systems (imaging systems) at Safety Net Hospital P-13.1 Metric: Documentation of planning and installation of new systems. Goal: Specialty system implementation. Data Source: Documentation of specialty system implementation plan. Milestone 6 Estimated Incentive Payment: $818,597.50	**Milestone 10: I-22**. Increase the number of specialist providers, clinic hours and/or procedure hours available for high impact/most impacted medical specialties. I-22.1 Metric: Increase number of specialist providers and clinic hours and/or procedure hours in targeted specialties Goal: Increase specialist hours and providers at Safety Net Hospital facilities and provide increased clinic hours and/or procedure hours in the rural clinics in RHP 19 as well as priority scheduling with Safety Net Hospital specialists for	**Milestone 13: I-22**. Increase the number of specialist providers, clinic hours and/or procedure hours available for high impact/most impacted medical specialties. I-22.1 Metric: Increase number of specialist providers and clinic hours and/or procedure hours in targeted specialties Goal: Increase specialist hours and providers at Safety Net Hospital facilities and provide increased clinic hours and/or procedure hours in the rural clinics in RHP 19 as well as priority scheduling with Safety Net Hospital specialists for

NEW ID: 135034009.1.5 (OLD ID: 135034009.1.2)	PROJECT OPTION 1.9.2	PROJECT COMPONENTS 1.9.2.A, 1.9.2.B, 1.9.2.C, AND 1.9.2.D	EXPAND SPECIALTY CARE CAPACITY	
Electra Memorial Hospital				135034009
Related Category 3 Outcome Measure(s):	IT-3.2	135034009.3.6 (135034009.3.2)	Congestive Heart Failure 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			patients outside Wichita Falls zip codes. Data Source: HR Documents, Clinic Records Milestone 10 Estimated Incentive Payment: $1,094,636	patients outside Wichita Falls zip codes. Data Source: HR Documents, Clinic Records Milestone 13 Estimated Incentive Payment: $904,264.66

NEW ID: 135034009.1.5 (OLD ID: 135034009.1.2)	PROJECT OPTION 1.9.2	PROJECT COMPONENTS 1.9.2.A, 1.9.2.B, 1.9.2.C, AND 1.9.2.D	EXPAND SPECIALTY CARE CAPACITY
Electra Memorial Hospital			135034009
Related Category 3 Outcome Measure(s):	IT-3.2	135034009.3.6 (135034009.3.2)	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 3: I-33. Increase specialty care capacity - Recruit/hire more trainees / graduates to TSC positions in the Safety Net Hospital's facilities or practices to facilitate regional TSC needs. I-33.1 Metric: Change in the number of graduates/trainees accepting positions in the Safety Net Hospital's facilities or practices over baseline Baseline/Goal: Work with Safety Net Hospital to Recruit/hire two Providers to TSC positions in the Safety Net Hospital's facilities or practices	**Milestone 7: I-33.** Increase specialty care capacity - Recruit/hire more trainees / graduates to TSC positions in the Safety Net Hospital's facilities or practices to facilitate regional TSC needs. I-33.1 Metric: Change in the number of graduates/trainees accepting positions in the Safety Net Hospital's facilities or practices over baseline Baseline/Goal: Work with Safety Net Hospital to Recruit/hire two Providers to TSC positions in the Safety Net Hospital's facilities or practices		

NEW ID: 135034009.1.5 (OLD ID: 135034009.1.2)	PROJECT OPTION 1.9.2	PROJECT COMPONENTS 1.9.2.A, 1.9.2.B, 1.9.2.C, AND 1.9.2.D	EXPAND SPECIALTY CARE CAPACITY
Electra Memorial Hospital			135034009
Related Category 3 Outcome Measure(s):	IT-3.2	135034009.3.6 (135034009.3.2)	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: HR documents Milestone 3 Estimated Incentive Payment: $750,355.25	Data Source: HR documents Milestone 7 Estimated Incentive Payment: $818,597.50		
Milestone 4: P-11. Expand a specialty care clinic (CHF Clinic). P-11.1 Metric: Expand specialty care clinics	**Milestone 8: P-11.** Expand a specialty care clinic (CHF Clinic). P-11.1 Metric: Expand specialty care clinics	**Milestone 11: P-11.** Expand a specialty care clinic (CHF Clinic). P-11.1 Metric: Expand specialty care clinic	**Milestone 14: P-11.** Expand a specialty care clinic (CHF Clinic). P-11.1 Metric: Expand specialty care clinic

NEW ID: 135034009.1.5 (OLD ID: 135034009.1.2)	PROJECT OPTION 1.9.2	PROJECT COMPONENTS 1.9.2.A, 1.9.2.B, 1.9.2.C, AND 1.9.2.D	EXPAND SPECIALTY CARE CAPACITY
Electra Memorial Hospital			135034009
Related Category 3 Outcome Measure(s):	IT-3.2	135034009.3.6 (135034009.3.2)	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Baseline: 625 CHF specialty clinic visits based on January – December 2012 statistics. Data Source: Documentation of expanded specialty care clinic Milestone 4 Estimated Incentive Payment: $750,355.25	Goal: Increase the number of visits by the URPG for CHF specialty care to 637, either in Wichita Falls or RHP 19 rural clinics. Data Source: EHR Documentation of number of patients served Milestone 8 Estimated Incentive Payment: $818,597.50	Goal: Increase the number of visits by the URPG for CHF specialty care to 650, either in Wichita Falls or RHP 19 rural clinics. Data Source: EHR Documentation of number of patients served Milestone 11 Estimated Incentive Payment: $1,094,636	Goal: Increase the number of visits by the URPG for CHF specialty care to 663, either in Wichita Falls or RHP 19 rural clinics. Data Source: EHR Documentation of number of patients served Milestone 14 Estimated Incentive Payment: $904,264.67
Year 2 Estimated Milestone Bundle Amount: $3,001,421	Year 3 Estimated Milestone Bundle Amount: $3,274,390	Year 4 Estimated Milestone Bundle Amount: $3,283,908	Year 5 Estimated Milestone Bundle Amount: $2,712,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $12,272,513			

Summary Information: Electra Memorial Hospital

Pass 1 Project 135034009.1.3

- Provider: Electra Memorial Hospital is a 19-bed critical access hospital in Electra, Texas on the western edge of Wichita County that currently serves a 25 square mile area and a population of approximately 8,000. This project seeks to expand the service area to include the city of Iowa Park, 15 miles to the east, which has a population of an additional 8,000 people.

- Intervention(s): This project will open a new clinic in Iowa Park, which is located in central Wichita County, approximately 15 miles east of Electra.

- Need for the project: There is currently only one single-physician clinic in Iowa Park, a community of approximately 8,000 people. New patient appointments are difficult to obtain, especially for Medicaid and uninsured patients. The current physician is only enrolled in one Medicaid Managed Care plan.

- Medicaid and Uninsured Target population: The target population will be approximately ½ of the Iowa Park population, or 4,000 people. Since approximately 15% of patients in RHP 19 are either Medicaid eligible or indigent, we expect that 600 Medicaid or uninsured patients will benefit from the increased availability of primary care services.

- Category 1 or 2 expected patient benefits: The project seeks to provide approximately 2,000 primary care visits by the end of the waiver period to all patients, including Medicaid and uninsured patients that might not otherwise have had local access. By doing so, we expect to better control high blood pressure for those patients being treated at the Iowa Park clinic. Additionally, new providers at the clinic will be trained in the Texas Health Steps program, which will help to establish medical homes for children and their families. We expect to have 500 unique patients by the end of the waiver.

- Category 3 outcomes: OD-1. IT-1.7. Our goal is to increase the number of primary care visits for Medicaid and uninsured patients in Iowa Park by 2,000 from DY 3 -DY 5 in order to control high blood pressure.

Pass 3

Category 1: Infrastructure Development

Project Option: Expand primary care capacity/Establish more primary care clinics

RHP Project Number: 135034009.1.3

RHP Performing Provider: Electra Memorial Hospital-135034009

- **Identifying Project and Provider Information: 1.1, Option 1.1.1** Expand primary care capacity/Establish more primary care clinics **135034009.1.3**. Electra Memorial Hospital/135034009.
- **Project Description:** In order to meet the Triple Aim goals of RHP 19 of right care, right place, right time, and to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, Electra Memorial Hospital (EMH) plans to establish a primary care clinic in Iowa Park, which is a city of approximately 8,000 people located in Wichita County with no hospital within its zip code. Iowa Park is approximately 15 miles to the east of Electra and approximately 15 miles west of Wichita Falls. There is currently one primary care clinic in Iowa Park that houses a one physician practice. Residents of the community have expressed frustration in their inability to get an appointment at the local clinic, and have expressed great interest in a new clinic there. The clinic physician is a Medicaid provider that contracts with Superior Health Care, but is not a provider for First Care or Amerigroup managed care plans as a Texas Health Steps provider. By providing primary care services locally, including Medicaid services for all three managed care plans, patients can receive the right care at the right time in the right setting, and Medicaid patients will have access to preventive services no matter what managed care plan they choose. This project addresses the current challenge almost all rural Texas communities face of having a limited number of providers available to provide primary care services. Other projects in this region reflect similar needs, but do not address the Iowa Park community. By opening a new clinic, patients will have greater access to primary care, greater access to preventative services and increased ability to control chronic diseases, such as high blood pressure. Our goal is to provide patients with additional appointment and provider options in order to control high blood pressure in that area of the region.
- **Starting Point/Baseline:** There is currently one primary care clinic in the Iowa Park community with only one physician. In DY 2, we will begin establishing a new primary care clinic with at least one primary care provider in that community. During DY 3, we expect to begin providing primary care services to Iowa Park residents. In DY 4, we will gather data from DY 3 operations that will be used to establish baselines for future comparatives. By providing additional primary care availability and choices, we plan to increase the number of patients receiving primary care and reduce the number of patients with uncontrolled blood pressure in Iowa Park.

- **Rationale:** As evidenced by the health statistics in our community needs assessment in CN.4 and CN.5, there is low utilization of preventive services in the region, as well as a need to overcome barriers to patient access. Wichita County includes the Iowa Park community. Electra Memorial Hospital (EMH) has selected Project 1.1 Expand Primary Care Capacity due to the need for increased access to primary care in Iowa Park and the entire RHP 19 region. Iowa Park is approximately 15 miles from Electra and Wichita Falls. There is currently only one primary care physician in Iowa Park, limiting the access of its 8,000 residents to primary care services. While some patients can seek care elsewhere, the Medicaid and low-income populations face financial and transportation barriers that often prohibit leaving the community. The consequence of neglecting primary care can result in unnecessary emergency department utilization, the costs of which far outweigh the costs of care in a clinic setting. In order to accommodate the needs of the Iowa Park community and reform the delivery system in that area, we will establish a new clinic to provide space for at least two additional providers. These providers would provide primary care in the clinic setting, including preventative services and chronic disease management. At least one provider will be training in the Texas Health Steps program to serve the needs of Medicaid patients. Over the next 5 years, we expect to increase primary care access and the number of patients with a blood pressure of less than 140/90.
- **Related Category 3 Outcome Measure(s):**
    - **OD- 1 Primary Care and Chronic Disease Management 135034009.3.4**
        - **IT-1.7 Controlling high blood pressure *(Standalone measure)***
    - OD-1 Primary Care and Chronic Disease Management and IT-1.7 Controlling high blood pressure was selected because a large number of potentially preventable admissions in RHP 19 are a result of heart disease, as noted in CN.1 of the CNA. No baseline data has been established, but we will generate the data in DY 2, and then compile and analyze it in DY 3. By making primary and preventive care more readily available, the health of the Iowa Park community can be improved and potentially preventable admissions reduced. By training additional providers in the Texas Health Steps program, Medicaid and low-income populations will be given greater access to preventive services.
- **Relationship to other Projects:** As noted above, this project relates to the Category 3 project, 135034009.3.4 to improve on the number of patients with controlled high blood pressure. 135034009.1.3, Expanded Primary Care Capacity, is a common project throughout the region due to the rural nature of RHP 19. Treating patients in the appropriate setting throughout the region will lower the cost of services significantly. Information gathered from electronic health records can be analyzed to evaluate PPAs for CHF, as in our project 135034009.3.6 (135034009.3.2), and Diabetes, Behavioral Health admission rates, COPD/Asthma admission rates, hypertension admission rates, pediatric asthma encounters, bacterial pneumonia immunizations, and influenza immunizations. 30-day readmissions for these as well as stroke can be tracked and potentially reduced. Through this project, we expect the overall health of the Iowa Park community to be improved, thereby improving the health of the entire region. Our project 135034009.1.4 (135034009.1.1), Expanded Primary Care Capacity, targets the

Electra community and does not include Iowa Park. Expanded Specialty Care, 135034009.1.5 (135034009.1.2), compliments this project by providing greater access to specialty care, which can also result in lowering ED visits, but also reduce potentially preventable readmissions. Together with the care transitions project, 135034009.2.2 (135034009.2.1), and the placement of ED case managers throughout the region, ED admissions as well as all types of potentially preventable admissions and readmissions, 135034009.3.7 (135034009.3.3), can be deterred.

- **Relationship to Other Performing Providers' Projects in the RHP:** While other Performing Providers in RHP 19 may be doing similar projects in their local areas, there are not any others that address the Iowa Park community. These performing providers are also doing projects that address primary care in their local communities:

  Bowie Memorial Hospital 127305405.1.2 (127305405.1.1)
  Clay County Memorial Hospital 094138703.1.2 (094138703.1.1)
  Graham Regional Medical Center 130613604.1.2 (130613604.1.1)
  Hamilton Hospital 110856504.1.2 (110856504.1.1)
  Hardeman County Memorial Hospital 121692107.1.2 (121692107.1.1)
  North Texas Medical Center 121777003.1.2 (121777003.1.1)
  United Regional Health Care System 135237906.1.2 (135237906.1.1)
  Wilbarger General Hospital 112707803.1.2 (112707803.1.1)

  It is well known that the national supply of primary care providers does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHP 19 is in real need of expanding primary care capacity in the entire region in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients, including the Medicaid and low-income populations.
- **Plan for Learning Collaborative:** N/A
- **Project Valuation:** The value of this project was determined by considering investment, scope, community need, and local available funds. We included the cost of employing practitioners and additional staff and systems to support the new clinic, as well as the community benefit of increased access to primary care which will result in an improved patient experience. As in the entire Region, Iowa Park has faced ongoing barriers to recruiting primary care providers. There are significant investments required to recruit physicians, nurse practitioners and other mid-levels to fill the void and address community needs. Electra Medical Clinic served 364 unique patients from the Iowa park community in 2012. 67 of those, or 18%, were Medicaid or uninsured patients, before considering Medicare patients that are dual eligible. More than 1,200 visits were provided to those Iowa Park patients, many of which expressed the need for additional physicians and/or mid-level practitioners in their local community. By establishing a new clinic in Iowa Park, we think that we can increase the number of unique patients to at least 500 and provide a minimum of 2,000 clinic visits by the end of the waiver. Other factors considered were the value of the reduction in cost to payers of providing primary care services in the appropriate clinic setting rather than in the emergency department of a hospital and the value of maintaining a healthy community for many

years to come. Using the assumptions above, 135034009.1.3 Expand Primary Care Capacity is valued at $2,083,891 over DY 2 – DY 5. This includes the value of additional professional and support staff, space, and systems to implement new primary care services. Each year we have at least one milestone, and in years with more than one, each is valued equally per the PFM Protocol. This project makes a significant investment into our low income population and provides additional access to primary care. This initiative is projected to reduced ED utilizations, increase vaccination rates and increase chronic disease management which would prevent hospitalizations. In addition to the project investments, we project savings to the public payer systems of at least $75,000 each year, as well as savings for uninsured patients.

135034009.1.3	***1.1.1***	***1.1.1***	***EXPAND PRIMARY CARE CAPACITY***	
Electra Memorial Hospital				***135034009***
Related Category 3 Outcome Measure(s):	***IT-1.7***	**135034009.3.4**	***Primary Care and Chronic Disease Management Controlling high blood pressure***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1. Establish more primary care clinics. <u>Metric 1</u> P-1.1. Number of additional clinics. Baseline/Goal: Establish a new clinic in Iowa Park, Texas. Data Source: Documentation of detailed expansion and/or construction plans. Milestone 1 Estimated Incentive Payment: $511,977	**Milestone 2** P-5. Train/hire additional primary care providers and staff <u>Metric 1</u> P-5.1. Documentation of increased number of providers and staff. Baseline/Goal: One additional provider in Iowa Park Clinic. Data Source: HR records indicating department and location of staff and provider. Milestone 2 Estimated Incentive Payment*:* $554,987		**Milestone 3** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of clinic visits. Demonstrate improvement over prior reporting period. Goal: Increase clinic visits from DY 2 to DY 3 by 400. Data Source: EHR reports indicating the total number of visits in DY 2 and DY 3. Milestone 3 Estimated Incentive Payment: $557,115	**Milestone 4** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of clinic visits. Demonstrate improvement over prior reporting period. Goal: Increase in clinic visits from DY 2 to DY 4 by 2,000. Data Source: EHR reports indicating the total number of visits in DY 2 and DY 4. Milestone 4 Estimated Incentive Payment: $459,812
Year 2 Estimated Milestone Bundle Amount: $511,977	Year 3 Estimated Milestone Bundle Amount: $554,987		Year 4 Estimated Milestone Bundle Amount: $557,115	Year 5 Estimated Milestone Bundle Amount: $459,812
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $2,083,891				

Summary Information: Graham Regional Medical Center

New Pass 3B Project 130613604.1.2
(Old Pass 2 Project 130613604.1.1)

- Provider: Graham Regional Medical Center (GRMC) is a 42-bed General Hospital in Young County, a county with a population of 18,484. GRMC is centrally situated in the middle of four Acute Care Facilities, all approximately 30 to 45 miles away-to the North, West, East, and South. Young County has a population living at or below the poverty level of over 15% has a population with no insurance of over 25%. In 2011, GRMC recorded $2 million in Charity Care, not including unpaid Self-Pay accounts of individuals that fell through the screening cracks.

- Intervention(s): Graham Regional Medical Center plans to expand and improve access to the residents of Young County and the surrounding areas by expanding its Rural Health Clinic. This goal is to improve cost-effectiveness of care through improved care delivery of the RHC service for individuals, families, employers, and the government.

- Need for the project: GRMC has selected this innovative project to better serve the residents of Young County and the surrounding areas. With a growing number of indigent patients and an increase need for non-emergent primary care services, this new clinic provides a safety net alternative to more expensive care provided in an emergency room setting. GRMC plans to add capacity of at least 300 patients per month.

- Medicaid and Uninsured Target population: Young County has a population living at or below the poverty level of 15.6%, has a population with no insurance of 25%. We believe more patients that would not have sought treatment at the start of their illness, to utilize our increased capacity in our clinic. This would be a great benefit, as it will reduce hospitalization and emergency room care.

- Category 1 expected patient benefits: This project will help the patient by providing adequate non-emergent primary care services in a rural health clinic setting, which is staffed with physician(s) and mid-level provider(s) acting as a medical-home for those with limited or no insurance coverage. By DY5 an increase of 4,800 patient visits per year is our goal and expected benefit.

- Category 3 outcomes: Improved cost savings outcome measure; a Rural Health Clinic provides services to patients regardless of their ability to pay, within guidelines established by the state of Texas. Patients seeking care in an RHC decreases cost and increases the opportunity to diagnose and treat earlier without having to transport patients for more advanced/higher cost care such as emergency room care.

I. Category 1: Infrastructure Development

- **Identifying Project and Provider Information:**
  - Expand Primary Care Capacity 1.1.2
  - Graham Regional Medical Center 1.2 (130613604.1.1)
- **Project Description:**
  Graham Regional Medical Center, a sole community hospital, serves a rural area and higher volume of uninsured, Medicaid, and Medicare households. GRMC also located within a HPSA. Based on our rural area, aging population and higher poverty level, we will transform and improve access to primary and preventive care by enhancing access points, expanding clinic space, providing non-emergent care to our local population within our hospital campus area. We will add a physician and support staff and implement a broader range of care to better assist patients in need of urgent care in the clinic. Additionally we will expand to provide after-hours care and increase choice for patients. This will also improve access for the uninsured. Over the next four years of the waiver, we expect to increase clinic capacity from approximately 8,000 visits per year to 12,800 visits per year. This project achieves the goals of RHP 19 to transform healthcare and impact total population health outcomes by establishing a backbone of primary and preventive care in the system.

- **Starting Point/Baseline:**
  As of September 2012, the rural health care clinic was seeing 8,000 clinic visits per year with a need remaining as not all patients can be seen. This has resulted in patients using the ER for minor illnesses and non-emergent care.

- **Rationale:**
  GRMC has identified project option
  1.1.2 Expand existing primary care capacity
  Required core project components:
  a) We plan to expand primary care clinic space 4,000 sq feet
  b) Expand primary care clinic hours to be open until 8pm
  c) Expand primary care clinic staffing by 2 providers

Graham Regional Medical Center in Graham, Texas is a 42-bed acute care hospital.
Its' mission is to provide the best place for patients to receive care, people to work and physicians to practice medicine. Our focus is on individuals and populations in need.

Graham Regional has a hospital based rural health clinic that serves Young County residences and surrounding areas. Our RHC sees patients without regard to insurance or financial means. The city and county has a severe shortage of primary care physicians that will see Medicare and Medicaid patients in their offices. We are in need of expanding our capacity in response to growing community need for primary care services. This shortage of care and expansion

directly relates to CN 3; CN 5 and CN 8. There is a growing community need for primary care as the population ages as well has the high utilization of emergency room care that could be performed in a RHC setting.

- **Related Category 3 Outcome Measure(s):** ***130613604.3.2 (130613604.3.1)***
  GRMC has selected OD-9, IT-9.2 ED appropriate utilization to Reduce all ED visits (including ACSC), http://archive.ahrq.gov/data/safetynet/billappb.htm.
  - Non-emergent utilization of the GRMC ED, a 2010 rate of approximately 4,800 patients, supports the need to address improper utilization of the ED.
  - Various studies support access to primary and preventive care reduce non-emergent utilization of the ED.
  - A higher percent of Young and surrounding counties residents live below the federal poverty level. As the largest provider in the county, we expect to impact all low income, uninsured and Medicaid populations by increase capacity for primary and preventive care.

- **Relationship to other Projects:**
  GRMC projects interrelate as the addition of Primary Care (1.1) Family Practitioners will provide relief and support the Patient Centered Medical Home initiative (2.1) for pregnant women. Additionally increased capacity in Primary Care will also increase disease prevention (2.7) activities in the clinic and community settings.

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

- **Plan for Learning Collaborative: N/A**

- **Project Valuation:**
  Access to primary care is the foundation to building and improving patient health outcomes, improving preventive health and screenings and achieving patient access in low cost settings. We seek to provide an increase of access to primary care and preventive services for the residents of Graham and surrounding rural counties. By DY5 we expect and would like to see an increase of 4,800 patient encounters

New ID: 130613604.1.2 *(130613604.1.1)*	*1.1.2.*	*1.1.2.A* *1.1.2.B* *1.1.2.C*	1.1 Expand Primary Care Capacity
Graham Regional Medical Center			TPI
OD-9	130613604.3.2 *(130613604.3.1)*	*IT-9.2*	ED appropriate utilization *(Standalone measure)* Reduce all ED visits

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-1. Milestone: Establish additional/expand existing/relocate primary care clinics P-1.1. Metric: Number of additional clinics or expanded hours or space Documentation of detailed expansion plans Baseline/Goal: We currently have no space for additionally providers. We expect to expand our clinic to house exam rooms and space for an additional doctor and staff. Data Source: New primary care schedule or other Performing Provider document or other	**Milestone 3** P-7. Milestone: Establish a nurse advice line and/or primary care patient appointment unit. P-7.1. Metric: Documentation of nurse advice line and/or primary care patient appointment unit. Baseline/Goal: We do not have a nurse advice line. We expect to have a nurse advice line which will allow patients to discuss urgent issues. Data Source: Documentation of advice line and appointment unit implementation, operating hours and triage policies.	**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. a. Total number of visits for reporting period Goal: 16,000 visits per year. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 6 Estimated Incentive Payment: $69,212.31	**Milestone 9** I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period Goal: 20,800 visits per year. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 9 Estimated Incentive Payment: $57,175.39

New ID: 130613604.1.2 *(130613604.1.1)*	*1.1.2.*	*1.1.2.A* *1.1.2.B* *1.1.2.C*	1.1 Expand Primary Care Capacity	
Graham Regional Medical Center				TPI
OD-9	130613604.3.2 *(130613604.3.1)*	*IT-9.2*	ED appropriate utilization *(Standalone measure)* Reduce all ED visits	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
plans as designated by Performing Provider. Milestone 1 Estimated Incentive Payment *(maximum amount):* $94,887.84 **Milestone 2** P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: We currently have three physicians. We expect to hire and train at least	Advise line system logs, triage algorithms and appointment unit operations/ policies. Milestone 3 Estimated Incentive Payment: $60,011.69 **Milestone 4** I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period Goal: 16,000 visits per year.		**Milestone 7** I-13. Milestone: Enhanced capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates a. Numerator: number of patients receiving urgent care appointment within 2 days of request b. Denominator: number of patients requesting urgent care appointment.	**Milestone 10** I-13. Milestone: Enhanced capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates a. Numerator: number of patients receiving urgent care appointment within 2 days of request b. Denominator: number of patients requesting urgent care appointment.

New ID: 130613604.1.2 *(130613604.1.1)*	*1.1.2.*	*1.1.2.A* *1.1.2.B* *1.1.2.C*	1.1 Expand Primary Care Capacity	
Graham Regional Medical Center				TPI
OD-9	130613604.3.2 *(130613604.3.1)*	*IT-9.2*	ED appropriate utilization *(Standalone measure)* Reduce all ED visits	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
1 new physician and related staff. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. Milestone 2 Estimated Incentive Payment: $94,887.84	Data Source: Registry, EHR, claims or other Performing Provider source Milestone 4 Estimated Incentive Payment: $60,011.69 **Milestone 5** I-13. Milestone: Enhanced capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates a. Numerator: number of patients receiving urgent care		Goal: Reduce the wait time to same day to next day. Data Source: Registry, EHR, claims or other Performing Provider scheduling source Milestone 7 Estimated Incentive Payment: $69,212.31 **Milestone 8** I-14. Milestone: Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period. I-14.1. Metric: Number of patients served by the nurse advice line. Demonstrate improvement over baseline	Goal: Reduce the wait time to same day by DY 5. Data Source: Registry, EHR, claims or other Performing Provider scheduling source Milestone 10 Estimated Incentive Payment: $57,175.39 **Milestone 11** I-14. Milestone: Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period. I-14.1. Metric: Number of patients served by the nurse advice line. Demonstrate improvement over baseline

New ID: 130613604.1.2 *(130613604.1.1)*	*1.1.2.*	*1.1.2.A* *1.1.2.B* *1.1.2.C*	1.1 Expand Primary Care Capacity	
Graham Regional Medical Center				TPI
OD-9	130613604.3.2 *(130613604.3.1)*	*IT-9.2*	ED appropriate utilization *(Standalone measure)* Reduce all ED visits	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	appointment within 2 days of request b. Denominator: number of patients requesting urgent care appointment. Baseline/Goal: We currently have a wait time of up to 5 days for urgent care appointments. We expect to reduce the wait time to same day by DY 5. Data Source: Registry, EHR, claims or other Performing Provider scheduling source Milestone 5 Estimated Incentive Payment: $60,011.69		rates. a. Numerator: number of unique records created from calls received to the nurse advice line. b. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered). Baseline/Goal: This will be a new service, so we do not know how many patient calls to expect. Data Source: Automated data from call center Milestone 8 Estimated Incentive Payment: $69,212.31	rates. a. Numerator: number of unique records created from calls received to the nurse advice line. b. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered). Goal: Improvement over baseline. Data Source: Automated data from call center Milestone 11 Estimated Incentive Payment: $57,175.39

New ID: 130613604.1.2 *(130613604.1.1)*	*1.1.2.*	*1.1.2.A* *1.1.2.B* *1.1.2.C*	1.1 Expand Primary Care Capacity	
Graham Regional Medical Center				TPI
OD-9	130613604.3.2 *(130613604.3.1)*	*IT-9.2*	ED appropriate utilization *(Standalone measure)* Reduce all ED visits	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $189,776	Year 3 Estimated Milestone Bundle Amount: $207,035		Year 4 Estimated Milestone Bundle Amount: $207,637	Year 5 Estimated Milestone Bundle Amount: $171,526
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $775,974				

Summary Information: Hamilton Hospital 110856504

Pass 1 Project 110856504.1.1

- Provider: Hamilton Hospital is a 25-bed Critical Access Hospital in Olney, Texas serving a 25 square mile radius, including Archer City, with an approximate population of 7,000.

- Intervention(s): This project will offer health care to residents in Archer City, Texas by opening a Rural Health Clinic.

- Need for the project: There was not a clinic or a means to receive healthcare in Archer City.

- Medicaid and Uninsured Target population: The target population is Archer City and surrounding community patients that currently have to travel for any form of healthcare. Approximately 35% of our patients are either Medicaid eligible or indigent, and we expect all of them to benefit from our clinic.

- Category 1 or 2 expected patient benefits: The project seeks to provide 1,800 clinic visits DY4 and 2,200 in DY5.

- Category 3 outcomes: IT-9.2 Our goal is to improve ED Appropriate Utilization by decreasing unnecessary ED visits from the Archer City area by 10% by DY5.

Category 1: Infrastructure Development

Project Option: Establish More Primary Care Clinics

RHP Project Number: 110856504.1.1

RHP Performing Provider: Hamilton Hospital 110856504

Project Description:

We are going to expand primary care services to open another clinic located in Archer City. According to HRSA (Health Resources and Services Administration), as of November 1, 2011 Archer City was considered a Primary Care Health Professional Shortage Area. By operating a clinic we can serve patients from Archer City and surrounding communities; consequently, enhancing patient access to healthcare and decreasing ED utilization. We expect to see 20 new patients per year by DY 5. In fact, our goal is to see 11 patients per day in a 4 day work week, or 2,200 visits per year by the end DY 5. Our challenge is that we do not have the resources to properly equip, staff and upgrade this clinic in Archer City.

Starting Point/Baseline:

As of July 31, 2012 there was not a Clinic in Archer City; therefore, there were no encounters for my baseline.

Rationale:

Archer City does not have access to healthcare at all at this time. As referenced above Archer City is a current HPSA according to HRSA. CN. 5., Need to overcome patient access to care barriers, supports the need for increased access to primary care throughout RHP 19. We will recruit and staff more primary care providers to make sure that our uninsured or Medicaid insured population has access to primary care as needed. We will ensure that neighboring counties in our service area that are underserviced have access to primary health care. Recruiting primary care providers, as sighted in by Vaughn in Health Aff May 2010 vol. 29 no. 5 933-940, is challenging as people weigh financial gains not offered in the primary care arena. This exacerbates the limited access to primary and preventative care in rural communities, where the burden to recruitment proves even more difficult. We will address this problem by offering benefits to the health care providers who will come to Archer City and provide the needed access for residents. Primary and preventative care should reduce the burden on our hospitals preventable admissions and ED.

Related Category 3 Outcome Measure(s):

The Category # Outcome Measure that this project will address is IT-9.2 ED appropriate utilization. This will be accomplished by offering the residents of Archer City and surrounding

areas access to primary care; consequently lowering the utilization of the ED. It will also help improve the health of the low-income population of Archer City by offering local health care and alleviating the burden of travel expenses.

Project Valuation:

By adding a Provider and a clinic to Archer City we will help with the prevention of readmissions and admissions due to chronic illness and diseases. We will also ease the load on our Hospital ED. Patients will save time and money related to transportation to and from Olney and will have the opportunity to access primary and preventive care in their local community for services like immunizations and everyday illnesses. In fact, our goal is to see 11 patients per day in a 4 day work week, or 2,200 visits per year by the end DY 5.

110856504.1.1	1.1	1.1.1	ESTABLISH MORE PRIMARY CARE CLINICS	
Hamilton Hospital				110856504
Related Category 3 Outcome Measure(s): 110856504.3.1.	IT-9.2	P-1: Establish additional/expand existing/relocate primary care clinics.	ED Appropriate Utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Establish additional/expand existing/relocate primary care clinics. We will open a clinic in Archer City and expand hours to see more patients. Metric 1 P-1.1: Number of additional clinics or expanded hours or space. Baseline/Goal: July 31, 2012 no clinic in Archer City so no baseline. Goal is to open the clinic 4 days a week and see 5 patients per day by the end of DY 2 Data Source: Operating system printed admissions report. Milestone 1 Estimated Incentive Payment: $318,848	**Milestone 2** P-1: Establish additional/expand existing/relocate primary care clinics. Metric 1 P-1.1: Number of additional clinics or expanded hours or space. Baseline/Goal: Baseline will be opening the clinic in Archer City and seeing 5 patients per day by the end of DY 2. Goal is to see 7 patients per day by the end of DY 3 Data Source: Operating system printed admissions report. Milestone 2 Estimated Incentive Payment: $347,847		**Milestone 3** I 12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I 12.1: Documentation of increased number of visits. Goal: 9 patients per day by the end of DY 4 for a total of 1,800 patients Data Source: Operating system printed admissions report. Milestone 3 Estimated Incentive Payment: $348,858	**Milestone 3** I 12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I 12.1: Documentation of increased number of visits. Goal: 11 patients per day by the end of DY 5 for a total of 2,200 patients Data Source: Operating system printed admissions report. Milestone 4 Estimated Incentive Payment: $288,187

110856504.1.1	1.1	1.1.1	ESTABLISH MORE PRIMARY CARE CLINICS
Hamilton Hospital			110856504
Related Category 3 Outcome Measure(s): 110856504.3.1.	IT-9.2	P-1: Establish additional/expand existing/relocate primary care clinics.	ED Appropriate Utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: $318,848	Year 3 Estimated Milestone Bundle Amount: $347,847	Year 4 Estimated Milestone Bundle Amount: $348,858	Year 5 Estimated Milestone Bundle Amount: $288,187
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,303,740			

Summary Information (RHP19): Helen Farabee Center
Pass 1 Project 127373205.1.1

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

- Intervention(s): This project involves hiring three licensed substance abuse counselors who will provide substance abuse services in the Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton county region.

- Need for the project: Currently, Substance Abuse Services are provided in only one county within Helen Farabee Center's catchment area. As a result, substance abuse services are not available for many communities we serve. This project addresses that challenge by expanding services to a community that has previously lacked services.

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

- Category 1 or 2 expected patient benefits: The project seeks to provide substance abuse services to 160 consumers by 9/30/14, increasing services by 10% (176) and 20% (192) over baseline for Demonstration Years 4 and 5, respectively.

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

Category 1: Infrastructure Development

Project Title: Expand the number of community based settings where behavioral health services may be delivered in underserved

Project Option: 1.12.2 Expand service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.

RHP Project Number: 127373205.1.1

RHP Performing Provider: Helen Farabee Center-127373205

Project Description:

This project involves hiring three licensed substance abuse counselors who will provide substance abuse services in the Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton county region. The target population for this project includes Adults/Children with a single substance-abuse or dependence diagnoses who do not meet Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. As referrals come in, individuals' treatment needs are assessed by the counselors, treatments are planned and conducted on an outpatient basis at center facilities in the region. Continuous assessments are conducted that inform treatment or if discharge/referral services are indicated. Services are terminated when the needs have been met. The project fits within the Project Area by enhancing the availability of substance abuse services in a location not currently providing them. The project fits the intervention through expanding the number of settings where substance abuse services are provided. The goal is to establish a substance abuse division in key regional areas by hiring staff members and then providing substance abuse services in those counties. Currently, Substance Abuse Services are provided in only one county within Helen Farabee Center's catchment area. As a result, substance abuse services are not available for many communities we serve. This project addresses that challenge by expanding services to a community that has previously lacked services. The expected outcome for the provider is to have established a substance abuse division in additional counties, provide needed services in that community, and to see improved quality of life as measured through standard assessments. Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides access to qualified Substance Abuse counselors as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time in order to begin treatments quickly if indicated (Right Time). This project improves patient experience by providing timely access to care. It improves health by creating a system to begin treatment sooner. It is designed to reduce costs by using alternative and efficient routes of access to substance abuse professionals and by providing care designed to reduce hospitalization and emergency department usage.

Starting Point/Baseline:

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

Rationale:

During the month of May 2012, the Helen Farabee Center solicited feedback via a survey from local stakeholders to inform planning for expansion and improvement of behavioral health services. Access to Mental/ behavioral health care was identified as difficult by 41.2% of the respondents and Substance Abuse services were ranked as the most important service NOT currently provided in all service areas. Access to mental health appointments occurs on a walk-in basis, however if patients require substance abuse services we cannot provide them outside Wichita County at this time. Enhancing service availability for substance abuse services will help meet this need.

When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[17]. Many patients could be diverted from emergency departments if an immediate Substance Abuse screenings/ interventions were available. Enhancing substance abuse service availability for additional counties requires an expansion of those services into that underserved area. The milestones and metrics were chosen based on the elements required to be in place in order to provide substance abuse services at a new location where none had been provided before. Substance abuse divisions require state licenses, equipment, administrative protocols/guidelines, hiring and training staff, evaluation and improvement activity and tracking utilization. A customizable improvement milestone was selected based on existing milestone I-11.1. This milestone (I-X.1) was customized by removing the "mobile clinic" aspect since this project involves creating a new substance abuse division at an existing facility in Wise County. The customized milestone still measures increased utilization of behavioral health services using roughly the same data source (without referencing expanded transportation programs). The project addresses community need CN.2 and CN.5. The project enhances care delivery by providing the Substance Abuse intervention dimension which is currently lacking. It provides Center psychiatrists with immediate referral and coordination options if clinically indicated. It allows the local Mental Health Authority to provide complete behavioral healthcare which includes Substance Abuse services.

[17] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Related Category 3 Outcome Measure(s):

IT-10.1 Quality of Life. This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[18]. Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate Substance Abuse screening/ intervention were available. The outcome also reflects any impact substance abuse services will have in ensuring patients remain in the community and abstinent from drugs/alcohol. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

Relationship to other Projects:

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

The project relates to "127373205.1.3 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system" in that it also provides immediate access to services not currently provided in the service area.

Relationship to Other Performing Providers' Projects in the RHP:

The target population for this project includes Adults/Children with a single substance-abuse or dependence diagnosis who do not meet Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. Part of this eligibility includes geographic location limited to Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties with the Helen Farabee Center catchment area. We do not believe the project duplicates another provider's intervention for the same target population in these counties.

Plan for Learning Collaborative: N/A

[18] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Project Valuation:

This project serves the population located in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. We estimate 271 persons may require substance abuse services based on substance abuse arrest records by county. The project seeks to provide substance abuse services to 160 consumers by 9/30/14, increasing services by 10% (176) and 15% (192) over baseline for Demonstration Years 4 and 5, respectively. The benefit to the community is in the form of outpatient access to local substance abuse services which avoids costs associated with emergency department usage or hospitalization. Local funding is in the form of IGT from Helen Farabee Center.

Substance abuse imposes a heavy burden on emergency room and primary care settings. When individuals are screened for substance abuse and receive appropriate treatment, the related utilization and abuse of health care settings will go down 50% with a savings of $3.81 to $4.30 for every dollar spent on treatment services. We used the average of $4.05 saved for every dollar spent on treatment services. The savings of $4.05 was determined by the Texas Drug Demand Reduction Advisory Committee Report to state leadership[19]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[19] Texas Drug Demand Reduction Advisory Committee: Report to State Leadership, January 2009 (http://www.dshs.state.tx.us/sa/ddrac/)

127373205.1.1	**1.12.2**	**1.12.2**	**EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS.**	
[The Helen Farabee Center]				[127373205]
Related Category 3 Outcome Measure(s):	IT-10.1	127373205.3.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-2. Milestone: Identify licenses, equipment requirements and other components needed to implement and operate options selected Metric 1; P-2.1. Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components ▯ Research existing regulations pertaining to the licensure requirements of psychiatric clinics in general to determine what requirements must be met.	**Process Milestone 3**: P-6. Milestone: Establish behavioral health services in new community-based settings in underserved areas Metric 3: P-6.1. Metric: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: Provide Substance Abuse services to 160 consumers by 09-30-14. Data Source: Number of patients served at these new community-based sites Milestone 3 Estimated		**Improvement Milestone 1**: I-11. Milestone: Increased utilization of community behavioral healthcare Metric 1: I-X.1. Metric: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from new substance abuse division after access expansion b. Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision	**Improvement Milestone 2**: I-11. Milestone: Increased utilization of community behavioral healthcare Metric 2: I-X.1. Metric: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from new substance abuse division after access expansion b. Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision

127373205.1.1	**1.12.2**	**1.12.2**	**EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS.**	
[The Helen Farabee Center]				[127373205]
Related Category 3 Outcome Measure(s):	IT-10.1	127373205.3.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
▯ When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate. Baseline/Goal: Develop plan and secure licenses in preparation for delivery of Substance Abuse services. Data Source: Project Plan Milestone 1 Estimated Incentive Payment (maximum amount): $289,239.50 **Process Milestone 2:** P-4. Milestone: Hire and train staff to operate and manage projects selected Metric 2:	Incentive Payment: $292,625 **Milestone 4**: P-7. Milestone: Evaluate and continuously improve services Metric 4: P-7.1. Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline/Goal: Complete first project report which includes a review of service encounters, analysis and recommended changes. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to		of Substance Abuse services by 10% over baseline (176) by 09-30-15 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 1 Estimated Incentive Payment: $675,982	of Substance Abuse services by 20% over baseline (192) by 09-30-16. Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 2 Estimated Incentive Payment: $695,693

127373205.1.1	**1.12.2**	**1.12.2**	**EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS.**	
[The Helen Farabee Center]				[127373205]
Related Category 3 Outcome Measure(s):	IT-10.1	127373205.3.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-4.1. Metric: Number of staff secured and trained Baseline/Goal: Hire and train three Licensed Chemical Dependency Counselors to provide Substance Abuse services. Data Source: Project records; Training curricula as develop in P-2 Milestone 2 Estimated Incentive Payment (maximum amount): $289,239.50	guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 4 Estimated Incentive Payment: $292,625			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $578,479	Year 3 Estimated Milestone Bundle Amount: $585,250		Year 4 Estimated Milestone Bundle Amount: $675,982	Year 5 Estimated Milestone Bundle Amount: $695,693
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $2,535,404				

Summary Information (RHP19): Helen Farabee Center
Pass 1 Project 127373205.1.2

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

- Intervention(s): This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services. The expanded hours will provide for open-access (on-demand) routine psychiatric evaluations for individuals determined eligible to receive services under the Texas Recovery and Resiliency model.

- Need for the project: Currently, the average wait time for an initial psychiatric evaluation is ten weeks making access to much needed psychiatric medical care delayed at the Helen Farabee Center. The project addresses this barrier by creating on open-access (on-demand) model for psychiatric evaluation via telemedicine occurring within 1 business day.

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

- Category 1 or 2 expected patient benefits: Current utilization of scheduled psychiatric evaluation is approximately 459 per year on average. Using this estimate as a starting baseline, the project seeks to provide on-demand psychiatric evaluations at 5% over baseline (482) increasing to 10% (505) over Demonstration Years 4 and 5, respectively. Another goal is to increase the number of unique patients over baseline (baseline FY 2012 5650 for the region) by 2.5% (5791) increasing to 5% (5932) over Demonstration Years 4 and 5, respectively.

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

Category 1: Infrastructure Development

Project Option: 1.9.2. Expand Specialty Care Capacity/Improve access to specialty care

RHP Project Number: 127373205.1. 2

RHP Performing Provider: Helen Farabee Center-127373205

Project Description:

This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services. The expanded hours will provide for open-access (on-demand) routine psychiatric evaluations for individuals determined eligible to receive services under the Texas Recovery and Resiliency model. The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). The projects fits within the Project Area since psychiatry is considered specialty care and is being expanded. The project fits within the Intervention in that the expansion of psychiatric availability improves access to these services by eligible individuals. The project goals include collecting baseline data for wait times, completing and submitting a plan for electronic referrals, training medical staff, implementing referral technology to improve provider communications, and incrementally increasing the volume of specialty care visits via the open-access model. Currently, the average wait time for an initial psychiatric evaluation is ten weeks making access to much needed psychiatric medical care delayed at the Helen Farabee Center. The project addresses this barrier by creating on open-access (on-demand) model for psychiatric evaluation via telemedicine.

The team implementing this project consists of initial intake clinicians who make the initial referrals for psychiatric evaluations, support staff who coordinate the video session, and contracted psychiatrists and other medical support personnel who conduct the evaluations. There is currently no mechanism for on-demand (walk-in) psychiatric evaluations for routine outpatient behavioral health services. The expected outcome during the waiver period is to increase the number of psychiatric evaluations provided within one business day by creating an on-demand model. This is designed to have the anticipated effect of improving quality of life through removing a barrier to outpatient behavioral health services. Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides an on-demand psychiatric evaluation for routine mental health inquiries as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time which is within one business day of the inquiry in order to begin treatments quickly if indicated (Right Time). This project improves patient experience by providing timely access to care. It improves health by creating a system to begin treatment sooner. It is designed to reduce costs by using

alternative and efficient routes of access to prescribing professionals and by providing care designed to reduce hospitalization and emergency department usage.

Starting Point/Baseline:

As of September 30, 2012 there are no on-demand psychiatric evaluations for routine behavioral health services.

Rationale:

Expediting services can decrease symptoms and increase functioning in individuals ensuring timely access to initial evaluations and freeing up other prescribers to provide quicker follow up encounters. Neufeld, et al. (2012)[20] used the mean time between appointments as potential indicators for measuring quality of life. An on-demand (walk-in) model of care would expedite services, potentially reduce psychiatric admissions[21], and potentially reduce emergency department usage by individuals in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The project component -- (a) increasing service availability with extended hours -- was chosen in order to provide a cost-effective[22] and concrete way to improve access to psychiatric services. Core component (b) "Increase the number of specialty clinic locations" was not address since our region has an adequate number of physical access points. Component (c) "Implement transparent , standardized referrals across the system" is chosen in order to ensure efficient access to the new on-demand evaluation services. Component (d) "Conduct quality improvement for project using methods such as rapid cycle improvement" is achieved by tracking and reporting on project impacts such as evaluation utilization and wait times. This data is reported monthly to the Center's Improvement and Oversight Committee. Access to behavioral health care was identified as difficult by 41.2% of community stakeholder respondents and barriers to access in terms of long wait times were identified as most important by 40.9%. Baseline data is being collected in order to know the extent to which access to psychiatric services has been improved through then open access model. Implementation plans for e-referrals ensure efficiency in the referral process. Training specialty care providers is required with a new access model of care. Developing and implementing technical referral capabilities will enable improved and streamlined provider communications. The improvement milestone of increasing clinic volume and improving patient access will help remove access barriers perceived by the community. The project addresses community need CN.2 and CN.5. The project significantly enhances the existing delivery of psychiatric evaluations by eliminating the potentially 10 week wait for

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[20] Neufeld, J. (2012). Walk-In Telemedicine Clinics Improve Access and Efficiency: A Program Evaluation From the Perspective of a Rural Community Mental Health Center. *Rural Mental Health, Fall/Winter 2012,* 33-37. Retrieved October 12, 2012, from http://newprairiepress.org/journals.html

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

[22] Neufeld, J. (2012). Walk-In Telemedicine Clinics Improve Access and Efficiency: A Program Evaluation From the Perspective of a Rural Community Mental Health Center. *Rural Mental Health, Fall/Winter 2012,* 33-37. Retrieved October 12, 2012, from http://newprairiepress.org/journals.html

medical interventions for routine behavioral health conditions. The open-access model is designed to provide psychiatric evaluations the same day as or next business day following the determination that they are eligible for services.

Related Category 3 Outcome Measure(s):

IT-10.1 Quality of Life. This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[23]. Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate psychiatric evaluation were available. The outcome also reflects any impact psychiatric evaluation services will have in ensuring patients remain in the community. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the ANSA, for 5% of patients in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

Relationship to other Projects:

The Project relates to "127373205.1.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas" in that it also provides a behavioral health service in an area that currently has very limited access to the service.

The project relates to "127373205.1.3 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system" in that it also provides immediate access to services not currently provided in the service area.

Relationship to Other Performing Providers' Projects in the RHP:

The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). Part of this eligibility includes geographic location limited to Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clary, Jack, and Throckmorton counties within the Helen Farabee Center catchment area. The services provided by the mental health

[23] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

authority are specific to DSHS's Texas Recovery and Resiliency model of care. We do not believe the project duplicates another provider's intervention for the same target population.

Plan for Learning Collaborative: N/A

Project Valuation:

This project serves the population located in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clary, Jack, and Throckmorton counties. We estimate providing intakes to 459 persons in DY2 based on past demand. This number would increase by 5% over baseline (482) increasing to 10% (505) over Demonstration Years 4 and 5, respectively. Another goal is to increase the number of unique patients over baseline (baseline FY 2012 5650 for the region) by 2.5% (5791) increasing to 5% (5932) over Demonstration Years 4 and 5, respectively. The benefit to the community is in the form of on-demand access to services which avoids costs associated with emergency department usage or hospitalization. Local funding is in the form of IGT from Helen Farabee Center. No other federal funds associated with the Center's DSHS contract are being used for this project.

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years. Based on the literature, an estimated Quality of Life Year gained by this intervention is 0.0245 years. The result is a $1,225 quality of life improvement per patient impacted. The valuation is aligned with the Medicaid Waiver goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research). Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The number of life-years added is based on a review of the scientific literature. A search of the scientific literature identified the following two studies. The first study looked at telemedicine and mental health and was conducted by Pyne (2010) [24] which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression

[24] Pyne, J. M., Fortney, J. C., Tripathi, S. P., Maciejewski, M. L., Edlund, M. J., & Williams, D. K. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Arch Gen Psychiatry, 67*(8), 812-821.

treatment by telemedicine. Another study by Hollinghurst et al. (2010) [25] examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

[25] Hollinghurst, S., Peters, T. J., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomized controlled trial. *Br J Psychiatry, 197*(4), 297-304.

127373205.1.2	**1.9.2**	**1.9.2.A** **1.9.2.B** **1.9.2.C** **1.9.2.D**	**IMPROVE ACCESS TO SPECIALTY CARE.**
[The Helen Farabee Center]			[127373205]
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.2	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-3. Milestone: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1: P-3.1. Metric: Establish baseline for performance indicators a. Numerator: Total number of days patients waited from evaluation request to evaluation encounter. b. Denominator: Number of clients requesting psychiatric evaluations—DY2 projected impact is 459. Baseline/Goal: To determine	**Process Milestone 4:** P-8. Milestone: Develop the technical capabilities to facilitate electronic referral Metric 4: P-8.1. Metric: Demonstrate technical mechanisms to be used to operate referral system are in place Baseline/Goal: Develop a Referral Management system that will enable providers to efficiently refer consumers for psychiatric evaluations in the on-demand model Data Source: Referral Management system	**Improvement Milestone 1:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). a. Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by	**Improvement Milestone 2:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). a. Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by

127373205.1.2	**1.9.2**	**1.9.2.A** **1.9.2.B** **1.9.2.C** **1.9.2.D**	**IMPROVE ACCESS TO SPECIALTY CARE.**	
[The Helen Farabee Center]				[127373205]
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.2	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
the average wait time for an initial psychiatric evaluation. Data Source: EHR, Internal Database Milestone 1 Estimated Incentive Payment (maximum amount): $177,932 **Process Milestone 2:** P-7. Milestone: Complete a planning process/submit a plan to implement electronic referral technology (choose at least one metric): Metric 2: P-7.2. Metric: Development of an implementation plan for e-referral	Milestone 4 Estimated Incentive Payment (maximum amount): $187,162 **Process Milestone 5:** P-9. Milestone: Implement referral technology and processes that enable improved and more streamlined provider communications Metric 5: Documentation of referrals technology Baseline/Goal: With improved technology and e-referral, to establish more efficient and fluid communication among providers for the on-demand		5% over baseline (482) by 09-30-15. Data Source: Registry, EHR, claims or other Performing Provider source Metric 2 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2 is 5650). Total number of unique patients encountered in the clinic for reporting period. Goal: Increase unique number of patients by 2.5% over baseline (5791). Data Source: patient registry	10% over baseline (505) by 09-30-16 Data Source: Registry, EHR, claims or other Performing Provider source Metric 3 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2 is 5650). Total number of unique patients encountered in the clinic for reporting period. Goal: Increase unique number of patients by 5% over baseline (5932). Data Source: patient registry

127373205.1.2	**1.9.2**	**1.9.2.A** **1.9.2.B** **1.9.2.C** **1.9.2.D**	**IMPROVE ACCESS TO SPECIALTY CARE.**	
[The Helen Farabee Center]				[127373205]
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.2	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Develop a plan that will guide the implementation and technical needs of e-referrals for the on-demand model Data Source: Referral plan, which describes the technical mechanisms needed to operate e-referral system. Milestone 2 Estimated Incentive Payment (maximum amount): $177,932 **Process Milestone 3:** P-2. Milestone: Train care providers and staff on	model of care Data Source: Referral system Milestone 5 Estimated Incentive Payment (maximum amount): $187,162 **Process Milestone 6:** P-11. Milestone: Launch/expand a specialty care clinic (e.g., pain management clinic) Metric 6: P-11.1. Metric: Establish/expand specialty care clinics a. Number of patients served by specialty care clinic		Milestone 1 Estimated Incentive Payment: $576,956	Milestone 2 Estimated Incentive Payment: $537,142

127373205.1.2	1.9.2	1.9.2.A 1.9.2.B 1.9.2.C 1.9.2.D	IMPROVE ACCESS TO SPECIALTY CARE.	
[The Helen Farabee Center]				[127373205]
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.2	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
processes, guidelines and technology for referrals and consultations into selected medical specialties Metric 3: P-2.1. Metric: Training of staff and providers on referral guidelines, process and technology a. Numerator: Number of staff and providers trained and documentation of training materials b. Denominator: Total number of staff and providers working in specialty care and medical specialty clinics Baseline/Goal: To train providers on e-referrals so that	Baseline/Goal: To initiate the on-demand model of care for psychiatric evaluations. Data Source: Documentation of new/expanded specialty care clinic Milestone 6 Estimated Incentive Payment (maximum amount): $187,162			

127373205.1.2	**1.9.2**	**1.9.2.A** **1.9.2.B** **1.9.2.C** **1.9.2.D**	**IMPROVE ACCESS TO SPECIALTY CARE.**
[The Helen Farabee Center]			[127373205]
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.2	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
the on-demand model of care is a more efficient and effective service for the consumer. Data Source: Log of specialty care personnel trained and Curriculum for training. Milestone 3 Estimated Incentive Payment (maximum amount): $177,932			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $533,796	Year 3 Estimated Milestone Bundle Amount: $561,486	Year 4 Estimated Milestone Bundle Amount: $576,956	Year 5 Estimated Milestone Bundle Amount: $537,142
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $2,209,380			

Summary Information (RHP19): Helen Farabee Center

Pass 1 Project 127373205.1.3

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

- Intervention(s): Creating a crisis respite unit to serve the Intellectual & Developmental Disability population throughout the Center's service region. Hiring a Case Management Behavioral Support Team to serve clients at the unit and while transitioning back to the regular community setting.

- Need for the project: Currently, the only option for an individual with Intellectual and Developmental Disabilities who presents in a behavioral health crisis is admission to a State Hospital. Creation of a Crisis Respite Unit designed to meet the needs of this particular population and an Intensive Case Management Behavioral Support Team would offer a less restrictive option for this population to remain in the community without an inpatient admission.

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

- Category 1 or 2 expected patient benefits: The project seeks to increase utilization of appropriate crisis alternatives (e.g. the respite unit versus state hospitalization) by 5% over baseline (21) increasing to 15% (23) over Demonstration Years 4 and 5, respectively. Baseline = 20 persons a year based on IDD state hospitalization over the past 2 years.

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

Category 1: Infrastructure Development

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

RHP Project Number: 127373205.1.3

RHP Performing Provider: Helen Farabee Centers-127373205

- **Identifying Project and Provider Information:**
  Project 1.13, Option 1.13.1. Development of behavioral health crisis stabilization services as alternatives to hospitalization/Develop and Implement crisis stabilization services to address the identified gaps in the current community crisis system. 127373205.1.3, Helen Farabee Centers/127373205.
- **Project Description:**
  During the month of May 2012, the Helen Farabee Center solicited feedback via a survey from local stakeholders to inform planning for expansion and improvement of behavioral health services. Access to Mental/ Behavioral health care was described as difficult by 41.2% of the respondents and crisis response and behavioral supports for the Intellectual and Developmental Disability (IDD) population were identified as a need in the community. Currently, the only option for an individual with Intellectual and Developmental Disabilities who presents in a behavioral health crisis is admission to a State Hospital. Creation of a Crisis Respite Unit designed to meet the needs of this particular population and an Intensive Case Management Behavioral Support Team would offer a less restrictive option for this population to remain in the community without an inpatient admission. While the Crisis Respite Unit and the Intensive Case Management Behavioral Support Team would be located in Wichita Falls, Texas patients from Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton Counties would be eligible to utilize the Unit and the services provided by the Intensive Case Management Behavioral Support Team. Utilization of the unit begins after a Qualified Mental Health Professional conducts a crisis assessment and a Licensed Professional of the Healing Arts authorizes a respite unit admission. While residing at the unit the individual receives care from members of the Intensive Case Management Behavioral Support Team until the crisis is resolved and community re-integration is clinically indicated. This is designed to have the anticipated effect of improving quality of life through removing a barrier to crisis resolution services in the least restrictive environment. Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides crisis stabilization services for the IDD population as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time which is within crisis response timeframes order to begin treatments quickly if indicated (Right

Time). This project improves patient experience by providing timely access to care. It improves health by creating a system to begin treatment sooner. It is designed to reduce costs by using alternative and efficient means of crisis resolution and by providing care designed to reduce hospitalization and emergency department usage.

- **Starting Point/Baseline:**
  Average hospitalization for the Intellectual and Developmental Disability population is two per month (March - June 2012). Data source is Admissions/ Absences/ Discharges/ Placements by Local Service Area - Weekly Report # HC022130 and Notice of Registration/ Assignment Report # HCS 020030. Additionally based on data from the Service Activity Database there were 39 admissions to a Psychiatric inpatient Hospital in the last two years.

- **Rationale:**
  The project option was selected in order to meet the community's identified need of crisis respite services for the Intellectually and Developmentally Disabled (IDD) population who have Medicaid or are indigent and who experience behavioral health issues, have a co-occurring mental health condition, and/or are at risk for being placed in jail or an inpatient psychiatric facility. Many private IDD Waiver providers do not have sufficient behavioral health services to intervene in these cases and consequently many consumers may over utilize Emergency Departments, State Hospitals, or end up in jail. Typically, when these individuals are placed in a State Hospital their length of stay is at about 90 days ($36,000, assuming $400 a bed day) or even longer when placed in a State Supported Living Center (over $130,000 annually). When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. All available component options were selected which will require (a) a community gap analysis completed in collaboration with local stakeholders, (b) an analysis of the current stabilization system capacity/utilization/eligibility, (c) a gap analysis that is specific to populations served in jails/EDs/psych hospitals, (d) a review of potential respite models, and finally (e) a review of the impact the intervention has had. The project is a new initiative in our service area as there are currently no crisis respite services specifically designed for the IDD population. Adding these services enhances our current crisis delivery system. As of March 2012, the Helen Farabee Center identified 30 individuals with Intellectual and Developmental Disabilities who would have benefitted from a Respite intervention to avoid a crisis situation (jail, hospitalization, group home removal, suicidal/ homicidal behavior). This number of individuals represents a significant proportion of the Intellectual and Developmental Disability population currently served and providing a respite option would be valuable to the individual and community including family as well as providers. The project addresses community need CN.2 and CN.5.

Required QI Component: Category 1 Process Milestone 3 in DY3 demonstrates plan, do, study act quality improvement cycles. Process Milestone 4 requires a review of project data and a response to it every week with tests of new ideas, practices, tools, or solutions. Category 3 Process Milestones 1 and 2 require submission of findings, lessons learned and best practices to stakeholders.

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

  IT-10.1 Quality of Life. This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When individuals with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization[26]. Many individuals reporting improved QOL ratings may also be diverted from emergency departments if an immediate Substance Abuse screening/ interventions were available. The outcome also reflects any impact IDD crisis respite services will have in ensuring individuals remain in the community setting. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the DLA, for 5% of patients in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

- **Relationship to other Projects:**
  The Project relates to "127373205.1.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas" in that it also provides a behavioral health service for the IDD population in an area that currently has no access to the service.

  This IDD respite project is related to project "127373205.1. 2 Improve access to specialty care" in that it is providing access to a service that would otherwise require a long wait or not be available in the region.

- **Relationship to Other Performing Providers' Projects in the RHP:**
  The target population for this project is Adults/Children who meet service eligibility requirements per our contract with the Department of Aging and Disability Services (DADS). Part of this eligibility includes geographic location limited to Wichita, Montague,

[26] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties within the Helen Farabee Center catchment area. The services provided by Helen Farabee Center are specific to DADS model of care and performance contract. We do not believe the project duplicates another provider's intervention for the same target population.

- **Plan for Learning Collaborative:** N/A

- **Project Valuation:**

This project serves the population located in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. We estimate providing crisis respite to approximately 20 persons a year based on IDD state hospitalization over the past 2 years. The project seeks to increase utilization of appropriate crisis alternatives (e.g. the respite unit versus state hospitalization) by 5% over that baseline (21) increasing to 15% (23) over Demonstration Years 4 and 5, respectively. The benefit to the community is in the form of new crisis respite services which avoid costs associated with emergency department usage or hospitalization[27]. Local funding is in the form of IGT from Helen Farabee Center.

Valuation methodology consisted of applying a gain in Quality of Life Years (QALY) of 0.03 per standard value of one life year ($50,000) times 30 (estimated crisis-prevention cases in one year). The rational for this valuation begins with the goal of reducing unnecessary emergency department usage and psychiatric hospitalizations for people with Intellectual/Developmental Disabilities (IDD). Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The number of life-years added is being used as a common health goal or outcome. A standard value of $50,000 is assigned to one life year. One study by Clark et al. (1998)[28] considered the use of Assertive Community Treatment (ACT) for people with severe mental illness and substance abuse disorders versus standard care. This is not perfectly comparable to an IDD population. The Quality of Life Years (QALYs) gained through ACT versus standard care was 0.03 years. This QALY gain was considered in addition to Latimer's (2005)[29] review which found that a high-fidelity ACT team can reduce the number of hospital days by about 78%.

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[27] Sledge W. (1996). Day hospital/crisis respite care versus inpatient care, Part II: Service utilization and costs. *American Journal of Psychiatry, 153*(8), 1074-1083. Retrieved October 17, 2012 from http://www.ncbi.nlm.nih.gov/pubmed/8678177

[28] Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Serv Res, 33(5),* 1285-1308.

[29] Latimer, E. (2005). Economic considerations associated with assertive community treatment and supported employment for people with severe mental illness. *Journal of Psychiatry & Neuroscience 30(5),* 355-359.

127373205.1.3	1.13.1	*1.13.1.A-E*	Develop and Implement crisis stabilization services to address the identified gaps in the current community crisis system
Helen Farabee Center			127373205
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.3	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: P-5. Milestone: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 : P-5.1. Metric: Completion of policies and procedures. Baseline/Goal: To develop policy and procedures that will guide providers in the implementation and provision of quality crisis services. Data Source: Internal policy and procedures documents and operations manual. Milestone 1 Estimated Incentive Payment *(maximum*	**Process Milestone 3**: P-6. Milestone: Evaluate and continuously improve crisis services Metric 3: P-6.1. Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline/Goal: Complete first project report which includes a review of service encounters, analysis and recommended changes. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to	**Improvement Milestone 1**: I-12. Milestone: Utilization of appropriate crisis alternatives Metric 1: I-12.1. Metric: 5% increase (21) over baseline (baseline = 20 individuals per year) in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there	**Improvement Milestone 2**: I-12. Milestone: Utilization of appropriate crisis alternatives Metric 2: I-12.1. Metric: 15% increase (23) over baseline in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there was a decrease.

127373205.1.3	1.13.1	*1.13.1.A-E*	Develop and Implement crisis stabilization services to address the identified gaps in the current community crisis system	
Helen Farabee Center				127373205
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.3	Quality of Life	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
amount): $315,795 **Process Milestone 2**: P-4. Milestone: Hire and train staff to implement identified crisis stabilization services. Metric 2: P-4.1. Metric: Number of staff hired and trained. a. Staff rosters and training records Baseline/Goal: Contract with one Community partner for Crisis Respite services and hire one Psychologist or one Licensed Psychological Associate, one Case Manager, and one Community Support staff member for Intensive Case	guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 3 Estimated Incentive Payment: $384,122 **Process Milestone 4**: P-8. Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for	was a decrease. Goal: To provide the least restrictive alternative to care to individuals in crisis. Data Source: Claims, encounter, and clinical record data. Milestone 1 Estimated Incentive Payment: $795,645	Goal: To provide the least restrictive alternative to care to individuals in crisis. Data Source: Claims, encounter, and clinical record data. Milestone 2 Estimated Incentive Payment: $746,472

127373205.1.3	1.13.1	*1.13.1.A-E*	Develop and Implement crisis stabilization services to address the identified gaps in the current community crisis system	
Helen Farabee Center				127373205
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.3	Quality of Life	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Management Behavioral Support Team Data Source: Training curricula Milestone 2 Estimated Incentive Payment: $315,795 *Add more milestones and metrics as applicable*	the purposes of improvement. Metric 4: P-8.1. Metric: Number of new ideas, practices, tools, or solutions tested by each provider. Baseline/Goal: To establish a continuous quality improvement system of care that the providers will respond to in an on-going basis. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals		

127373205.1.3	1.13.1	*1.13.1.A-E*	Develop and Implement crisis stabilization services to address the identified gaps in the current community crisis system
Helen Farabee Center			127373205
Related Category 3 Outcome Measure(s):	3.10.1	127373205.3.3	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment: $384,122		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $631,590	Year 3 Estimated Milestone Bundle Amount: $768,243	Year 4 Estimated Milestone Bundle Amount: $795,645	Year 5 Estimated Milestone Bundle Amount: $746,472
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,941,950			

Category 1: Infrastructure Development

RHP Project Number: 120745806.1.1

RHP Performing Provider: Muenster Memorial Hospital-120745806
MMH
MUENSTER MEMORIAL HOSPITAL *120745806.1.2*
(120745806.1.1)

Summary

- **Provider:** Muenster Memorial Hospital is an 18-bed Critical Access Hospital in Muenster, Texas serving Cooke County and surrounding counties.

- **Interventions:** This project will implement telemedicine to improve patient safety through pharmacist oversight of prescriber orders for inpatient admits, discharge and new medications. Seven days a week to include nights and weekends.

- **Need for Project: CN.3 Shortages of health care professionals.** We currently only have one pharmacist onsite 8 hours per week and have noticed an increase in inpatient admission.

- **Medicaid and Uninsured Target Population:** The target population is 3228 patients admitted into the hospital last FY year that need pharmacist oversight on medications. Approximately 14% of our patients are either Medicaid eligible or indigent with numbers growing.

- **Category 1 or 2 expected patient benefits:** The project seeks to provide 200 pharmacist oversight review of medications on inpatients in DY 4 and 250 in DY5. In FYE 2012 their was 3228 patients admitted into the hospital and 450 of those patients where Medicaid or uninsured.

- **Category 3 outcomes:** Our goal is to reduce medication related falls on inpatients.

Category 1: Infrastructure Development

Project: 1.7 Introduce, Expand or Enhance Telemedicine/Telehealth

Project Option: 1.7.2 Implement remote patient monitoring programs for diagnosis and/or management of care.

RHP Project Number: 120745806.1.2 (120745806.1.1)

RHP Performing Provider: Muenster Memorial Hospital-120745806

Project Description:

Muenster Memorial Hospital wants to improve patient safety through improving pharmacist oversight of prescriber orders. With shortages in health care professionals to include hospital pharmacist CN.2 the use of remote service will increase the percentage of orders that are reviewed prospectively prior to initiation of therapy or decrease the amount of time between initiation of therapy and retrospective pharmacist order review. Currently Muenster Hospital District has a contract with a pharmacist group that sends one contract pharmacist to the hospital one day a week to review orders. With a low volume of admissions after hours it not possible to staff the hospital pharmacy 24/7 with either a pharmacist or a pharmacy tech. We are currently using RN's to pull medications from the pharmacy after hours for inpatients and emergency room visits with our doctors checking the orders. Remote pharmacists will perform a drug regimen review of all patients (including psychiatric and pediatric patients), that will include review for allergy contraindications; reasonable dose (special scrutiny of pediatric patients), route and directions for use; drug/drug, drug/food, and drug/disease interactions; and therapy duplications. Remote pharmacists will make clinical interventions to address any identified issues and to clarify orders. The pharmacist will intervene to make dosage adjustments for renal, vancomycin, aminoglycoside or other dosage recommendations. Pediatric doses can be assessed and a double check performed by a pharmacist for increased patient safety. More timely review of orders will help prevent near misses from becoming medication administration errors. Adverse drug reactions will be identified and reported. Remote pharmacists can assist with cost containment by assisting with conversion of IV to bioequivalent oral therapy, identification and use of patient's own medication, and recommendations for non-formulary to formulary agents.
Patient counseling will be provided by the remote pharmacist utilizing audio-visual communication. This will allow the patient and/or staff to interact with the pharmacist for a one-on-one dialogue to provide information and answer any questions the patient may have to increase medication therapy compliance. In summary, remote services will increase patient safety through more timely review of prescriber orders.

Starting Point/Baseline: With hospitals being held responsible for accidents that occur in the facility and with decrease in payments because of readmission rates the need for service to verify every prescription for accuracy and reactions not only benefits the hospital but will greatly benefit not only the Medicaid and uninsured patients but all patients. By providing a quality service to the community this will help in the overall health of the community. Currently the orders are reviewed once a week and adjustments are made after the review this in some cases is to long for the patient. From January 2012 through September 2012 6,085 inpatient medication orders where prescribed. Only 324 of the medication orders were viewed and checked by a Pharmacist before they where given.

Rationale:

From the American Society of Healthcare Pharmacists: Review of medication orders. All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated dispensing device, except in emergency situations in which the treatment of the patient would be significantly compromised by the delay that would result from pharmacist review of order. (American Society of Hospital Pharmacists. ASHP technical bulletin on hospital drug distribution and control. Am J Hosp Pharm. 1980; 37:1097-103.)
In its Statewide Health Plan 2011-2016 report, the Texas Statewide Health Council concluded: "Texas faces particular challenges with respect to physician and other healthcare workforces not primarily because of an overall shortage, but because of sharp disparities in the allocation of healthcare resources to different parts of the state. Given the various benefits observed through the provision of health care via telemedicine, there is a tremendous amount of momentum toward increasing access to care through the use of health information technologies, thereby creating an exciting and central role for innovation and implementation of new and advanced platforms for service delivery. Two such platforms include the use of wireless and telemonitoring technologies."

Muenster Memorial Hospital is located in Cooke County, Texas, which is a HPSA county. By providing a Level IV trauma center and acute hospital to the community, Muenster Memorial Hospital's pharmacy provides service 24 hours a day 7 days a week for both inpatient and emergency room services. By having the use of telemedicine for pharmaceutical review of all medications ordered by a remote pharmacist will reduce medication errors to Medicaid and uninsured patients and shorten length of stay. By reducing medication errors and decreasing the length of stay this will result in lower cost to Medicaid and provide better healthcare services to our community. The existing infrastructure for Muenster Memorial Hospital broadband communications is fiber-optic connections which has an upload speed of 35mbps and a download speed of 30mbps.

With the current fiber-optic connections and with the tele-pharmacy equipment that we will use from the company providing service the service will be provided in real time with no lag or delay in service.
The consulting company that we have chosen has this service running in other hospitals across the state already. By using their models for training, set-up and deployment plus the use of their equipment we will have the service running very quickly. This service is not connected or will not be funded with any EHR incentive program either Federal or State funding.
The expected outcome is an increase in the number of prescriber orders that are reviewed in a timely manner providing pharmacist oversight. Resulting clinical interventions and recommendations will decrease the number of falls related to medications ordered and given.

Required QI: In order to assure that the implementation of telemedicine for pharmaceutical services is effective, the quality improvement team will review inpatient stays on a regular basis to determine if review of pharmacy orders in a more timely manner has had a significant impact on improved outcomes for patients and/or reduced the length of stay.

Related Category 3 Outcome Measure(s): 120745806.3.2 (120745806.3.1)

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions
IT-4.5 Patient Fall Rate- NQF 0141255 (Standalone measure)

The expected outcome is an increase in the number of prescriber orders that are reviewed in a timely manner providing pharmacist oversight. Resulting clinical interventions and recommendations will decrease the number of falls related to medications ordered and given.

Project Valuation: Patient safety is a top concern and the ability to provide a safe environment for each patient during the healing process is very important. Included in patient safety is fall prevention to include proper medication doses. With proper medications we can ensure that there are no reactions and that other medications will not make a patient unstable and result in patient falls. We predict that this will affect all 3328 in-patients which includes 450 Medicaid and uninsured patients. Our goal is to provide 200 pharmacist interventions in DY 4 and 250 pharmacist interventions in DY5.

120745806.1.2 (120745806.1.1)	**1.7.2**	**- A,B,C 1.7.2**	**IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES**
Muenster Memorial Hospital/120745806			120745806
Related Category 3 Outcome Measure(s):	120745806.3.2 (20745806.3.1)	OD-4 IT -4.5	Patient Fall Rate

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [RHP PP Milestone – P-X]: Develop plan to increase pharmacist oversight of prescriber orders Metric P-X.1 Submission of plan. Baseline: Number of pharmacist interventions and counseling from January 2012 – September 2012, annualized. (0) Goal: Research and select vendor for remote service provision Milestone 1 Estimated Incentive Payment : $189,595	**Milestone 2** P-7: Create plan to monitor and enhance technical properties, bandwidth, of telemedicine/ telehealth program. Metric P-7.1: Documentation of bandwidth capacity in relationship to program needs Baseline: Bandwidth on September 30, 2012 Goal: Increase band width to support teleheath pharmaceutical services. Milestone 2 Estimated Incentive Payment: $109,883 **Milestone 3** [P-8]: Create plan to monitor and enhance internet use for telemedicine/	**Milestone 4** [I-12]: Increase number of telemedicine visits for each specialty identified as high need Metric [I-12.1]: Number of telemedicine visits Goal: Increase number of pharmacist interventions and counseling by 200 from DY2. Data Source: EHR medication data Milestone 4 Estimated Incentive Payment: $222,037	**Milestone 5** [I-12]: Increase number of telemedicine visits for each specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: Increase number of pharmacist interventions and counseling by 250 from DY2. Milestone 5 Estimated Incentive Payment: $190,236

	telehealth program. Metric 1 [P-8.1]: Documentation of expansion of services utilizing the internet as a medium. Baseline/Goal: Plan to identify which services can be made available through internet applications as well as steps to implement these services. Data Source: Program Plan Milestone 3 Estimated Incentive Payment: $109,883		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $189,595	Year 3 Estimated Milestone Bundle Amount: $219,766	Year 4 Estimated Milestone Bundle Amount: $222,037	Year 5 Estimated Milestone Bundle Amount: $190,236
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $821,634			

Summary Information: North Texas Medical Center

Old Project 121777003.1.1
Pass 3B New Project #121777003.1.2

- Provider: North Texas Medical Center is a 60 bed Hospital in Gainesville Texas serving a 583 square mile area and a population of approximately 40,000.

- Intervention(s): This project will expand an existing primary care clinic and relocate a second primary care clinic. The relocation will place the second clinic in very close proximity to full lab and X-ray services so that it may serve as an urgent care clinic. The project also includes adding three additional primary care providers and associated staff. Through education and outreach we will encourage patients to seek primary & preventative care in the clinic rather than the Emergency department.

- Need for the project: Prior to fall 2011 Cooke County had no primary care or urgent care during evening or weekend hours. This forced all patients to seek needed care during these hours via the Emergency Department. Most primary care physicians are not accepting or strictly limit the number of new Medicaid and/or Medicare patients they will accept in their practice due to declining reimbursement. Uninsured patients with no ability to pay have limited options as well. Often they have not option, except the Emergency Department. Additionally, 70% of family practice physicians in the district are older than 55 and can be expected to retire within the next five to ten years. These physicians are committed to traditional office hours which increases wait times for a primary care appointment particularly for low income and uninsured patients who frequently may have a more rigid work schedule and transportation difficulties.

- Medicaid and Uninsured Target population: The target population for this project is Cooke County as a whole. We will have the only clinic in the county open for evening and weekend hours. Approximately 55% of the patients in ED are either Medicaid or uninsured; This is significantly higher than the hospital inpatient admission rate of approximately 20% Medicaid/uninsured. Examination of payer mix vs. E/M codes in NTMC ED patients reveals that in the lower E/M codes approximately 60% of the patients are Medicaid/uninsured whereas the higher E/M codes are only about 45% Medicaid/uninsured. It is clear that Medicaid/uninsured patients are using the ED for nonemergent care in greater numbers than those patients with greater resources. We expect these Medicaid/uninsured patients to benefit significantly from the increased availability of primary care appointments particularly on evenings and weekends.

- Category 1 or 2 expected patient benefits: The expansion and relocation projects have not begun, so we anticipate that we will not be able to show a visit increase until DY4. The project will increase NTMC's primary care capacity by adding an additional 3120 visits in DY4 and another 3120 visits in DY5 for a total increase of 6240 primary care visits over the baseline of 13,896 by DY5 for a total of 20,136 visits.

- Category 3 outcomes: IT-9.2 Our goal is to reduce all ED visits including ACSC by a TBD amount by DY5.

Pass 3B

Project Option 1.1.2 – Expand Existing Primary Care Capacity

Old Unique Project ID# 121777003.1.1
New Unique Project ID# 121777003.1.2
North Texas Medical Center 121777003

Project Description:
North Texas Medical Center proposes to expand primary care capacity.

North Texas Medical Center is located in Gainesville, the county seat of Cooke County. Cooke County is located on the Texas-Oklahoma border north of the Dallas-Fort Worth Metroplex area. The county is rural with a population of approximately 40,000. The poverty level is similar to that of the rest of Texas. Cooke County has a significantly higher elderly population than Texas at 16%, versus Texas at 10% according to the 2009 Health Facts Profile on Cooke County by the Center for Health Statistics at the Department of State Health Services.

Challenges:
Prior to fall 2011 Cooke County had no primary care or urgent care during evening or weekend hours. This forced all patients to seek needed care during these hours via the Emergency Department. Most primary care physicians are not accepting or strictly limit the number of new Medicaid and/or Medicare patients they will accept in their practice due to declining reimbursement. Uninsured patients with no ability to pay have limited options as well. Often they have not option, except the Emergency Department. Additionally, 70% of family practice physicians in the district are older than 55 and can be expected to retire within the next five to ten years. These physicians are committed to traditional office hours which increases wait times for a primary care appointment particularly for low income and uninsured patients who frequently may have a more rigid work schedule and transportation difficulties.

In order to address these challenges, North Texas Medical Center will expand primary care so that patients receive the appropriate care in the appropriate setting. To do this we propose to expand one existing primary care clinic and relocate another clinic. The relocation of the second existing clinic will place it in very close proximity to full lab and x-ray services so that it can serve as an urgent care clinic also. Transformation of the healthcare delivery system requires patient centered care models in lower cost settings where efficiencies can be achieved. Providing access to ancillary services will increase continuity of care which will also increase health outcomes for patients who need those services. We will add additional providers and the associated support staff. Through education and outreach activities, we will encourage patients to seek primary and preventive care in the clinic and when care needs escalate and emergency care is necessary.

This project meets the following regional goals:

- Transform healthcare for the total population
- Further advance the goals of the Triple Aim: right care, right place, right setting.

RHP 19 is largely rural. Historically, there have been few options for healthcare outside of normal business hours other than the emergency room. The population of region is used to using the ED for non-emergent care needs when capacity limits access to care.

5-Year Expected Outcomes for Providers and Patients:

Over the four years of the waiver we expect to substantially improve NTMC's primary care capacity by adding an additional 6,240 primary care visits by DY 5. (See notes in the Table below)

Starting Point/Baseline:
Jan 1 2012 – June 30 2012 annualized
13,894 clinic encounters

Rationale:

Unique community need identification numbers the project addresses:

- As supported by CN.8 Emergency Department usage is high and we attribute this to inadequate options during evening and weekend hours and lack of access to primary care as a whole.
- Lack of access to primary care also contributes to CN.2, high costs associated with preventable hospitalization admissions and readmissions that RHP 19 is experiencing.
- And finally lack of access to primary care is a factor in the regions' CN.1, high rates of chronic disease, including cancer, diabetes, heart disease, respiratory diseases, and obesity.

For these reasons NTMC considers expanding primary care as the number one health need in the county. Expansion of primary care is the single biggest change we can make to effect system-wide improvement. With expanded primary care capacity, more patients will have access to primary and preventative care, which increases opportunities to prevent disease and treat it early and keep people out of the hospital. It is particularly important for inpatients to get follow-up appointments after their hospital stay for optimal recovery and to avoid readmission.

Project Components:

Through the expansion of primary care capacity, we propose to meet all required project components.

a) *Expand primary care clinic space* - The existing clinic (Cooke County Medical Center) is more than 20 years old, the antiquated design is not conductive to efficient patient flow, there are too few exam rooms and there is inadequate parking forcing patients and staff to park in illegal locations. The clinic is located in a low income area of Gainesville and is very convenient to Medicaid and low income patients. Expanding and renovating the existing clinic will provide the infrastructure needed to offer more primary care in a convenient location to Medicaid and uninsured patients. Relocation of an additional clinic focused on urgent care and close to imaging and lab services will further expand primary care and urgent options for Cooke County.

b) *Expand primary care clinic hours* - North Texas Medical Center began to address this challenge during the fall of 2011 by expanding clinic hours to some evenings and adding a midlevel provider. In January of 2012 the clinic was opened weekends and additional providers were added for pediatrics in March.

c) *Expand Primary Care Clinic staffing* - When we expanded primary care clinic hours the additional available slots were filled very quickly and patients are again being turned away for same day appointments. With the attempt to block adequate time for same day appointments it became difficult to manage chronic care patients' visits with the desired frequency. This could lead to avoidable admissions and readmissions for complex patients. We will also add three primary care providers and the associated staff so that we can meet the needs for same day appointments and we are able to appropriate manage chronic care patients' needs.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Expanding primary care capacity is a significant expansion of an existing delivery system for North Texas Medical Center. NTMC recognized that uninsured, Medicaid, and underinsured patients in Cooke County did not have access to adequate primary care by the disproportionate share of ED visits that were covered by Medicaid or private pay. The hospital district began to address this need in the fall of 2011, adding both evening and weekend hours and providers. The 1115 waiver offered a unique opportunity to further extend primary care services with more space, more providers, and locations convenient both for the population served and urgent care needs.

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

OD – 9 Right Care, Right Setting
IT – 9.2 ED Appropriate Utilization

- Reduce all ED visits (including ACSC)

Reasons/rationale for selecting the outcome measure:

ED appropriate utilization is the category 3 measure we feel will best reflect the success of our expansion of primary care capacity. Expanding primary care capacity and establishing a care transitions program will help achieve a decrease in inappropriate ED use in several ways. With an increase number of primary care encounters available during business, evening, and weekend hours patients will not be forced to seek care for primary care and urgent care via the ED. Additionally if patients get the appropriate care they need via primary care they avoid the ED visits associated with lack of preventative and chronic care.

Relationship to other Projects:

Expansion of primary care capacity will allow for more organized care delivery and a primary care home for patients served by NTMC's care transitions project (unique project ID: 121777003.2.1), who do not already have a primary care provider. NTMC is currently participating in Project Red and one of the challenges we are facing is inability to get a follow-up primary care appointment in the desired time frame.

Related Category 4 Population-focused Measures:

NTMC is exempt from reporting on category 4 measures, however we feel the measures below would be favorably impacted by expanding primary care capacity.

- RD-1 Potentially preventable admissions
- RD-2 Potentially preventable readmissions
- RD-4.1 Patient Satisfaction

Relationship to Other Performing Providers' Projects in the RHP:

Lack of access to primary care is a problem across region 19. In fact, this challenge is felt throughout much of Texas and the nation. Increasing primary care capacity was the DSRIP project area chosen more than any other among Region 19 performing providers. The closest performing provider also working on this problem is in a separate county so they are not serving the same target population. There is no learning collaborative planned for this measure within RHP 19. ED Appropriate Utilization is also the focus of RHP 19. Public hospitals in our region have long been utilized as the sole source of care by all persons. It is intrinsic in transformation, that we now lead initiatives to help our communities access care in appropriate and efficient and effective settings. To do this, we must address our most critical community need for primary care providers.

Project Valuation:

There are approximately forty thousand residents of Cooke County. However Cooke County has a disproportionate share (16%) of aged as compared to Texas as a whole. As noted by the Agency for Healthcare Research and Quality the elderly population is more expensive to treat.[4] Access to primary care at a time and place of convenience to the patient with limited wait times will lead to improved quality and a lower cost, as access to primary care has been shown to reduce more costly avoidable visits to the emergency department and the hospital.[1,2,3] Valuation assumes that we will provide an additional 3120 primary care/urgent care visits in

DY4 and an additional 3120 visits in DY5 for a total of 6240 visits above the baseline of 13, 894 visits per year in DY5. We propose a valuation of $5,857,337 which is supported by the community need for access to quality health care, the aging population, cost factors, and local funding which will support this project.

[1]Falik M, Needleman J, Wells BL, et al. Ambulatory care sensitive hospitalizations and emergency visits: experience of Medicaid patients using federally qualified health centers. Med Care. 2001;39:551-556
[2] Smith-Campbell B. Emergency department and community health center visits and costs in an uninsured population. J Nurs Scholarsh. 2005;37:80-86
[3] Kromen A, Ash A, Freund K, et al. Can Primary care Visits Reduce Hospital Utilization Among Medicare Beneficiaries at the End of Life. J Gen Internal Med. 2008 September 23(9): 1330-1335
[4] Stanton MW, Rutherford MK. The high concentration of U.S. health care expenditures. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 19. AHRQ Pub. No. 06-0060

OLD 121777003.1.1 *NEW 121777003.1.2*	*1.1.2*	*1.1.2.A,B,C*	*EXPAND PRIMARY CARE CAPACITY*	
North Texas Medical Center				*121777003*
Related Category 3 Outcome Measure(s): Right Care Right Setting	*OLD 121777003.3.1* *NEW* *121777003.3.3*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-1:Establish additional /expand existing/relocate primary care clinics Metric 1 P1.1 1 primary care clinic expansion and 1 primary care clinic relocation Baseline/Goal: blueprints for expansion of 1 clinic & new building blueprints for 2nd clinic Data Source: Blueprints for clinic expansion and blueprints for 2nd clinic relocation Milestone 1 Estimated Incentive Payment: $1,432,497	**Milestone 2 -** P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 3 additional providers Date Source: employment contract (provider) & HR documents (support staff) Milestone 2 Estimated Incentive Payment: $1,562,777		**Milestone 4** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 3,120 additional visits Over baseline of 13,894/yr in DY4 Data Source: EHR Milestone 4 Estimated Incentive Payment: $1,567,320	**Milestone 5** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 6,240 additional primary care visits over baseline of 13, 894/yr in DY 5 Data Source: EHR Milestone 4 Estimated Incentive Payment: $1,294,742

OLD 121777003.1.1 *NEW 121777003.1.2*	*1.1.2*	*1.1.2.A,B,C*	*EXPAND PRIMARY CARE CAPACITY*	
North Texas Medical Center				*121777003*
Related Category 3 Outcome Measure(s): Right Care Right Setting	*OLD 121777003.3.1* *NEW* *121777003.3.3*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**	
Year 2 Estimated Milestone Bundle Amount: $ 1,432,497	Year 3 Estimated Milestone Bundle Amount: $ 1,562,777	Year 4 Estimated Milestone Bundle Amount: $ 1,567,320	Year 5 Estimated Milestone Bundle Amount: $ 1,294,742	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 5,857,336				

Summary Information: Seymour Hospital

Pass 3B
New ID: 138353107.1.3
Old ID: 138353107.1.1

- Provider: Seymour Hospital is a 49-bed hospital located in Seymour, Texas. We are the only facility providing Obstetrics Services within a five county service area that includes Baylor, Foard, Haskell, Knox and Throckmorton counties in North Central Texas. These counties have a cumulative population of approximately 16,438.

- Intervention(s): This project will expand our existing Obstetrics Department to increase access to care, workflow, and efficiency as well as improve prenatal education efforts and promote adequate prenatal care.

- Need for the project: Our project was chosen because it directly addresses community needs CN.5 (Need to Overcome Patient Access to Care Barriers) and CN.6 (Need for Improvement in Fertility and Natality Care), which were identified in the Community Needs Assessment for RHP 19 that was conducted in July 2012. Due to the fact that the majority of our obstetric patients are either covered by Medicaid or are uninsured, we have an increased need for adequate and timely prenatal care and education. This is one of the most cost-effective interventions for improving birth outcomes. During the time period from January 1, 2012 to December 31, 2012, there were a total of 50 babies born at our facility to a total of 49 mothers. Of these deliveries, approximately 30% of the pregnancies, which in turn affected 15 mothers and 15 babies, did not receive prenatal care during the first trimester. Additionally, low birth-weight births accounted for approximately 8% or 4 of the 50 births. Finally, an alarming 48% or 24 out of 50 of our babies were born prior to 39 weeks for a variety of complications such as preterm labor, pregnancy induced hypertension, pre-eclampsia, decreased amniotic fluid, or repeat c-sections (it is recommended that healthy pregnancies continue to at least 39 weeks gestation in order to allow babies to be fully developed in the womb).

- Medicaid and Uninsured Target population: The target population which will be receiving patient benefit for this project includes the mothers (and their newborn babies) who do not receive prenatal care during the first trimester. We estimate that, by the end of DY5, our project will benefit 34 individual lives by providing timely and adequate prenatal care, with special emphasis on the first trimester. Of these patients, approximately 92% are covered by Medicaid or are uninsured.

- Category 1 or 2 expected patient benefits: The project seeks to increase access to adequate prenatal care and education to 34 patients by the end of DY5 (including mothers and babies), of which the vast majority are covered by Medicaid or are uninsured. By increasing access to care for these patients, we expect to see an overall improvement in the health of these pregnancies. Additionally, we anticipate a

reduction in pre-term deliveries, reduced low birth weight births and a potential reduction in serious complications related to pregnancy.

- Category 3 outcomes: IT-8.2 Percentage of Low Birth Weight Births: Our goal is to reduce the number of low birth weight births at our facility through the implementation of a comprehensive obstetrics program, which will increase access to adequate prenatal care and education. The total number of low birth weight births in Baylor County from the year 2010 was 12.5%, with the state average being only 8.4%. This ranks Baylor County 16th in the entire state for low birth weights.

Category 1: Infrastructure Development

Project Area: 1.9 Expand Specialty Care Capacity

Project Option: 1.9.3 Other Project Option: Increase Access to Specialty Services for Prenatal Care

RHP Project Number: New ID: 138353107.1.3
(Old ID: 138353107.1.1)

RHP Performing Provider: Seymour Hospital-138353107

Project Description:

Seymour Hospital plans to expand the specialty care capacity of our facility. Our project addresses the immediate needs of our community as identified by the RHP Needs Assessment CN.5 (Need to Overcome Patient Access to Care Barriers) and CN.6 (Need for Improvement in Fertility and Natality Care). The project will include the expansion and re-design of our existing Obstetrics Department. This project will allow us to improve the outcomes of not only our obstetrical patients but their newborns as well. The first goal of our project is to increase the workflow and efficiency of our obstetrical department. We will be meeting the need for increased access to specialty care by upgrading and enhancing our Obstetrical department and facilities. The second goal of our project is to increase prenatal education efforts and promote adequate prenatal care in order to reduce the rate of low-birth weight babies born within our facility. Inadequate use of prenatal care is often associated with increased risks of low-birth weight births, preterm births, prenatal complications, and in the most extreme cases, infant or maternal death. We plan to implement a comprehensive prenatal education program which will convey to our patients the importance of early prenatal care that continues throughout the pregnancy. This will include prenatal education classes in addition to providing educational outreach that emphasizes the importance of adequate prenatal nutrition, prenatal exercise and appropriate maternal care during pregnancy. Additionally, babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who receive adequate prenatal care. In a recent campaign launched by the March of Dimes entitled “Healthy Babies are Worth the Wait”, it has been proven that babies aren’t fully developed until at least 39 weeks in the womb. Important development of babies brains, lungs and eyes occur in the last few weeks of pregnancy and it is therefore recommended that healthy pregnancies continue to at least 39 weeks gestation. During 2012, approximately 48%, or 24 out of 50, of our babies were born prior to 39 weeks for complications such as preterm labor, pregnancy induced hypertension, pre-eclampsia, decreased amniotic fluid, or repeat c-sections. One of the primary challenges that our facility faces is that we are the only hospital providing obstetrical services within a five-county service area. This demonstrates the great need for our facility to provide a higher level of care to our patients, who often face geographic,

financial, and educational barriers which inhibit access to proper medical care. By expanding and improving our existing obstetrical department, we will be able to provide our patients with a higher level of care, more patient education and a more patient-centered stay, which in turn will increase the number of positive patient outcomes and provide greater levels of patient satisfaction. The 5-year expected outcome for our project is a measurable increase in the positive patient outcomes of our obstetrical department as well as decreases in the number of deliveries prior to 39 weeks gestation and a reduction in the number of low birth-weight births.

Starting Point/Baseline:

The starting point/baseline for our project includes two full-time physicians, which currently provide obstetrical care to the members of our community. During the 12-month period from January 1, 2012 to December 31, 2012, these physicians provided care to 49 obstetrical patients. These patients gave birth to a total of 50 newborns. On average, these patients had 11 prenatal visits during the extent their pregnancy, with the high being 22 visits and the low being 1 visit. Out of the total of 50 births, approximately 30% or 15 of the mothers and their 15 babies did not receive prenatal care during the first trimester of their pregnancies. We do not currently offer any prenatal, breastfeeding or child safety seat classes, nor do we offer dedicated patient surveys for our obstetrical department.

Rationale:

Our project was chosen due to the fact that it directly addresses community needs CN.5 (Need to Overcome Patient Access to Care Barriers) and CN.6 (Need for Improvement in Fertility and Natality Care), which were identified in the Community Needs Assessment for RHP 19 that was conducted in July 2012. By expanding and improving our Obstetrics Department, we will be offering our patients and our community increased access to prenatal care and education as well as improved outcomes for their newborns. Baylor County, which has a population of 3,781, is designated by HRSA as a Medically Underserved Area (MUA) and a Healthcare Professional Shortage Area (HPSA).

Related Category 3 Outcome Measure(s):

OD-8 Perinatal Outcomes was selected as the Outcome Domain for our project as it directly relates to the scope of our project. We then selected IT-8.2, Percentage of Low Birth Weight Births (CHIPRA/NQF #1382) as the standalone measure for our project. Monitoring the prevalence of low birth weight births is directly related to the care that is provided to our obstetric patients during their pregnancies.

Relationship to other Projects:

Each of our projects address the needs of our community, as identified by the Community Needs Assessment for Region 19, which was performed in July 2012.

Relationship to Other Performing Providers' Projects in the RHP:

While there is a regional project for specialty care; it does not include obstetrical care.

Project Valuation:

Through the expansion of our obstetrics department, we will be able to provide our patients with a higher level of care, more patient education and a more patient-centered stay, which in turn will increase the number of positive patient outcomes and provide greater levels of patient satisfaction. The estimated patient impact of this project is 34 individual patients by the end of DY5. Over 50 percent of all births in Texas and approximately 92% of the births at our facility are paid for by Medicaid. Therefore, it is essential that we establish and improve prenatal and birthing care to prevent more costly births and traumas, which can also negatively impact patient outcomes. Through the successful implementation of our project, we will also be able to reduce the incidence and length of stay for low birth weight babies. Cost savings for treating low birth weight babies, in addition to the value of healthier moms and babies during the first six months postpartum were both considerations for our project valuation. Taking into consideration all of the above listed factors, the valuation of our project is estimated at $944,881.

New ID: 138353107.1.3 (Old ID: 138353107.1.1)	**1.9.3**		**EXPAND SPECIALTY CARE CAPACITY**	
Seymour Hospital				138353107
OD-8	IT-8.2	138353107.3.4 (Old ID: 138353107.3.1)	Perinatal Outcomes	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-X Process Milestone P-X: Implement the Re-design of the Obstetrics Department in Order to Increase Operational Efficiency, Provide Space for Prenatal Patient Education and Increase Provider Productivity. Metric P-X.1:Completion of Obstetric Department Re-Design Data Source: Provider Documentation of Obstetric Department Re-Design Baseline/Goal: Complete Specialty Care Access Plan	**Milestone 2:** I-33 Improvement Milestone I-33: Increase Specialty Care Capacity Using Innovative Project Option Metric I-33.1: Increase Percentage of Target Population Reached a. Numerator: Number of Individuals of Target Population Reached by the Project b. Denominator: Number of Individuals in the Target Population Data Source: Documentation of Target Population Reached, as Designated in the Project Plan Baseline/Goal: Provide		**Milestone 3 :** I-33 Improvement Milestone I-33: Increase Specialty Care Capacity Using Innovative Project Option Metric I-33.2: Increased Number of Specialty Care/Obstetrical Visits a. Total Number of Visits for Reporting Period Data Source: Clinic Documentation/Reports of Obstetrical Patient Encounters Baseline/Goal: Provide Adequate and Documented Prenatal Care During the First Trimester to an Additional 2 Individual Patients Over DY3	**Milestone 4:** I-33 Improvement Milestone I-33: Increase Specialty Care Capacity Using Innovative Project Option Metric I-33.3: Documentation of Increased Number of Unique Patients or Size of Patient Panels. Demonstrate Improvement Over Prior Reporting Period a. Total Number of Unique Patients Encountered in the Clinic for Reporting Period Data Source: Clinic Documentation/Reports of Obstetrical Patient Encounters Baseline/Goal: Provide

New ID: 138353107.1.3 (Old ID: 138353107.1.1)	**1.9.3**		**EXPAND SPECIALTY CARE CAPACITY**	
Seymour Hospital				138353107
OD-8	IT-8.2	138353107.3.4 (Old ID: 138353107.3.1)	Perinatal Outcomes	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment : $218,035	Adequate and Documented Prenatal Care During the First Trimester to 15 Mothers (and Their 15 Babies), for a Total of 30 Individual Patients Milestone 2 Estimated Incentive Payment: $252,731		Milestone 3 Estimated Incentive Payment: $255,343	Adequate and Documented Prenatal Care During the First Trimester to an Additional 4 Individual Patients Over DY3 Milestone 4 Estimated Incentive Payment: $218,772
Year 2 Estimated Milestone Bundle Amount: $218,035	Year 3 Estimated Milestone Bundle Amount: $252,731		Year 4 Estimated Milestone Bundle Amount: $255,343	Year 5 Estimated Milestone Bundle Amount: $218,772
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $944,881				

Summary Information: Seymour Hospital

Pass 3 Project 138353107.1.2

- Provider: Seymour Hospital is a 49-bed hospital located in Seymour, Texas. We are located within the central portion of Baylor County at the crossroads of seven major highways and have a population of approximately 3,741 people.

- Intervention(s): Our project will provide an additional access point to primary care through the implementation of an Urgent Care Clinic. Additionally, it will reduce the misuse of our Emergency Department for non-urgent health care issues and offer an alternative which is more cost-effective, timely and appropriate to the level of care which is required.

- Need for the project: We have approximately 1950 patient encounters each year in our Emergency Department. However, only 487 or approximately 25% of these encounters are for truly life-threatening emergencies. Therefore, an estimated 1463 patient encounters would be better suited for treatment in an Urgent Care Clinic.

- Medicaid and Uninsured Target population: The target population for this project will be the underserved members of our community which include the elderly, indigent/charity populations, Medicaid/Medicare recipients, uninsured/ underinsured and those who face financial or geographical barriers to adequate and appropriate care.

- Category 1 or 2 expected patient benefits: The expected outcomes for this project will be a measurable decrease in the number of non-urgent visits to the Emergency Department as well as an increase in the number of patients that utilize the Urgent Care Clinic. The expected patient benefit of the implementation of an Urgent Care Clinic would be approximately 1300 patient visits per year by DY5. Our patients will be directly benefited by offering a timelier and more cost-effective encounter as well as an increase in patient satisfaction with the services and care that they receive.

- Category 3 outcomes: IT-9.2, ED Appropriate Utilization: Our goal is to document a reduction in Emergency Department visits through the proper utilization of an on-site Urgent Care Clinic for minor, non-urgent healthcare issues.

Pass 3

Category 1: Infrastructure Development

Project Option: 1.1 Expand Primary Care Capacity

RHP Project Number: 138353107.1.2

RHP Performing Provider: Seymour Hospital/138353107

Project Description:

Seymour Hospital plans to implement a comprehensive Urgent Care Clinic in an effort to reduce the misuse of our Emergency Department for non-urgent health care issues. This will be achieved through project option reference number 1.1.2. The Urgent Care Clinic will provide an additional access point to primary care for our patients. The average number of Emergency Room encounters at our facility is approximately 162 per month, of which only 25% of these visits are for truly life-threatening emergencies. This is equivalent to 1950 encounters per year, with an estimated 487 being emergent. We believe that by offering patients a more timely and cost effective way to deliver non-urgent health care, we will be able to improve the level of patient satisfaction with the healthcare that they receive. This will be accomplished through increasing staffing, decreasing wait times and improving the level of patient care provided. We will target the underserved members of our community which include the elderly, indigent and charity populations, Medicare/Medicaid recipients, the uninsured/underinsured and those who face financial or geographical barriers to care. Our project addresses the immediate needs of our community as identified by the RHP 19 Needs Assessment and will provide a convenient and cost effective alternative to the emergency room for patients seeking prompt care for non-life threatening injuries and illnesses. The first goal of our project is to implement a plan for the Urgent Care Clinic. The second goal of our project is to staff the Urgent Care Clinic. The primary challenge that our facility faces in the implementation of our project is the overuse of the Emergency Department for minor, non-urgent health issues. The Urgent Care Clinic would allow these patients to have their non-urgent conditions treated in a more affordable, timely and appropriate manner. The 5-year expected outcome for our project is a measurable decrease in the number of non-urgent visits to the Emergency Department as well as an increase in the number of patients that utilize the Urgent Care Clinic with the expected patient benefit to be approximately 1300 patient visits per year by DY5. Additionally, we expect to see an improvement in the patient surveys that are administered to our Urgent Care patients through shortened wait times and a higher patient perception of the quality of care they receive. This will be documented through patient surveys that will be administered to patients upon discharge from the Urgent Care Clinic.

Starting Point/Baseline:

Currently, we do not offer an Urgent Care Clinic. Therefore, we do not have any employees appointed to staff the clinic nor any patients receiving Urgent Care services. The average number of Emergency Room encounters at our facility is approximately 1950 encounters per year, of which 1463 of these encounters are classified as non-emergent and better suited for treatment in an Urgent Care setting.

Rationale:

Our project was chosen due to the fact that it directly addresses community need CN.5 (Need to Overcome Patient Access to Care), which was identified in the Community Needs Assessment for RHP 19 that was conducted in July 2012. We have approximately 1950 patient encounters each year in our Emergency Department. However, only 487 or approximately 25% of these encounters are for truly life-threatening emergencies. Therefore, an estimated 1463 patient encounters would be best suited for treatment in an Urgent Care Clinic. By implementing an Urgent Care Clinic, we will be offering our patients and our community a more timely and cost effective alternative to the Emergency Department for minor and non-life threatening illnesses and injuries. Additionally, we will be improving the satisfaction that our patients have in regard to their care at the Urgent Care Clinic. Baylor County, which has a population of 3,781, is designated by HRSA as a Medically Underserved Area (MUA) and a Healthcare Professional Shortage Area (HPSA) and is a Frontier County located in North Central Texas. The service area for Seymour Hospital includes the counties of Baylor, Foard, Haskell, Knox and Throckmorton counties, with a cumulative population of approximately 17, 179 people, which our project will have the potential to provide services for. Seymour Hospital is the Sole Community Hospital in the County and is located approximately 50 miles from the nearest Regional Hospital in Wichita Falls, Texas. We have a substantial indigent/charity population as well as a considerable level of Medicare and Medicaid recipients and uninsured/underinsured patients that would greatly benefit from the availability of a local Urgent Care Clinic. The percentage of people in Baylor County living below poverty level is 17.3%, which is greater than the state average of 16.8%[30]. Additionally, the percentage of people in Baylor County age 65 and older is 25.5%, which is higher than the state average of 10.5%[1]. The total Medicaid enrollment for April 2012 in Baylor County was 531 people, which is 14% of the population[31]

[30] United States Census Bureau, State & County Quickfacts, Baylor County, http://quickfacts.census.gov/qfd/states/48/48023.html

[31] Texas Health and Human Services Commission, Texas Medicaid Enrollment Statistics, Baylor County, April 2012, http://www.hhsc.state.tx.us/research/Medicaid Enrollment/ME/201204.html

Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting was selected as the Outcome Domain for our project as it directly relates to the scope of our project. We then selected IT-9.2, ED Appropriate Utilization as the standalone measure for our project. We will monitor Emergency Department encounters and document reductions in ED visits and pediatric ED visits. Additionally, we will monitor reductions in ED visits for target conditions such as Congestive Heart Failure (CHF), Diabetes, End Stage Renal Disease, Cardiovascular Disease/Hypertension, Behavioral Health/Substance Abuse, Chronic Obstructive Pulmonary Disease (COPD), and Asthma.

Relationship to other Projects:

Each of our projects address the needs of our community, as identified by the Community Needs Assessment for Region 19, which was completed in July 2012.

Relationship to Other Performing Providers' Projects in the RHP:

Our plan will complement other projects within RHP 19 by improving the delivery of appropriate healthcare in the appropriate setting to the patients of our region.

Project Valuation:

Through the successful implementation of an Urgent Care Clinic in Baylor County, we will be able to increase the overall health status of our community. We will be able to reduce the cost of care by providing our patients with a more cost-effective alternative to the Emergency Department for non-urgent health issues. We will also document measurable improvements in patient satisfaction with the quality of care received as well as the timeliness of care provided. Finally, we will be able to improve access to care by increasing staff and offering extended hours for our patients to receive primary care at the Urgent Care Clinic. The estimated patient impact for our project is 1300 patient visits per year by DY5, which would be better suited for treatment through an Urgent Care Clinic. The valuation for this project is $1,061,876.

Project: 138353107.1.2	**1.1.2**	**1.1.2 (A)** **1.1.2 (B)** **1.1.2 (C)**	**EXPAND PRIMARY CARE CAPACITY**
Seymour Hospital			138353107
Related Category 3 Outcome Measure(s): OD-9	IT-9.2	138353107.3.3	Right Care, Right Setting (ED Appropriate Utilization)

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Establish New Urgent Care Clinic Metric P-1.1: Number of Additional Urgent Care Clinics Data Source: New Urgent Care Clinic Documentation and Schedule Baseline/Goal: Establish an Urgent Care Clinic to Reduce the Use of the Emergency Department for Non-Urgent and Non-Life Threatening Health Issues.	**Milestone 2**: P-2 Establish Baseline Number of Patient Visits to the Urgent Care Clinic Metric P-2.1:Documentation of the Number of Visits to the Urgent Care Clinic Goal: 1,000 Urgent Care Clinic Visits Per Year Data Source: EHR, Claims Milestone 2 Estimated Incentive Payment: $282,801	**Milestone 3**: I-12 Increase Number of Urgent Care Clinic Visits Metric I-12.1: Documentation of Increased Number of Visits to the Urgent Care Clinic Over Prior Reporting Period Goal: Increase Number of Urgent Care Clinic Visits by 100 Over DY-3 Data Source: EHR, Claims Milestone 3 Estimated Incentive Payment: $283,886	**Milestone 3**: I-12 Increase Number of Urgent Care Clinic Visits Metric I-12.1: Documentation of Increased Number of Visits to the Urgent Care Clinic Over Prior Reporting Period Goal: Increase Number of Urgent Care Clinic Visits by 200 Over DY-3 Data Source: EHR, Claims Milestone 4 Estimated Incentive Payment: $234,304

Project: 138353107.1.2	**1.1.2**	**1.1.2 (A)** **1.1.2 (B)** **1.1.2 (C)**	**EXPAND PRIMARY CARE CAPACITY**	
Seymour Hospital				138353107
Related Category 3 Outcome Measure(s): OD-9	IT-9.2	138353107.3.3	Right Care, Right Setting (ED Appropriate Utilization)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment: $260,885				
Year 2 Estimated Milestone Bundle Amount: $260,885	Year 3 Estimated Milestone Bundle Amount: $282,801		Year 4 Estimated Milestone Bundle Amount: $283,886	Year 5 Estimated Milestone Bundle Amount: $234,304
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5)**:** $1,061,876				

SUMMARY PAGE: Texoma Community Center: Pass 1 Category 1 Project/084434201.1.1

Project Summary

Brief Description: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC has a clinic in Cooke County which has a 2011 census of 38,396 representing a stable population from the previous year. (1a) Including the approximate 200 patients in Cooke County, TCC has four primary clinics providing treatment to over 1,200 adults, children, and families who range in age from birth to death. Less than 1% of TCC's patients have private insurance and 38-40% have Medicaid, and 88% of children and 81.34% of adult patients are at or below the federal poverty level. TCC provides an average of 10,226 face to face patient contacts per month. (1b)

Interventions: Implement both new and expanded telemedicine services and electronic health records (EHR) for target population residing in RHP 19, specifically Cooke County. Interventions that will be expanded through this project include psychiatric appointments, psychosocial rehabilitation, skills training, case management, service coordination, assessments, counseling and crisis intervention.

Need for the Project: TCC selected this project to expand and improve medical and behavior health services RHP 19's Cooke County. Cooke County is identified by HRSA as an underserved behavioral health provider area. (1c) This project is essential to enhance the quality, efficiency, accuracy, and accessibility to medical data for individuals accessing public mental health. The goal is to improve TCC's ability to provide prompt, clinically efficient and appropriate services to a broader patient base. Finkelstein, et. al., (2012) said: "Ninety-two studies evaluated the impact of health IT applications on clinical outcomes. . . . Overall, we found that various health IT applications implemented to enhance PCC [patient centered care] generally improved clinical outcomes for patients with diabetes, heart disease, cancer, and other health conditions, and several of these interventions showed a statistically significant favorable impact." (1d) Please note that LMHA's, specifically TCC, have not received federal funding for EHR systems.

Target Population: Patients with severe and persistent mental illness, emotional disturbance and/or substance abuse where telemedicine capabilities can be established, such as an emergency department or law enforcement offices. Since 38% of current TCC patients receive Medicaid and 99+% are low-income or completely indigent, this is the population that would be receiving these services.

Category 1 or 2 Expected Patient Impact/Benefit: TCC currently uses telemedicine services in the Child and Adolescent Program for psychiatric appointments only, averaging 52 telemedicine encounters center-wide per month with about 1/3 (17) of these encounters for the approximate 40 children and adolescents in Cooke County. The DY 2 goal is to procure additional telemedicine equipment. DY 3 goal is to select 1 additional telemedicine site, install the equipment and have staff fully trained. Telemedicine services will be expanded in this region to different types of services, for a goal of 100 additional patients being served in DY 4 and 140 in DY 5 through expanded telehealth services. Overall, 240 patients will benefit from this $294,813.00 project by DY 5. (9c, 9d) Another goal is for 20% to be new patients receiving substance abuse treatment in DY 4 and 25% receiving substance abuse treatment in DY 5.

Category 3 Outcomes: TCC's Category 3 goal is to improve patients' Quality of Life which has been shown to have a significant per life-year gained impact by improving the functional status and overall quality of life of individuals served and reduce health care costs in the region in the form of significantly fewer emergency department visits, psychiatric hospitalizations and preventable admits and re-admits.

Category I: Infrastructure Development

RHP Project Number: 084434201.1.1

RHP Performing Provider: Texoma Community Center-084434201

Project Title: 1.11 -- Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services

Project Option: 1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers
Required core project components:

a) Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.
b) Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.
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, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer.
d) Identify modifiers needed to track encounters performed via telehealth technology.
e) Develop and implement data collection and reporting standards for electronically delivered services
f) Review the intervention(s) impact on access to specialty care and identify "lessons learned," opportunities to scale all or part of the 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.
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.
h) Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions)

Project Description: Texoma Community Center (TCC) intends to expand & improve service access, facilitate quality patient care and enhance the number of patients served by scaling up an existing telemedicine system into broader, more comprehensive telehealth services. TCC is committed to patient safety and uninterrupted access to critical patient information, clinicians and staff. Most counties in Texas (CN.6, CN.11) face several access barriers that make the deployment of workable integrated health care models a challenge and this is particularly true for the three-county area served by TCC, which includes Cooke County. Also, the RHP Needs Assessment (CN.3) clearly shows that the availability of health care providers is severely limited in many of these sparsely populated areas. The University of Wisconsin Population Health Institute's 2012 County Health Rankings shows Cooke County has a ratio of 2,261 residents to 1 physician provider.(11) TCC agrees that modern communications technology holds the greatest promise of bridging the gap between medical need in underserved areas and the provision of needed services (CN.2, CN.4, CN.5). The

State of Texas has 195 counties (77% of all Texas counties) that have been designated by the US Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs). (12) (13)

TCC's goal to use internet-based communications will extend services to more individuals through high quality, real time technology. This will require TCC to provide additional technological infrastructure development by enhancing the telecommunications system in all TCC facilities, adding an Electronic Health Record system, and installing additional telehealth equipment in expanded service sites. TCC proposes to use telecommunications for new initiatives that will include mental health assessments, treatment, education, monitoring, mentoring and collaboration, in addition to the existing psychiatric treatment which will also be expanded to include additional patients.

In order to meet these goals, all **core components** will be addressed in that TCC will: (1) develop appropriate administrative and clinical protocols for all telecommunication services; (2) determine if a pilot project is needed and engage in rapid-cycle improvement strategies; (3) will utilize the staff already employed and trained in telemedicine services, plus add and train new staff, to be successful in meeting the provider and regional goals; (4) utilize and adapt current modifiers used to tracks encounters and add new ones as needed as part of the utilization management and quality improvement endeavors; (5) develop and implement improved data management and reporting standards; (6) review and evaluate the impact these services have on specialty care and be able to identify and share the "lessons learned"; (7) "scale up" program as warranted to serve a larger patient population through telehealth services as efficiencies are recognized; and (8) engage in a continuous quality improvement process to determine pertinent patient outcomes.

This expansion project is essential to improve quality and expand capacity, reduce risk of harm, and improve cost-effectiveness, efficiency, and access to behavioral health treatment. TCC's goals also meets RHP 19 regional goals, specifically to improve access to high quality, affordable health care services.

The projected five year outcome will be to have a broader telehealth system that serves low-income individuals in the service area through telemedicine/telemonitoring/telementoring sites for therapy, internship supervision, substance abuse treatment, and additional children's psychiatrist time. TCC expects to have improved functioning and better access to care through an organized Electronic Health Records (EHR) system and improve overall communications system, that will: "Improve quality, safety, and efficiency of health care to reduce health disparities" as outlined by the MU [Meaningful Use] Press Release of April 18, 2011 evaluating the Electronic Health Record Meaningful Use initiative. (14)

Starting Point/Baseline:

TCC has four primary clinics in a three county area providing treatment to over 1,200 adults, children, and families with severe and persistent mental illnesses, co-occurring substance abuse issues, emotional disturbances, and/or developmental delays with an average of 10,226 face to face contacts per month. The child and adolescent psychiatrists serve over 140 individuals and families, over-serving by 103%. (15) In the Child and Adolescent Department, access to psychiatric care is exclusively through telemedicine and currently both the telemedicine and face to face services are limited by a paper/chart system where access to vital patient information is delayed, clerical staff time is wasted by scanning and uploading patient data from charts for physician access, and clinician time is regularly wasted by inability to access critical patient data on an immediate basis. TCC has received no funding of any type, including federal funding, for implementing an Electronic Health Record system. The current telecommunications system is degraded to the point that all telemedicine contact is frequently disrupted and telephone calls are dropped and/or static-laden on a daily basis for all staff, including Crisis Team staff handling potentially life-threatening emergency calls. TCC employs 138 individuals who provide or support services to these 1,200+ people as well as other citizens in Cooke, Grayson and Fannin counties who are in crisis. Patient safety is compromised by the current

telecommunications system, especially in the midst of a crisis call where there is potential for risk of harm with a suicidal patient if consistent, clear contact is not maintainable.

The current baseline beginning in DY 2 is limited psychiatric telemedicine appointment time, a degraded, disruptive and inadequate communications system with rudimentary telemedicine capacity and no EHR system at all. TCC provides telemedicine services to approximately 122 children and adolescents, 40 of whom reside in RHP 19, so 40 will be the baseline for expansion in this region. Please note that LMHA's, specifically TCC, have not received federal funding for EHR systems.

Rationale:

Texoma Community Center selected this broad project in order to move our services firmly into the future. In RHP 19, a primary need has been identified (CN.3) regarding insufficient access to physician and behavior health services in Cooke County. In order to address these needs and enhance service improvement, overhauling the telecommunications infrastructure will be necessary. Upgrading and expanding the electronic and communications infrastructure will vastly improve patient safety, enhance communication as well as continuity of care for patients while allowing for more patients to be served with better quality care.

The Institute of Medicine (US) reports that not only does telemedicine address the distance from services barrier, but other barriers are hurdled as well, such as "poor transportation … inadequate financial resources … cultural factors … delivery system characteristics … and gaps in our knowledge about how these factors interact …." (16) It can be concluded, then, that efficient, reliable technology is vital in providing all of TCC services and for meeting regional health care goals. TCC recognizes that there is a need to facilitate: (a) new and increased service access across counties; (b) allow for immediate and collaborative treatment by clinicians across service sites; and (c) implement concurrent documentation. In order to meet these goals, TCC will address all core components.

These improvements to the system will allow TCC to be more efficient and have a reliable communication infrastructure that will improve contact quality through a comprehensive telehealth system. The RHP 19 and TCC service area is identified by HRSA as an underserved area in behavioral health services and there is a significant community need to expand all behavioral health services, especially for those with severe and persistent mental illness, substance abuse problems, or those with co-occurring physical health disorders (CN.3). This project is essential to improve treatment quality, reduce risk of fraud, improve patient satisfaction, and enhance the quality, efficiency, accuracy, and access to medical and/or treatment data for individuals accessing public mental health in extremely under-funded, rural service areas (CN.2, CN.3, CN.5).

While telemedicine is not a new initiative for TCC, developing the center's telehealth infrastructure will significantly enhance existing telemedicine services for "high utilizer" patients in our aggressive outpatient services program. In addition, telementoring and telemonitoring will be new initiatives for TCC and will further support the regional goals of reducing the cost while improving access to health care. It will also allow TCC to add telemedicine services to new patients in the planned Substance Abuse Program (DSRIP Project 1.1.2) that will be in an additional facility. Further, telementoring in the planned LCDC Internship Program will be a new initiative. These expanded services will improve TCC's existing positive patient outcomes.

Related Category 3 Outcome Measure(s):

OD-10 Quality of Life/Functional Status
IT-10.1 Quality of life- (standalone measure)

Rationale/Evidence:

The Quality of Life/Functional Status Outcome Measure was selected by TCC in order to assess service delivery improvement across expansion efforts and to collect data to measure the Category 3 outcomes. Without an improved telecommunications infrastructure, including an EHR system and expanded

technological abilities, the Category 3 Outcome Measures will be difficult to track and assess. "Health IT," an on-line EHR resource, reports on studies that have demonstrated how EHR systems improve health care and reduce costs, stating that EHR systems create: "Increased accuracy in coding, leading to average billable gains of $26 per patient visit . . . Increased patient flow, staff productivity, and increased revenue" (17) are all benefits to health. These efforts support the regional goals of improving quality of care and patient satisfaction, improving population health and reducing the cost of health care. The related Category 1 Projects (1.1.1) that will improve the technological system and expand services will help realize the selected Category 3 outcome measure of improved patient functioning and quality of life. Quality of Life and functional status are key elements in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful telehealth system (Project 1.1.1) is vital to enhancing service access and thus improving the functional abilities and Quality of Life status of the target populations served. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

If the goal of Category 3 is quality improvement, then a usable and reliable EHR and telehealth system is vital to accomplish these goals. The Indian Health Service has been innovative in developing their EHR system and was the first federal agency to earn the "Meaningful Use" Certification. They report: "The goal of meaningful use of EHRs is to improve the safety, quality, and efficiency of care. EHRs could achieve significant improvements in health care processes and outcomes through the use of software applications that provide secure access to health information for both patients and providers, the ability to document patient care services, clinical decision support, performance reporting, and exchange of information with other providers of care. These features help clinicians make better decisions and avoid preventable errors." (18) In addition, Dr. J. Knight Finkelstein, et. al., reported in a June 2012 article "Enabling Patient Centered Care Through Health Information Technology" that: "Ninety-two studies evaluated the impact of health IT applications on clinical outcomes. . . . Overall, we found that various health IT applications implemented to enhance PCC [patient centered care] generally improved clinical outcomes for patients with diabetes, heart disease, cancer, and other health conditions, and several of these interventions showed a statistically significant favorable impact." (19)

Accomplishing these goals through an improved telehealth systems and a new EHR system will help TCC go a long way in furthering Category 3 goals for improving the health care system for low-income patients in Cooke County and the other counties in the service area.

Relationship to other Projects:

This project will support, reinforce and enhance overall service availability and broaden the range of services for three of the other projects submitted by our RHP, specifically those related to substance abuse (084434201.1.2), counseling (084434201.1.3), expanding behavioral health care and combining primary care and behavioral health care (084434201.2.1). These services will be more effective and efficient when supported by improved telehealth/telemedicine technologies which will allow for more accurate, timely and cost-effective continuity of care and collaboration. EHR and Telemedicine additions and expansions will facilitate an integrated healthcare model (084434201.2.1) to allow for both physical and behavioral health issues to be addressed efficiently, while broadening access to unfunded and underserved individuals within our community (CN.3).

Relationship to Other Performing Providers' Projects in the RHP:

Texoma Community Center's Telehealth Project supports, reinforces and relates to the other projects and providers in RHP 19 by enhancing collaboration, sharing data and information, as well as engendering referrals

as appropriate. TCC has designed projects that fulfill the community needs (CN.1, CN.2, CN.4, & CN.5). There are no specific TCC projects that are combined in implementation with other providers in the region, but all TCC projects will contribute to the RHP 19 initiatives through collaboration and sharing data, expanding knowledge and experiences with other providers in RHP 19 and expand services in order to enhance best-practice models throughout the region. TCC will communicate directly with providers to enhance services, such as Helen Farabee for both substance abuse treatment and counseling projects. Our projects meet specific needs for the underserved in our area, and will not duplicate services since the needs far exceed provider capacity in this region (CN.3).

Plan for Learning Collaborative Plan for Learning Collaborative:

At this point, RHP 19 has not committed to a learning collaborative, however, IF the region does facilitate such meetings, then Texoma Community Center will participate. If a RHP 19 collaborative is not facilitated, then TCC will individually seek collaboration with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. Expanding the telehealth infrastructure through this project will be an essential element in having the necessary data to share with other providers in the region. This project will significantly improve TCC's ability to share information and experiences in a collaborative way by recording patient information rapidly. This experience will help direct TCC's growth and expansion toward even more sound, cost-effective, evidence-based practices. Focus in the learning collaborative will be to identify and expand the projects to a broader patient population. TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences

Project Valuation:

TCC recognizes the need for a front-end high-cost technological infrastructure development that will rapidly increase overall community and patient value by providing rapid information and provider treatment access. This initial cost will, however, reduce operational costs over an indefinite period of time. Principal patient benefactors of the improved telecommunication system will be people who are uninsured, under-insured, or have Medicaid. The project will produce higher quality behavioral/medical care through patient-centered telemedicine treatment, collaborative stakeholder communications, and expedited input and access of secure electronically transmitted and stored information.

TCC's service area is comprised of a sparsely populated rural geographical area that has four, almost equally distanced nuclear communities, which is a natural barrier to expanding service. Service access has been identified as a recognized community need (CN.3) such that rapid access to care is not currently a reasonable/obtainable outcome. Quick access to electronically stored information, video-conferencing among collaborating stakeholders, and telemedicine treatment for patients is an attractive option and viable solution for access to care in the area because most patients can be transported to one of the four relatively convenient locations where the telehealth services can connect them to providers. Enhancing the telecommunication infrastructure will result in cost savings through reduced staff travel, a reduction in personnel currently needed to manage massive amounts of paperwork, and reduced higher-cost hospital visits by increasing out-patient service access.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that

it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project **(9a)** This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A search of the scientific literature identified the following two studies. The first study we identified looking at telemedicine and mental health was conducted by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine**.(9c)** Another study by Hollinghurst, et. al. (2010) examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALy gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245**. (9d)** Utilizing this methodology, the project valuation impacts 240 patients by DY 5 for a total valuation of $294,813.00.

The value of the project will increase over time as expedient communications/treatments reduce other costs, including emergency room visits, hospitalizations and criminal justice system involvement. Actual cost of the project will be quickly reduced over subsequent years, limited primarily to system maintenance and upgrades. Increased values will also facilitate advancements in continuous quality improvement through rapid access to electronically stored data/information. Continued training of staff will be supported by updated clinical protocols and training guidelines that will be developed.

TCC will look, as has been its practice, to support from foundations and fund raisers, other collaborating stakeholders, and third-party billing sources as local funding that will help sustain a greatly improved service delivery system.

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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-4 – Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment P-4.1 Metric: Inventory of new equipment purchased Baseline: No equipment purchased Goal: Necessary equipment purchased Data Source: Purchase Orders/Receipts	Milestone 2-P-6- Establishment of Remote Site Locations where equipment/software will be available to consumers P-6.1 Metric: Documentation of completion of site acquisition/remodel Baseline: No documentation in place and no site procured Goal: Purchase/contractor/lease documentation in place Data Source: Purchase/contractor receipts/financial records		Milestone 4-P-9- Develop operations manual of telemedicine or telehealth with protocols and clinical guidelines P-9.1 Metric: Documentation of completion of manual and of use of manual in training sessions of providers/peers Baseline: No documentation of operations manual in place Goal: Documentation of operations manual in place and evidence it is being used in training. Data Source: Operations manual with written protocols and guidelines Milestone 4 Estimated Incentive Payment (maximum amount): $19,637.00	Milestone 8-P-11- Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and/or telemonitoring services for treatment of mental illness / substance use disorders P-11.1Metric: Increase the number of individuals residing in underserved area of the health partnership region who have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness / substance use disorders. Baseline: 40 current patients. Numerator: Number of

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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 Estimated Incentive Payment (maximum amount): $66,867.00	Milestone 2 Estimated Incentive Payment (maximum amount): $36,720.00 Milestone 3-P-8- Continue Training for providers / peers on use of equipment / software P-8.1 Metric: Documentation of completions of training on use of equipment / software Baseline: Zero staff trained Goal: 75% staff trained Data Source: Training Rosters Milestone 3 Estimated		Milestone 5-P-11- Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and/or telemonitoring services for treatment of mental illness / substance use disorders P-11.1Metric: Increase the number of individuals residing in underserved area of the health partnership region who have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness / substance use disorders. Baseline: 40 current patients. Numerator: Number of individuals served by TCC residing in underserved	individuals served by TCC residing in underserved areas that have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders Denominator: Number of individuals residing in underserved area of health partnership region who have received treatment for mental illness or substance use disorders. Goal: Increase number of individuals residing in underserved areas served by TCC that have used telemedicine, telehealth, telementoring and/or

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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)
	Incentive Payment (maximum amount): $36,720.00		areas that have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders Denominator: Number of individuals residing in underserved area of health partnership region who have received treatment for mental illness or substance use disorders. Goal: Increase number of individuals residing in underserved areas served by TCC that have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders to 100 Data Source: Encounter and Claims	telemonitoring services for treatment of mental illness or substance use disorders to 240 total by DY 5 Data Source: Encounter and Claims data (based on coding DSHS modifiers or HCPC's level ll Modifiers) Milestone 8 Estimated Incentive Payment (maximum amount): $37,978.00 Milestone: 9- I–18 – Improve access to substance abuse treatment for individuals residing in underserved areas that have used telemedicine, telehealth, and/or telemonitoring services.

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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 (based on coding DSHS modifiers or HCPC's level ll Modifiers) Milestone 5 Estimated Incentive Payment (maximum amount): $19,637.00 Milestone 6: P-14 – 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	I-18.2 Metric: – Increased percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an outpatient telehealth or telemedicine visit within 14 days of the diagnosis and who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit. Baseline: 40 current telemedicine patients Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD and

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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)
			publicly commit to implementing these improvements. P-14.1 Metric: – Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No documented participation in meetings. Goal: Two documented regional meetings attended by staff. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Rationale/Evidence: The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor"	had two or more additional services with an AOD diagnosis within 30 days of the initial telemedicine or telehealth visit. Denominator: Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence who are referred for telemedicine, telehealth, or telemonitoring services. Goal: 25% increase in telemedicine patients (10) initiated and are receiving substance abuse treatment. Data Source: Encounter Data Milestone 9 Estimated Incentive Payment (maximum amount): $37,979.00

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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)
			for performance across all providers. P-14.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives identified. Goal: Initiatives identified and being implemented. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is	

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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)
			central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 6 Estimated Incentive Payment (maximum amount): $19,637.00	
Year 2 Estimated Milestone Bundle Amount:$66,867.00	Year 3 Estimated Milestone Bundle Amount: $ 73,440.00		Milestone: 7- I–18 – Improve access to substance abuse treatment for individuals residing in underserved areas that have used telemedicine, telehealth, and/or telemonitoring	Year 5 Estimated Milestone Bundle Amount: $75,957.00

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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)
			services. I-18.2 Metric: – Increased percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an outpatient telehealth or telemedicine visit within 14 days of the diagnosis and who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit. Baseline: 40 patients currently using telemedicine services Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for	

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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)
			AOD and had two or more additional services with an AOD diagnosis within 30 days of the initial telemedicine or telehealth visit. Denominator: Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence who are referred for telemedicine, telehealth, or telemonitoring services. Goal: 20% increase in telemedicine patients (8) who initiated and are receiving substance abuse treatment. Data Source: Encounter Data Milestone 7 Estimated Incentive Payment (maximum amount): $ 19,638.00	

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	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 4 Estimated Milestone Bundle Amount: $ 78,549.00	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $294,813.00				

SUMMARY PAGE:Texoma Community Center:Pass 1 Category 1 Project/084434201.1.2

Brief Description: Texoma Community Center (TCC) TCC is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas, including Cooke County that covers 874.76 square miles. TCC has a clinic in Cooke County which has a 2011 census of 38,396 reflecting a stable population from the year before. (1a) TCC has four clinics providing treatment to over 1,200, about 200 of which receive services in Cooke County, and provide approximately 10,226 face-to-face encounters with adults, children, and families ranging from birth to death. Less than 1% of TCC's patients have private insurance and 38-40% have Medicaid; 88% children and 81.34% adult patients are at or below the federal poverty level. (1b)

Interventions: Category 1 Project 084434201.2 will enhance behavioral health service availability, specifically substance abuse (SA) treatment services, and increase the number of substance abuse providers in Cooke County. A stand-alone (SA) treatment center will be initiated and a SAMHSA-based LCDC internship program will increase the provider pool.

Need for the Project: TCC selected this project to expand and improve behavioral health services in RHP 19's Cooke County. Cooke County is identified by HRSA as an underserved behavioral health provider area. (1c) Currently, TCC can only provide substance abuse treatment for individuals with one of the state-mandated target diagnoses of schizophrenia, bipolar disorder or major depressive disorder. TCC's own crisis service data reveals that 57% of patients in crisis report substance abuse as a precipitating cause of their crisis event. (1d) Hyde (2011) says: "… and 90% of people (>20 million) who need substance abuse treatment do not receive care" (1e)

Target Population: Patients needing intensive out-patient substance abuse treatment, along with access to all other TCC services, comprise the target population for Project 084434201.1.2. The same TCC Medicaid and poverty level percentages explained above will apply to all patients treated in these programs.

Category 1 or 2 Expected Patient Impact/ Benefits: TCC will establish one new substance abuse treatment site accommodating this under-served county and expects to provide intensive substance-abuse out-patient treatment to 15 patients by DY 4 and 44 (29 additional) patients by DY 5 and provide LCDC supervision to at least 3 interns by DY 5. Intensive services typically result in four to six encounters per patient per month or 2,112 to 3,168 face-to-face patient encounters annually. The 44 individuals served through this project will exemplify a savings to the health treatment community of $246,449.00.

Category 3 Outcomes: The Category 3 Quality Improvement Project is IT-10.1, Quality of Life. Expanding substance abuse treatment options will positively impact patients ability to function, improving outcomes to the community through **reduced** emergency department visits, psychiatric hospitalizations and preventable admits and re-admits.

Category I: Infrastructure Development

Project Option: 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas

RHP Project Number: 084434201.1.2

RHP Performing Provider: Texoma Community Center-084434201
Category I: Infrastructure Development
Project Title: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care

Project Option: 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas

RHP Project Number: 084434201.1.2

RHP Performing Provider: Texoma Community Center-084434201

Project Description:

Texoma Community Center (TCC) intends to reduce the geographical area's limited access to outpatient substance abuse recovery opportunities by expanding treatment options for patients while concurrently increasing licensed provider internship opportunities by becoming a Licensed Substance Abuse Treatment Center, without regard to TCC's current dual-diagnosis mandate which limits treatment to individuals with just three co-occurring diagnoses, and by operating a Certified Training Institute (CTI) for Licensed Chemical Dependency Providers (LCDC). TCC's service area is identified by the National Health Service Corp as an "underserved" area for physicians and behavioral health providers which also show there is a shortage of providers for substance abuse treatment. Although there are existing outpatient substance abuse programs in the area, the waiting lists are long and the need for treatment and support is usually immediate. Along with providing additional treatment services, this project addresses the need for a platform to increase the number of qualified LCDC counselors who will remain in the area as a result of participation in a required internship through a state certified training program. The primary treatment target population of the project will be persons who are uninsured, under-insured, and with low incomes. Also, qualified individuals seeking internships to become a Licensed Chemical Dependency Counselor are included.

The expected five-year outcome will be expanded substance abuse treatment options, increased number of individuals that are not abusing substances and therefore, not being placed in jails or prison and who are not utilizing emergency rooms. This is consistent with and enhances RHP 19 regional goals. It is also expected that an impact can be made to reduce inpatient substance abuse and psychiatric hospital days as patients stabilize. An additional five-year outcome will be an increase in LCDC providers in the three-county service area, expanding access to health care, which is a regional goal.

Starting Point/Baseline:

Currently, TCC can only provide substance abuse treatment for individuals who have a co-occurring severe and persistent mental illness, with one of the state-mandated target diagnoses of schizophrenia, bipolar disorder or major depressive disorder. While co-occurring disorders are high priority, any individual who do not have one of these three DSHS' target diagnoses are not in treatment with TCC. The majority of our crisis events are with individuals who do NOT have a co-occurring severe and persistent mental illness. The baseline for treating individuals without a co-occurring target diagnosis of severe and persistent mental illness in a stand-alone treatment facility currently is zero for TCC.

Rationale:

Texoma Community Center selected this project to expand services to low-income individuals not currently being served. TCC has successfully demonstrated clinical and fiduciary responsibility while improving and enhancing service provision. This is evident in the reduction of average psychiatric hospitalizations for Alternative Treatment Team patients over a four year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. (22) There is a direct link between the intensified and improved services provided to "high-utilizer" patients and the reduction of hospitalizations overall.

TCC's own crisis service data reveals that, of the average 124 face to face crisis encounters each month, 57% report substance abuse as a precipitating cause of their crisis event. (20) However, substance abuse being a significant cause of crisis events is a nation-wide problem according to a July 11, 2012 SAMHSA Release the DAWN Report which is intended to help agencies to implement policies that will provide "prevention, intervention and treatment of substance abuse… and 47% of the ER visits they reviewed were due to drug abuse or misuse" which is a 115 % increase in just six years. (21) Referral sources in the three-county service area include two out-patient programs and 1 faith-based support-group program, but this is still "out of county" for individuals in Fannin County. When these treatment programs are at capacity and they often have waiting lists of several months, patients must be referred out of county. This area is underserved by licensed providers overall (CN.3).

Our own experience as the Local Mental Health Authority has been frustrating at the lack of substance abuse treatment options within the tri-county service area (CN.3). SAMHSA reports that: "By 2020, mental & substance use disorders (M/SUDs) will surpass all physical diseases as a major cause of disability worldwide." (23) With state-funded substance abuse reductions having occurred in the past few years, patients have to be sent out of area, separated from families and support, to receive treatment when the few existing resource options are at capacity, which is all of the time. Providing substance abuse treatment is not a new initiative for TCC but establishing a separate, licensed substance abuse treatment program that also provides LCDC Internship opportunities is a new initiative plus it significantly enhances the current service effort. TCC is dedicated to achieving these desired health outcomes, to improving efficiency and reducing costs; therefore, enhancing substance abuse treatment and provider licensing internship programs will improve outcomes and making a positive impact on the lives and well-being of the populations served.

Related Category 3 Outcome Measure(s):

OD-10 Quality of Life/Functional Status
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: Assessment of Quality of Life Tool Data Results
c. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was selected

by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

Expanding substance abuse treatment services and developing an internship program for additional LCDC providers will definitely impact the functional status and overall quality of life of individuals serviced through these projects. Laudet (2011) writes in his article The case for Considering Quality of Life in Addiction Research and Clinical Practice, that: "Substance use disorders (SUDs) are characterized as 'maladaptive patterns of substance use leading to clinically severe impairment or distress' potentially affecting physical or psychological functioning; personal safety; social relations, roles, and obligations; work; and other areas (American Psychiatric Association, 1994) … SUD is a chronic condition for most affected individuals, and QOL [Quality of Life] improvement is a particularly important goal in treating conditions that cannot be cured." (24) As such, having the Quality of Life/Functional Status Outcome Measure to determine impact to patient care. Assessing patient access and outcomes is relevant to contributing to the overall goals identified in Category 3.

Relationship to other Projects:

This Substance Abuse/Internship Expansion project relates directly to this RHP's proposals involving expanding counseling services (084434201.1.3) to non-priority populations, combining primary and behavioral healthcare (084434201.2.1), and expanding telehealth services (084434201.1.1) in that its development and implementation will significantly augment the

other projects and it will satisfy a need for additional service options and increase providers. This, in turn, will support and reinforce the regional goals to improve quality of care, improve the health of this population and improve access. This augmentation will have notable implications on the initial and ongoing success of the project due to enhanced availability and range of services which can be accessed by individuals seeking treatment, as well as improved and expanded communication between various treatment providers.

Relationship to Other Performing Providers' Projects in the RHP:

The primary relationship that the Expansion of Substance Abuse Project will have to the other Projects in RHP 19 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 19 in order to enhance best practice models is a definite TCC goal. It is acknowledged that Lakes Regional MHMR Center is the contracted LMHA providing DSHS substance abuse treatment in Cooke County, however, and the TCC expansion is in no way intended to replace that provider source for the area. The community need (CN.3) for additional substance abuse and behavioral health providers in Cooke County allows for both LMHA's to provide substance abuse treatment without duplicating services or even meeting the need fully.

Plan for Learning Collaborative:

At this point, RHP 19 has not committed to a learning collaborative, however, IF the region does facilitate such meetings, then Texoma Community Center will participate. If a RHP 19 collaborative is not facilitated, then TCC will individually seek collaboration with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. Expanding the telehealth infrastructure through this project will be an essential element in having the necessary data to share with other providers in the region. This project will significantly improve TCC's ability to share information and experiences in a collaborative way by recording patient information rapidly. This experience will help direct TCC's growth and expansion toward even more sound, cost-effective, evidence-based practices. Focus in the learning collaborative will be to identify and expand the projects to a broader patient population. TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences.

Project Valuation:

The value of this project expands the scope of TCC's services to a population identified as a primary contributor to community costs. RHP needs assessments (CN.2, CN.3, CN.5) indicate

that there is a recognized need for additional outpatient treatment services for persons with chemical dependency problems.

The individuals to be served by this new program are those who create the greatest distress within the community are often found in crisis in local emergency rooms, or who are frequently incarcerated. Both are high-dollar expenses for the community. This expansion of TCC services will create increased community value by providing additional treatment support services which, in turn, reduces higher dollar intervention services by providing additional options and affording the opportunity for greater numbers of individuals to become stable. Additional treatment options and additional providers will enhance crisis intervention responsibilities for the Local Mental Health Authority, reducing ED and jail costs. The cost for the project will be greatly outweighed by the evidence-based recognition of a multiplier impact on cost reduction as interventions and treatment reduce emergency room and hospital re-admissions, lower the prospect of future encounters with the medical and criminal justice systems, and help individuals into recovery where they can become contributing members of their community. Adding a certified internship program will make a needed contribution to the practitioner resource pool, and will increase the prospect for TCC and other local providers to hire and retain practitioners that are difficult to find. Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The cost of the project will increase over time, but it is expected that there will be an exponentially greater value brought to community by bringing earlier resolution to challenges for individuals who currently cost our communities a great deal through emergency room admissions, re-admissions, criminal adjudication and detention. (9a) Two studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. (9e) Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. The average of these two values is 0.11135 (9f) Using these methodologies, the 44 individuals served through this project will exemplify a savings to the community of $246,449.00 alone. This does not account

for additional health care savings related to additional providers that will eventually serve the community or reduced criminal justice costs or primary or emergency health care costs.

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-10	**084434201.3.2**	**IT-10.1**	**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 -- Identify licenses, equipment requirements and other components needed to implement and operate options selected. P.2.1 Metric- Develop a project plan and timeline detailing the operational needs, training materials, equipment and components— • Research existing regulations pertaining to the licensure requirements of substance abuse clinics to determine what requirements must be met. • When required, obtain	Milestone 3- P-4- Hire and train 1 Certified & experienced licensed counselor/program co-ordinator to manage and oversee Substance Abuse Treatment & Internship Program and 1 clerical staff to support program administration. P-4.1 Metric - Number of Staff secured and trained Baseline: Zero staff secured and trained Goal: Both positions filled & staff trained in respective duties Data Source: Project records, HR records and training records Milestone 3 Estimated	Milestone 6-I.11- Increased utilization of substance abuse community behavioral healthcare program. I-11.1 Metric–Increase utilization percentage of patients receiving TCC substance abuse community behavioral healthcare services. Baseline: Zero patients receiving stand-alone SA services from TCC Numerator: Number receiving community behavioral healthcare services through TCC clinics from access expansion. Denominator: Number of people receiving community behavioral health services	Milestone 8-I.11- Increased utilization of substance abuse community behavioral healthcare program. I-11.1 Metric–Increase utilization percentage of patients receiving TCC substance abuse community behavioral healthcare services. Baseline: Zero patients receiving stand-alone SA services from TCC Numerator: Number receiving community behavioral healthcare services through TCC clinics from access expansion. Denominator: Number of people receiving community behavioral health services

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-10	**084434201.3.2**	**IT-10.1**	**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)
licenses and operational permits as required by the state, county or city in which the clinic will operate. Baseline: No project plan in place; no operational timeline in place; licenses not obtained; training materials, equipment, components not in place. Goal: Project plan in place, operational timeline in place, licenses obtained, training materials, equipment and components all in place for successful operations a. Data Source: Available Detailed Project Plan Milestone 1 Estimated Incentive Payment: $27,957.00	Incentive Payment: $20,466.00 Milestone 4-P-6 – Establish 1 new behavioral health service site in community-based setting in underserved areas with 8 patients being served. P-6.1Metric –Number of new community-based sites where behavioral health services are delivered and number of patients being served. a. Number of patients served at these new community-based sites: Baseline: Zero patients served Goal: 8 Patients served Data Source: Encounter data and project site documentation	after access expansion. Goal: 15 patients receiving substance abuse services after access expansion; 2 interns receiving supervision after expansion Data Source: Claims data and encounter data from behavioral health site; internship verification reports Milestone 6 Estimated Incentive Payment: $32,842.50 Milestone 7- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar	after access expansion. Goal: 29 new patients receiving substance abuse services after access expansion (40 total); 3 interns receiving supervision after expansion Data Source: Claims data and encounter data from behavioral health site; internship verification reports Milestone 8 Estimated Incentive Payment: $31,726.00 Milestone 9- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-10	**084434201.3.2**	**IT-10.1**	**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-P-3- Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for the substance abuse and internship programs) P-3.1 Metric- Manual detailing administrative protocols and clinical guidelines are in place Baseline/Goal: Manual written and in place. a. Data Source: Administrative protocols; Clinical guidelines Estimated Milestone 2 Incentive Payment (maximum amount):	Milestone 4 Estimated Incentive Payment: $20,466.00 Milestone 5- -10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	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-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings	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-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff Data Source: Documentation

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-10	**084434201.3.2**	**IT-10.1**	**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)
$27,957.00	P-10.1 Metric: – Participate in semi-annual face- to-face meetings or seminars organized by the RHP: a.Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. b.Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.	including meeting agendas, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives	of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting.

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-10	**084434201.3.2**	**IT-10.1**	**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-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. a.Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. b.Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning	identified Goal: Initiatives identified and being implemented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the	Baseline: No initiatives identified Goal: Initiatives identified and being implemented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-10	**084434201.3.2**	**IT-10.1**	**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)
	and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 5 Estimated Incentive Payment (maximum amount): $20,466.00	floor" and "raise the bar" for performance across providers. Milestone 7 Estimated Incentive Payment (maximum amount): $32,842.50	collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 9 Estimated Incentive Payment (maximum amount): $31,726.00
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $55,914.00	Year 3 Estimated Milestone Bundle Amount: $61,398.00	Year 4 Estimated Milestone Bundle Amount: $65,685.00	Year 5 Estimated Milestone Bundle Amount: $63,452.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $246,449.00			

Category 1: Infrastructure Development
SUMMARY PAGE: Texoma Community Center: Pass 1 Category 1 Project/084434201.1.3

Brief Description: Texoma Community Center (TCC) TCC is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas, including Cooke County which covers 874.76 square miles. TCC has a clinic in Cooke County which has a 2011 census of 38,396 reflecting a stable population from the year before. (1a) TCC has four primary clinics providing treatment to over 1,200, approximately 200 of which are served in Cooke County, and provide 10,226 face-to-face encounters with adults, children, and families ranging from birth to death. Less than 1% of TCC's patients have private insurance; 38% have Medicaid, 88% children and 81.34% adult patients are at or below the federal poverty level. (1b)

Interventions: Category 1 Project 084434201.3 will enhance behavioral health service availability, specifically evidence-based counseling treatment. TCC intends to provide prompt, evidenced-based, clinically appropriate counseling to a broader patient base of individuals needing treatment for Post-Traumatic Stress Disorder, depression, personality disorders and other emotional disturbances.

Need for the Project: TCC selected this project to expand and improve behavior health services in Cooke County, specifically evidenced-based counseling. TCC's current DSHS diagnostic criteria are very restrictive as to who can access state-funded services. TCC's internal data show that in 2011 and to-date in 2012, 618 individuals sought but were denied mental health treatment due to the exclusionary diagnostic criteria. Of those 618, all but a few needed counseling. (1f) Cooke County is an underserved behavioral health provider area. (1c) This project will enhance access to treatment for individuals who have no other resources to pay for those services.

Target Population: Patients needing therapeutic counseling, specifically for Medicaid and/or low-income patients, are the target population for this project. TCC clinicians are credentialed in providing evidenced-based therapy appropriate for presenting problems.

Category 1 or 2 Expected Patient Benefits: Patient impact will include one additional counseling site for Medicaid-funded or indigent and a conservative minimum target of 25 individuals **over** the current target population by DY 5. There are typically four face-to-face patient encounter hours per month with counseling services which will result in approximately 1,104 additional hours of counseling valued by Katon's (2012) methodology, as he examined collaborative care interventions for multi-symptom patients, at $391,951.00. By DY 3 TCC will serve 14 new counseling patients, 19 in DY 4 and 23 in DY 5. Using Daly's methodology, the valuation for just 23 patients would be $1,246,544.00. These patients would not otherwise have access to counseling due to a lack of funding.

Category 3 Outcomes: TCC's Category 3 Project is IT 10.1 Quality of Life of which functional status is a component. Improving patients' Quality of Life has been shown to significantly

reduce community health care costs. A critical metric will be better utilization of telemedicine capacity.

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

Project Option: 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

RHP Project Number: 084434201.1.3

RHP Performing Provider: Texoma Community Center-084434201

Project Description:

Texoma Community Center (TCC) will expand counseling services to new behavioral health patients by providing a minimum of two additional licensed staff designated to provide evidenced-based therapeutic counseling to those who do not meet criteria for TCC's DSHS-funded services as well as provide the office space, furniture, telementalhealth and other equipment, supplies and clerical support for efficient business operations. The TCC service area is deemed underserved in behavioral health services and the community has a need for counseling options (CN.3, CN.4). These clinicians will provide evidenced-based counseling interventions to unfunded and low income patients. (CN.3) The current DSHS diagnostic criteria are very restrictive and regimented for who can be served with state funds. TCC's own internal data sources show that in 2011 and to-date in 2012, 618 individuals sought mental health treatment, but were denied services because they did not have a "target population" diagnosis. The majority of those 618 individuals had a valid mental health or emotional disturbance issue and could have benefitted from counseling services. (25) Because these individuals had no health coverage, there were no counseling resources available except for support groups primarily based in the Dallas area. There are area counselors, but they all require a funding source.

The ability to broaden the scope of counseling treatment and opening up the restrictive diagnostic criteria will allow staff clinicians to provide a much needed service, as evidenced by the 618 individuals a year seeking TCC services who have to be denied due exclusively to diagnostic criteria. While some of the individuals who were denied services might not require counseling, the majority definitely requested counseling and could benefit from such a service. Internal clinical data shows that many of those individuals assessed suffered from Post-Traumatic Stress Disorder and/or depressive disorders with Global Assessment of Functioning Scores (26) above 50, thus ruling them out of services, or they had anxiety disorders, all of which respond well to appropriate evidenced-based therapy. A significant number of patients accessing emergency rooms and/or psychiatric hospitals suffer from one of these disorders. Providing expanded out-patient services to these individuals and using the best evidenced-based treatment modalities for the identified diagnosis will improve treatment outcomes, reduce potentially preventable hospital admits and reduce potentially preventable and very costly hospital readmissions. Expanding services to non-DSHS target individuals will address a

deficit in this underserved area for individuals needing therapeutic counseling services but lacking a funding source (CN.3).

The expected five-year outcome is as follows: There are typically four face-to-face patient encounter hours per month with counseling services which will result in approximately 1,104 additional hours of counseling valued by Katon's (2012) methodology, as he examined collaborative care interventions for multi-symptom patients, at $391,951.00. By DY 3 TCC expects to serve 14 new counseling patients, 19 in DY 4 and 25 in DY 5 or two over the expected impact valuation. Using Daly's methodology, the valuation for 23 patients would be $1,246,544.00. Outcomes also expected are a reduction in the use of emergency rooms and psychiatric or acute-care hospitals for illnesses precipitated or exacerbated by an affective mental health disorder, and an increase in stabilized citizens in the community, all of which address regional goals. TCC does not receive any federal funds relative to these services.

Starting Point/Baseline:

Currently TCC is only allowed to provide counseling services to individuals diagnosed with one of the DSHS state-mandated target diagnoses of schizophrenia, bipolar disorder or major depressive disorder. While treating these disorders is a priority (TCC serves over 900 adults and 140 children and adolescents with mental illness or emotional disturbance), individuals who do not have one of these three diagnoses are not allowed treatment with TCC. The majority of our crisis events involve individuals who do NOT have a co-occurring severe and persistent mental illness. The baseline for treating individuals **without** a target diagnosis of severe and persistent mental illness in a stand-alone counseling facility is currently zero for TCC for DY 3 but if the expected 14 patients are seen in DY 3, then 14 becomes the baseline for improvement targets in DY 4 and DY 5.

Rationale:

TCC chose this project in order to expand behavioral services in this region to low-income individuals. Overall, Texas healthcare is grossly underfunded. A lack of insurance by many Texans causes them to use the emergency rooms as a primary care clinic. Texas has 1,247,300 children and 4,886,100 adults who are uninsured and ranks 51st among all states in providing health care for individuals with mental illness and developmental delays.(27) All of the TCC projects, including expanded counseling access, are designed to help solve several identified needs in the region by increasing the number of patients served and preventing unnecessary emergency room visits. (CN.2, CN.3, CN.5). TCC was approved for the National Health Service Corp's federal loan repayment program for qualified staff specifically due to NHSC statistics showing that the three county service area was significantly underserved by all licensed providers, including counselors and psychiatrists. Expanding therapeutic services reduces these shortages. (CN.3) While counseling is not a new initiative for TCC, expanding those services beyond the DSHS target population will be new. Being able to expand the diagnostic criteria will also be a new and exciting initiative for TCC.

As previously stated, especially during the past six years, Texoma Community Center has successfully demonstrated clinical and financial responsibility while improving and enhancing

service provision. Providing an additional counseling treatment site and employing additional clinicians to provide needed services (CN.3), in addition to ensuring the support, oversight and guidance necessary to meet and exceed performance measures, will expand and enhance the quantity and quality of services to patients. There is a direct correlation between the intensified and improved out-patient services provided to "high-utilizer" patients seeking care in emergency rooms and local hospitals, including psychiatric hospitals, and the reduction of hospitalizations and incarcerations overall which supports and reinforces regional goals. TCC tracked hospitalizations for the "high utilizer" psychosocial rehabilitation patients and an outcome was that increased services appeared to reduce crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (29) The ability to provide intensive oversight of services while demanding highly ethical provider behavior, along with our willingness to collaborate with other providers and stakeholders, has helped produce positive outcomes over time. TCC is dedicated to achieving these desired health outcomes, to improving efficiency and reducing costs. Those measures have a positive impact on the lives and well-being of the populations served.

Related Category 3 Outcome Measure(s):

OD-10 Quality of Life/Functional Status

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: Assessment of Quality of Life Tool Data Results
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 status 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.

The Quality of Life/Functional Status Outcome Measure was selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, and upon accurately interpreting the quantifiable effects that the other projects are expected to have on patient care. This data can then be used to improve outcomes. Quality of Life and functional status are a key element in assessing project impact results which will direct a future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs within the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well

as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on patient outcomes.

Treatment efficacy can be determined by assessing the functioning and quality of life outcomes of individual patients, which in turn, supports Category 3 goals. Clark & Kirisci (1996) report in a study of adolescents suffering from affective disorders, including PTSD, that: PTSD showed significant adverse effects on Psychological, physical, and social functioning. Major depression showed a similar pattern. In contrast, alcohol use disorders primarily affected role functioning. While PTSD, major depression, and alcohol use disorders all adversely influenced adolescent QOL [quality of life] ….”(30) In addition, Zatrick, MD ((1997) stated: “The prevalence of PTSD also increased consistently with the number of self-reported chronic diseases (t2). Only 9,6%of subjects reporting no chronic conditions had PTSD, whereas 31.9% of subjects with four or more conditions had PTSD . . . . Subjects with PTSD demonstrated consistently higher risks of functional impairment; for five of the six outcomes the risks of impaired functioning . . . exceeded 20% (t3).” (31)

Logic follows that improving access to therapeutic interventions to treat affective disorders including PTSD and depression for individuals without a funding source would improve quality of life outcomes while improving functioning and patient outcomes to be assessed by Category 3 measures.

Relationship to other Projects:

This project supports, reinforces and is related directly to TCC’s proposals involving expanding substance abuse services (084434201.1.2), combining primary and behavioral healthcare (084434201.2.1), implementing a Quality Improvement Department (084434201.1.4), and expanding telehealth services (084434201.1.1) in that its development and implementation will be significantly augment the other projects, provide data, and be a expansion service site for telehealth. This augmentation will have notable implications on the initial and ongoing success of the project and regional goals due to enhanced availability and range of services which can be accessed by individuals seeking treatment. All TCC projects support, reinforce, and relate to each other in order to expand and improve services.

Relationship to Other Performing Providers’ Projects in the RHP:

The primary relationship that the Expansion of Counseling Services Project will have to the other Projects in RHP 19 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 19 in order to enhance best practice models is a definite TCC goal. There are several projects where telehealth is included in implementation, as it is with TCC, which will open up the possibility of communicating directly with these specific providers

through telecommunications. Also, Lakes Regional MHMR Center also plans to expand counseling services and cross-referrals and collaboration will be sought. The extensive need (CN.3) for additional behavioral health providers allows for both LMHA's to expand counseling services outside of their respective county diagnostic restrictions without duplicating services or even meeting the need fully.

Plan for Learning Collaborative:

At this point the RHP 19 Anchor has not committed to a learning collaborative; however, if one is developed, TCC will participate. If one is not developed, TCC will seek collaboration with other providers in the region as appropriate to the services. TCC recognizes the value in having an opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. TCC has demonstrated therapeutic collaborations with community stakeholders, and is willing to exchange our expansion experiences with others in the region, learn from other entities in the region what has "worked or not worked" in their experience and to bring that information back to the management table to help direct center growth and expansion toward sound, cost-effective, evidence-based practices. Focus on the learning collaborative will be to identify project impacts, what was learned within the Center and from other entities, producing positive clinical outcomes and expanding the projects to a broader patient population. Addressing key challenges will be done internally and as part of the learning collaborative within the region because TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences. It is especially important in the area of therapy and clinical treatment to maintain awareness of the research and evidenced-based practices and to share that knowledge base with other clinicians in order to "do no harm" and provide the best services possible. Sharing clinical experiences in a collegial environment is the best way possible to produce positive outcomes that can spread throughout the region.

Project Valuation:

The value of this project expands the scope of TCC's services to a population identified as a primary contributor to community costs. RHP needs assessments (CN.2, CN.3, CN.5) indicate that there is a recognized need for additional outpatient treatment services for persons with affective behavior problems. These individuals often create the greatest distress in the community by being found in emergency rooms in crisis and they often manifest the emotional distress in physician ways, also driving health costs up. This expansion of TCC services will create community value by providing the treatment to those who have no funding source to become stable.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. We also looked at cost savings in valuing this program. (9a)

A study by Jones et al. (2003) showed that participants receiving Critical Care Intervention had 58 fewer homeless nights compared with standard treatment participants. A night of homelessness was valued at $152 using a societal perspective which results in a value gain of $8,816 per participant. **(9j)** Larimer et al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost-offset of $2,449 per month per individual. **(9k)** But using Katon's (2012) methodology, as he examined collaborative care interventions for multi-symptom patients, the $391,951.00 valuation for this project would benefit an additional 23 RHP 19 patients and the cost for the project will be outweighed by the recognition of a multiplier impact on cost reduction as such evidence-based interventions and treatment that reduce emergency room and hospital re-admissions, lower the prospect of future encounters with the medical and criminal justice systems. The value of the project will increase over time, but it is expected that there will be an exponentially greater value brought to the community by early resolution of challenges that currently cost our communities through emergency room admissions and re-admissions and to the criminal justice system for adjudication and detention. TCC expects to continue expansion of the counseling program and will look to other local sources of support and third-party payment systems for continuation and expansion.

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	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- Identify licenses, equipment requirements and other components needed to implement and operate options selected. P.2.1-Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components: --Research existing regulations pertaining to the licensure requirements of clinicians to determine what requirements must be met. -When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate. Baseline: No plan operational Goal: Project plan in place and	Milestone 3- P-4- Hire and train 2 licensed clinicians to provide counseling services in newly established counseling program. P-4.1-Metric : Number of Staff secured and trained Baseline: Zero staff secured and trained Goal: 2 staff secured and trained in respective positions Data Source: Project records, HR records and training records	Milestone 6-I.11- Increase utilization of counseling community behavioral healthcare program. I-11.1 Metric– Increase number of patients receiving TCC counseling community behavioral healthcare services. Baseline: zero patients receiving counseling services at new site Goal: 19 (36% increase) over DY 3 baseline of 14 patients receiving counseling services after access expansion Data Source: Claims data and encounter data from behavioral health site Milestone 6 Estimated Incentive Payment: $ 52,232.00 Milestone 7- P-10- Participate in face-to-	Milestone 8-I.11- Increase utilization of counseling behavioral healthcare program. I-11.1 Metric– Increase number of patients receiving TCC counseling community behavioral healthcare services. Baseline: zero patients receiving counseling services at new site Goal: 23 (64% increase) over DY 3 baseline of 14 patients receiving counseling services after access expansion Data Source: Claims data and encounter data from behavioral health site Milestone 8 Estimated Incentive Payment: $ 50,457.00 Milestone 9- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	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)
operational needs met. Data Source: Documentation of plan / operation evidence Milestone 1 Estimated Incentive Payment: $ 44,463.00 Milestone 2-P-3- Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for the counseling project). Metric-P-3.1 – Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline: No Operations Manual in place Goal: Manual in place and operations occurring Data Source: Administrative protocols; Clinical guidelines Milestone 2 Estimated Incentive	Milestone 3 Estimated Incentive Payment: $48,823.00 Milestone 4-P-6 – Establish counseling behavioral health services in new community-based setting in underserved area. P-6.1-Metric : Number of patients receiving counseling services in 1 new community-based setting Baseline: 3 sites/zero patients Goal: 4 sites/ 14 patients being served Data Source: Encounter Data	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-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.	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. Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff P-10.1 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. b.Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	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)
Payment: $44,463.00 Estimated Incentive Payment (maximum amount): $88,926.00	Milestone 4 Estimated Incentive Payment: $ 48,824.00	P-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives identified Goal: Initiatives identified and being implemented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 7 Estimated Incentive Payment (maximum amount): $ 52,232.00	P-10.2- Metric: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented"raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 9 Estimated Incentive Payment (maximum amount): $ 50,457.00

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	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: $88,926.00	Year 3 Estimated Milestone Bundle Amount: $97,647.00	Year 4 Estimated Milestone Bundle Amount: $ 104,464.00	Year 5 Estimated Milestone Bundle Amount: $100,914.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 391,951.00			

SUMMARY PAGE: Texoma Community Center: Pass 1 Category 1 Project/084434201.1.4

Project Summary—

Brief Description: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles, of which Cooke County covers 874.76 square miles. TCC has a clinic in Cooke County which has a 2011 census of 38, 396, representing a stable population compared to 2010 census. (1a) TCC has four primary clinics treating over 1,200 adults, children, and families, including the approximately 200 patients in the Cooke County Clinic, and which range in age from birth to death. Staff provide an average of 10,226 face to face contacts per month. Less than 1% of TCC's patients have private insurance, between 38% have Medicaid on average and 88.05% of children and 81.34% of adult patients are below the federal poverty level. (1b)

Interventions: This project expands quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement by implementing an expanded Quality Improvement Department (QI) at TCC. The interventions will expand the patient population and services by increasing efficiencies and solving key challenges through focused and frequent (weekly) evaluation of intervention barriers and progress in service areas, and through focused attention on special populations for further treatment expansion.

Need for the Project: TCC has addressed quality improvement issues, but has not had dedicated, full-time staff specifically targeting quality improvement. This is an increasing need as TCC seeks to address the underserved health needs in the community and ensure that quality, evidenced-based services are provided in the most effective and efficient manner. Cooke County is an underserved behavioral health provider area. (1c) This project ensures prompt, efficient and appropriate services to more patients.

Target Population: The target population benefit for Project 084434201.3 is spread across the entire existing and prospective patient population, which is 200 current Cooke County patients, approximately 250 annual face-face crisis encounters for this region, and expected future patients. Each service area will have appropriate implementation, improved efficiency, and clinically sound application of services ensured through continuous quality improvement processes. Approximately 38% of TCC patients have Medicaid or are Medicaid eligible and almost 100% are indigent, so we expect between 200 and 300 current and potential TCC patients in Cooke County will benefit from this project. (1b)

Category 1 Expected Patient Impact and Benefit: System improvements are projected using a count of quality improvement reports used regularly. Currently TCC reviews a minimum of twelve QI reports weekly, bi-weekly or monthly. The expectation is to increase the reports utilized to assess improvement by 10% in DY3, 15% in DY 4, and 20% in DY 5. This means that by DY 5, the QI Department will be using a minimum of 18 different QI reports to track improvement trends. While the valuation used for this project is $119,367.00, using additional methodologies to consider patient impact, studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), were used to show that an additional 80 individuals would be served within the region based on an enhancement of capacity at an average cost savings of $13,856 per person, which calculated to a total saving of $1,108,480.00 for the region. (9i, 9k, 9l, 9m)

Category 3 Outcomes: The related Category 3 Project is IT-9.2 ED Appropriate utilization to Reduce Emergency Department visits for target conditions. TCC expects to reduce emergency department visits for target populations significantly by DY5, but exact targets will be determined in DY 2 because this is a new service and precise numbers are not available until the first year of the project.

Category 1: Infrastructure Development

Project Option: 1.10.3 Enhance improvement capacity within systems

RHP Project Number: 084434201.1.4

RHP Performing Provider: Texoma Community Center-084434201

Category 1: Infrastructure Development

Project Title: Enhance Performance Improvement and Reporting Capacity
Project Option: 1.10.3 Enhance improvement capacity within systems
Required core project components**:**

(a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture;
(b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

RHP Project Number: 084434201.1.4

RHP Performing Provider: Texoma Community Center-084434201

Project Description:

Texoma Community Center (TCC) has a goal to expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement . The focus of this project is to implement process improvement methodologies to improve safety, quality, and efficiency. A 2007 report from the Agency for Healthcare Research and Quality entitled Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination) states: "Quality problems and spiraling costs have resulted in widespread interest in solutions that improve the effectiveness and efficiency of the health care system." (1) Implementation will require researching and selecting specific tools to identify and progressively eliminate inefficiencies, while at the same time provide quality care for the population served.

TCC commits to meet the required core components by developing initiatives based on process improvement methodologies appropriate to rapid communication, integrated system workflows, providing data to providers and patients, eliminating waste, enhancing provider performance and improving patient-centered care. TCC will: (a) provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture and will (b) develop an employee suggestion system assesses project impact on work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. Further, TCC will:

(1) develop protocols and tools designed to identify project impacts;
(2) understand what "lessons have been learned;"
(3) expand the patient population and services;
(4) identify and solve key challenges to successful expansion; and
(5) identify special considerations for target populations.

TCC will continue to address issues of safety, quality, and efficiency through continuous quality improvement in order to contribute to the regional (RHP 19) overarching goals to improve access to affordable healthcare across the region. Texoma Community Center recognizes that project success requires essential quality improvement elements such as being open to change, fostering patient safety, effective problem solving, soliciting stakeholder feedback and engaging in continuous monitoring of performance in order to report findings and use those finding to direct and improve services, as well as meet regional goals to improve access and quality of health care services.

The expected five-year outcome is to have a well-organized, evidenced-based Quality Improvement Program in place and operating at capacity for continuous quality improvement to enhance and expand behavioral health services to individuals in the underserved region, thus helping meet regional goals. It is also expected that in five years, such a QI program will reduce internal costs as well as reduce high dollar costs for the area hospitals' emergency rooms, in-patient acute care hospitals and psychiatric hospitals (CN.2, CN.3, CN.5).

Starting Point/Baseline: While TCC has continuously addressed quality improvement and change elements on an on-going basis through management meetings and a weekly "Action Team" meeting. During this meeting, a minimum of twelve QI reports are reviewed as of DY 2, which is the baseline. Also, there has not been a concerted effort to develop evidenced-based strategies utilizing specific tools or a full time position just for quality improvement and reporting capacities. The expectation is to increase the reports utilized to assess improvement by 10% in DY3, 15% in DY 4, and 20% in DY 5. This means that by DY 5, the Center will be using a minimum of 18 different QI reports to track improvement trends. To consider patient impact, the studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), were used to show that an additional 80 individuals would be served within the region based on an enhancement of capacity at an average cost savings of $13,856 per person, which calculated to a total saving of $1,108,480.00 for the region. (9i, 9k, 9l, 9m)

Rationale:

TCC chose this project in order to insure success of all projects and to contribute to regional health care improvement goals. TCC is starting this Quality Improvement Project with an established "track record" in stabilizing high utilizer patients in the area's medical community. The following "look back" at what TCC has accomplished during the past six years is <u>only</u> to connect those accomplishments to the RHP 19 regional goals and the health care transformation goals because they exemplify what can be accomplished if expanded to a regional level. Since 2006, TCC's management team has made comprehensive changes that have been an on-going process of consistent communication with supervisory and soliciting stakeholder feedback necessary to identify problems along the way. The management team has been aggressive in finding creative solutions that are both clinically sound with "evidenced-based" treatment, and financially sound with frequent oversight and open disclosure. These efforts were successful to differing degrees in our three-county service area. Overall, the changes and collaborations had a significant impact on improving the Center's financial stability and contributed to positive are outcomes. The following internal data exemplify goals that are completely consistent with current regional transformation goals. TCC intends to continue this improvement model by creating a specific department dedicated to enhance the reporting capacity, continue performance improvement and expand rapid solutions to inefficiencies, waste, and barriers.

The first major change for TCC occurred with the Assertive Community Treatment Program (ACT) for those with severe and persistent mental illness. Those out-patient, wraparound-style services were ramped up with specific goals to reduce hospitalization costs. The result was a reduction of average psychiatric hospitalizations for this discreet population over a four-year time period from 1.8% in 2007, 1.6% in 2008,

.23% in 2009, 0% in 2010. Hospitalization rates for these individuals in 2011 were at .56% due to adding new patients to this caseload who required initial stabilization. (2) Also, other "high utilizer" patients are in TCC's out-patient psychosocial rehabilitation program. This group showed a reduction in crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, to 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (3) The following table also exemplifies how TCC already has expertise in reducing costs and TCC is poised to continue improving on these existing accomplishments:

	FY06	FY 07	FY 08	FY 09	FY 10	FY 11	%
MEDICATION COSTS	$905,652	$191,491	$152,257	$132,072	$93,355	$72,511	-92%
HOSPITAL COSTS	$346,530	$126,575	$64,929	$40,197	$18,375	$12,600	-97%
COMMUNITY OUTREACH EFFORTS	Began jail diversion meetings/ began medication formulary	Began mobile crisis & Crisis Residential unit; trained law enforcement & Judges; ↑PAP	Mental Health Court in 1 county; expanded crisis service	Begin Drug Court involvement& enhanced community training	Began telemedicine services in all counties & jails	Continued outreach efforts and increased trainings in community	
OUTCOMES/ SERVICE PROVISION	Sweeping personnel changes; program targets not met; MH program "in the red"	Renegotiated local hospital contract; met ACT performance measures for 1st time; reduced mental health financial deficit	Improved rehab oversight; exceeded all required targets ; reduced financial deficit	Began Incentive Program; exceeded all performance measures; MH "in the black" for 1st time	Expanded crisis follow-ups; continued exceeding all contract measures ; clinical contacts increased	Expanded Incentive Program to Children's area; exceeded performance measures; Center "in the black."	

(4)

These initiatives and cost reductions show the broad improvements made by TCC between the years 2006 to present, which were accomplished largely due to a weekly oversight committee that was dedicated to identifying weaknesses, developing strengths and overseeing the changes that were essential for meeting DSHS contract measures and program requirements across all service areas. Strong oversight of rehab services provides the support and guidance necessary to meet and exceed performance measures, while increasing quality of services to patients. The targeted changes led to dramatic reductions between 2006 and 2011 in both local hospitalization costs to the Center and reduced hospitalizations for funded Center patients as well. Medication costs were reduced by addressing prescribing practices with psychiatrists and developing a medication formulary and aggressively pursuing Patient Assistance Program medications, all while still

ensuring patients were stabilized. This improvement trend has continued into 2012. There appears to be a direct link between the intensified and improved services provided to "high-utilizer" patients and the reduction of hospitalizations. Additionally, utilization of the Department of State Health Services' State Hospital allocation was reduced from 140% overuse in 2006 to its current rate of 60% of the DSHS allocation (5) already supporting regional goals to reduce health care costs and improve the quality of care.

Increased and active intervention by the MCOT (Crisis) Team in the five area emergency departments (EDs) has resulted in more appropriate dispositions of crisis events and fewer overall hospitalizations. There was a critical need in the community for an alternative to hospitalization for individuals in crisis who were exhibiting some risk or manipulative behavior, or were involved in drug/alcohol use, but who did not REQUIRE hospitalization. It was determined that a 16-bed crisis residential unit (CRU) would be the most cost-effective option for TCC and this was implemented in 2007. This option has dramatically reduced local psychiatric hospitalizations when TCC crisis staff is called for an assessment. However, an identified barrier to hospital reduction costs was the need to educate local ED doctors to allow TCC crisis staff to make the outcome determination. It is critical to note that when ED doctors dictated the outcome, hospitalizations were excessive, but when TCC crisis staff made the determination, patients were effectively stabilized in less costly environments, with continued follow up, and no increase in negative patient outcomes. This collaborative initiative resulted in state-funded local hospital costs being reduced to zero for the past 18 months. (6)

As demonstrated above, enhancing the quality improvement and data management strategies is not a "new initiative" for TCC but this project will "significantly enhance" the improvement process that led to the outlined changes. This enhancement is essential to continue the endeavors, support the regional goals, and address the identified regional needs (CN.2, CN.3, CN.4 & CN.5). TCC intends to accomplish additional improvements by adopting more specific, evidenced-based process-improvement techniques that will continue to identify inefficiencies, inadequate care and preventable errors. TCC recognizes that quality improvement is a dynamic process that requires a multitude of tools that address multiple areas of change in over-lapping systems, and an evidence-based, dedicated approach to improving these systems is essential to meeting improvement outcomes while making a positive impact on the lives and well-being of the populations served.

Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting
IT-9.2 ED Appropriate utilization (standalone measure)

a. Reduce Emergency Department visits for target conditions
   Behavioral Health//substance Abuse
b. Data Base: Center Encounter Data and Center Clinical Data
c. Rationale/Evidence: The Right Care, Right Setting Outcome Domain was selected by TCC

in order assess service delivery impact specific to a target populations—individuals with mental illness, emotional disturbance and substance abuse issues who live within the region. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually impacting patient outcomes, to improve patient functioning and thus to intentionally reduce potentially preventable hospitalizations in the area of behavioral health and substance abuse. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Project will seek to discern the impact that the newly planned substance abuse treatment program will have in relation to reducing emergency department visits for the patients served. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

The Quality Improvement Project is especially relevant to the Category 3 emphasis on outcome measure assessment. While the Right Care, Right Setting Domain seems to be a simple and single evaluation focus,

directing attention and tracking the data for related hospitalizations will provide a more complete picture of the intervention impact on the behavioral health status of Fannin counties' low-income population. In fact, Cooke County's health ranking from the US Department of Health & Human Services' "2012 County Health Rankings" shows that Cooke County residents have " "89 preventable hospital stays, compared to the Texas average of 73 hospital stays." (7) Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment, especially if they lack health insurance because unfunded patients tend to use the ED as a primary care clinic for minor medical issues. TCC projects intend to focus on and positively impact outcomes that will improve the mental, physical and behavioral health of low-income individuals who live within the RHP 19 region.

Clearly, with a dedicated Quality Improvement program as described in this project, TCC will be able to focus on tracking, assessing and improving the emergency department use for Cooke County residents, which will go a long way toward accomplishing the desired Category 3 goal for this health-professional underserved area (CN.2, CN.3, CN.4, CN.5).

Relationship to other Projects:

The Performance Improvement and Reporting Capacity project is central to all of the other projects submitted by Texoma Community Center (084434201.1.1, 084434201.1.2, 084434201.1.3, and 084434201.2.1). Implementation of this project will facilitate data driven oversight, coordination and facilitate outcome success of ALL other TCC projects as well as allow for inter-agency communication which will reduce redundancy in services and increase the compliance of individuals seeking services. This project is a vital element in assuring that milestones and metrics are achieved across the other projects. This one project undergirds the other projects by supporting the focus and data, by reinforcing goal attainment, and enabling the implementation in a coordinated, efficient manner. The data and "lessons learned" will be shared in regional collaborations with other providers in order to support and reinforce the overall regional goals.

Relationship to Other Performing Providers' Projects in the RHP:

The primary relationship that the Qualify Improvement Project will have to the other Projects in RHP 19 is one of collaboration, sharing of data and information, and referrals as appropriate. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 19 in order to enhance best practice models is a definite TCC goal. There are several projects where telehealth is included in implementation, as it is with TCC, which will open up the possibility of communicating directly with these specific providers through telecommunications. For example, Lakes Regional MHMR Center plans to expand behavioral health care within this region and data sharing and collaboration will occur. Also, the Andrews Center will also be expanding care and collaboration will also occur. The need (CN.3) for additional behavioral health providers allows for all RHP 19 LMHA's to expand behavioral health services without duplicating services or even meeting the need fully.

Plan for Learning Collaborative:

The RHP 19 Anchor has not yet committed to having Learning Collaborative opportunities with regional providers; however, if they develop such a collaborative, TCC will commit to attending and exchanging information. Texoma Community Center does plan to participate in the learning collaborative meetings in order to share knowledge, experience and outcomes across the region for quality improvement purposes. TCC

will use the "lessons learned" to help direct TCC's future growth toward even more sound, cost-effective, evidence-based practices.

Project Valuation:

TCC's establishment of a Quality Improvement Department will add value to all of its DSRIP projects with consideration being given to project size, scope, community benefit, cost-avoidance, community need and estimated local funding. This project will create an even broader system of continuing self-evaluation and improvements consistent with the U.S. Department of Health and Human Services' objective to "Reduce the growth of healthcare costs while promoting high-value effective care. "**(8)** The value of the new department will quickly be recognized as it monitors and reports on the projects, assuring that metrics and milestones are being met, and that attention and resources are directed toward resolving any issues inhibiting implementation and progress. TCC will also be considering evaluative involvement in all areas of operation by staff, from the bottom to top of the organization, and recognize that: "From the perspective of a service provider or program manager, quality ensures effectiveness and efficiency. From the perspective of the policy maker, quality is the key to improving the mental health population, ensuring value for money expended and accountability." **(9)** Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual.
In addition, cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a**) A cost-utility analysis by Holtgrave, 2012 was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life. (**9b**) While the Holtgrave valuation methodology used for this project is $119,367.00, using additional methodologies to consider patient impact, studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), were used to show that an additional 80 individuals would be served within the region based on an enhancement of capacity at an average cost savings of $13,856 per person, which calculated to a total saving of $1,108,480.00 for the region. (9i, 9k, 9l, 9m)

As TCC looks to a future of improved and better-coordinated services, it now seeks a greatly improved telecommunication system that will extend quality improvement across its communities. A report from the Judge David L Brazelton Center for Mental Health Law states that: "Technology has dramatically changed our understanding and practices in healthcare – from data collection and analysis to clinicians' use of PDAs. Expansion of electronic medical records is critical for the 21st century and can form the basis for aggregation of

data by health plans so as to monitor and then improve quality and efficiency.” **(10)** These technological improvements will exponentially allow the QI department to function at capacity.

084434201.1.4	PROJECT OPTION: 1.10.3	PROJECT COMPONENTS: 1.10.3.A.B	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.4	IT-9.2	ED Appropriate Utilization (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-6: Hire/train 2 quality improvement staff who will be trained in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics for reporting purposes (e.g., to measure improvement and trends). P-6.1 Metric: Hire and train 2 staff in quality and efficiency improvement principles Baseline: zero Goal: 2 trained staff Data Source: HR records, Training Rosters and Sign-in Sheets or Certificates of Completion Milestone 1 Estimated Incentive	Milestone 2 I-7: Implement quality improvement data systems, collection, and reporting capabilities I-7.1 Metric : Increase the number of reports generated through these quality improvement data systems Baseline: Twelve (12) Numerator: Number of reports generated Goal: 13 Data Source: Quality Improvement Data System Rationale/Evidence: It is important to accurately collect data on quality outcomes and patient experience as well as present the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions. These reports		Milestone 3 – I-7: Implement quality improvement data systems, collection, and reporting capabilities I-7.1Metric: Increase the number of reports generated through these quality improvement data systems Baseline: 12 Numerator: Number of reports generated Goal: 14 Data Source: Quality Improvement Data System To consider patient impact, studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), were used to show that an	Milestone 4 – I-7: Implement quality improvement data systems, collection, and reporting capabilities I-7.1Metric: Increase the number of reports generated through these quality improvement data systems Baseline: 12 Numerator: Number of reports generated Goal: 18 Data Source: Quality Improvement Data System To consider patient impact, studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and

084434201.1.4	PROJECT OPTION: 1.10.3	PROJECT COMPONENTS: 1.10.3.A.B	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.4	IT-9.2	ED Appropriate Utilization (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: $ 27,082.00 Year 2 Estimated Milestone Bundle Amount: $ 27,082.00	should be generated monthly, if not more frequently, to measure the impact of improvement activities on the improvement goals/targets. Milestone 2 Estimated Incentive Payment: $ 29,737.00 Year 3 Estimated Milestone Bundle Amount: $29,737.00		additional 80 individuals would be served within the region based on an enhancement of capacity at an average cost savings of $13,856 per person, which calculated to a total saving of $1,108,480.00 for the region. (9i, 9k, 9l, 9m) Milestone 3 Estimated Incentive Payment: $31,814.00 Year 4 Estimated Milestone Bundle Amount: $31,814.00	Lehamn (1999), were used to show that an additional 80 individuals would be served within the region based on an enhancement of capacity at an average cost savings of $13,856 per person, which calculated to a total saving of $1,108,480.00 for the region. (9i, 9k, 9l, 9m) Milestone 4 Estimated Incentive Payment: $30,733.00 Year 5 Estimated Milestone Bundle Amount: $30,733.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $ 119,367.00				

Summary Information: United Regional Health Care System

Pass 1 Project 135237906.1.1: Expand Primary Care Capacity

- Provider: United Regional Health Care System is a 325-bed hospital in Wichita Falls, Wichita County, Texas serving Wichita and Archer County Texas covering an area of approximately 1,530 square miles and a population of approximately 140,580.

- Intervention(s): We expect to increase the availability of primary care services as a result of establishing more primary care clinics, expanding primary care clinic staffing and extending hours of our primary care clinic. With all patient populations having access to primary care, chronic disease processes can be better managed avoiding escalation of conditions to a point where emergent intervention is required.

- Need for the project: We have 11.9% fewer Direct Care Physicians (those who work directly with patients) than the State of Texas as a whole. Other projects in this region reflect similar needs, but do not address primary care in the city of Wichita Falls. We currently have one primary care clinic staffed by four family practice physicians, one internal medicine physician and two Nurse Practitioners. This clinic provides a Walk-In Clinic, Monday through Friday from 7:30 am to 5 pm. currently. The Walk-In Clinic was established to provide appropriate access to primary care services rather than seeking care in our Emergency Department. Our Emergency Department volume has continued to increase, and statistics show that the increase has primarily been in pediatric patients.

- Medicaid and Uninsured Target population: We can significantly enhance and expand our efforts to provide quality primary care for the uninsured, underinsured, Medicaid and Medicare populations. Approximately 31.6% of our patients are either Medicaid eligible or indigent.

- Category 1 or 2 expected patient benefits: The presence of more Primary Care Providers in Wichita Falls will help over 76% of the population in the RHP access by providing much needed health care services with less effort. In 2012, our Primary Care clinic had 18, 247 patient encounters, with approximately 43% Medicare, Medicaid, or uninsured/underinsured. In 2012, our Emergency Department had 65,782 patient encounters in DY1, with approximately 57.3% Medicare, Medicaid, or uninsured/underinsured. The project seeks to hire two new Primary Care Providers per year in DY2 through DY5. The projected primary care clinic volume of visits will increase by approximately 9,000 in DY4, and 13,000 in DY5, and have clinic space for providers who are recruited over the course of this project.

- Category 3 outcomes: IT.3.5, Acute Myocardial Infarction 30 Day Readmission Rate. Increasing access to primary care services could reduce readmissions for acute

myocardial infarction by allowing them to follow up with their primary care physician in a timely manner. Our goal to reduce the 30-day Acute Myocardial Infarction readmission rate is to be determined

Category 1: Infrastructure Development

Project Option: Expand Primary Care Capacity, Project 1.1.2

RHP Project Number: 135237906.1.1

RHP Performing Provider: United Regional Health Care System-135237906

Project Description:

This project addresses the current challenge many safety net hospitals face of patients presenting to the Emergency Department for primary care services and the limited number of providers available to provide those services. Patients currently have limited access to primary care providers other than a hospital's emergency department after hours and on weekends. Other projects in this region reflect similar needs, but do not address primary care in the city of Wichita Falls.

In order to better accommodate the needs of the regional patient population and community, as identified by the RHP 19 needs assessment, we plan to expand our existing clinic space, expand the hours of the clinic, and employ primary care providers and staff so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Our goal is to **:** 1) Expand our primary care clinic, 2) Increase primary care clinic staffing; 3) Extend Walk-In Clinic hours; 4) Investigate establishing an urgent care clinic; 5) Mount consumer education campaign regarding increased access to primary care services, locations, and what types of services can be provided in a primary care setting

By expanding clinic space to accommodate additional providers and extended hours, patients will have greater access to primary care, which should reduce emergency department encounters. By increasing Primary Care clinic visits and capacity, there will be a decrease in non-emergent emergency department visits at United Regional. Specifically, we want provide increased access to care for those who are uninsured and for Medicaid enrollees. Many times uninsured patients will avoid seeking health care services until they experience a medical emergency. With more access to care it will be easier for the uninsured and Medicaid enrollees to obtain health care services before emergencies arise.

Our regional goals will be met by effectively addressing the Community Needs outline in the Rationale section. Over the next five years, we expect to implement each core component as outlined below:

1.1.2.a. Expand primary care clinic space through construction, renovation or leasing/renting of existing space.

1.1.2.b. Expand primary care clinic hours by providing pediatric walk-in hours after 5 p.m.

1.1.2.c. Expand primary care clinic staffing by appropriately staffing the walk-in clinic.

Starting Point/Baseline:

Baseline: 01/01/2012-12/31/2012.
We currently have one primary care clinic staffed by four family practice physicians, one internal medicine physician and two Nurse Practitioners. This clinic provides a Walk-In Clinic, Monday through Friday from 7:30 am to 5 pm. The Walk-In Clinic was established to provide appropriate access to primary care services rather than seeking care in our Emergency Department. In 2012, Primary Care provided 18,247 visits, with approximately 43% Medicare, Medicaid, or uninsured/underinsured. In 2012, our Emergency Department provided 65,782 visits, with approximately 57.3% Medicare, Medicaid, or uninsured/underinsured. Our Emergency Department volume has continued to increase, and statistics show that the increase has primarily been in pediatric patients and after 5 pm. We plan to establish a Pediatric Walk-In Clinic, to open at 5 pm to help alleviate the non-emergent pediatric population we are seeing in our Emergency Department. This in turn should decrease wait times in our Emergency Department and improve patient satisfaction

Rationale:

RPH 19 currently has 11.9% fewer Direct Care Physicians (those who work directly with patients) than the State of Texas a whole. (Source: Region 19 Community Needs Assessment) Our goal to expand the capacity of primary care will better accommodate the needs of the patient population and community so that patients can receive the right care at the right time in the right setting.
Our Community Needs will be addressed as follows:

- Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions; Data Source: Texas Department of State Health Services, Center for Health Statistics.
- Community Needs identification CN.3, Shortages of health care professionals, including mental health care providers; Data Source: Texas Center for Public Policy Priorities; Texas Department of State Health Services, Center for Health Statistics; Texas Medical Board; and US Department of Health and Human Services, Health Resources and Services Administration.

United Regional is committed to providing quality care and access to appropriate care settings. Therefore, with incentive funds, we can significantly enhance and expand our efforts to provide quality primary care for the uninsured, underinsured, Medicaid and Medicare populations. Required core project components will be addressed as follows:

- Expand clinic space to accommodate additional providers for extended hours, allowing patients greater access to primary care, and reducing emergency department encounters.
- Increase clinic visits with the additional clinic capacity, thereby decreasing non-emergent emergency department visits at United Regional.
- Provide increased access to care for those who are uninsured and for Medicaid enrollees.

With all patient populations having access to primary care, chronic disease process can be better managed avoiding escalation of conditions to emergent intervention. This is a priority project for us because we have seen an increase in our Emergency Department volume of non-emergent cases. It is also a goal to provide more preventive and primary care to keep individuals and families healthier and avoid more costly emergency department visits.

Related Category 3 Outcome Measure(s):

3.5, Acute Myocardial Infarction 30 Day Readmission Rate.
Medicare Payment Advisory Commission (MedPAC) has identified acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN) readmissions as common, costly, and often preventable (MedPAC 2007). Increasing access to primary care services could reduce readmissions for acute myocardial infarction by allowing them to follow up with their primary care physician in a timely manner. In order to improve access to primary care, URHCS's project will include the following components: conduct quality improvement by identifying project impacts, opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project. By recruiting key additional providers, the goal is to allow all providers to see more patients in the outpatient setting and to provide inpatient services. Patients in the clinic and hospital settings trust and value the compassionate and quality of care they receive in both the outpatient and inpatient setting. There is, however, no doubt that having to wait weeks, and in some specialty areas months, to get an appointment is having an impact on improving the rate of potentially preventable admissions, potentially preventable readmissions, and patient care outcomes.

Relationship to other Projects:

Project 135237906.2.2 Use of Palliative Care Programs: We want to better serve our patients in the appropriate care setting. Therefore, we want Primary Care Providers to be able to engage patients in the treatment and health goals. An increase in the number and availability of Primary Care Providers will foster the development of more patient-centered treatment service mentality. Also related to Category 4 reporting domains: Potentially preventable admissions (PPAs) and Patient-centered healthcare.

Relationship to Other Performing Providers' Projects in the RHP:

Bowie Memorial Hospital, Clay County Memorial Hospital, Electra Memorial Hospital, Hardeman County Memorial Hospital, North Texas Medical Center and Seymour Hospital all reside within RPH 19 and all have planned to participate in Project 1.1, Expand Primary Care Capacity in their local communities. Region 19 as a whole covers 10,401 square miles of land. Primary care is provided at the local level throughout our RHP and across the State of Texas. Therefore, it is logical to see several Performing Providers across RHP 19 submitting a project to Expand Primary Care Capacity. Otherwise, the need for Primary Care Providers across our RHP would not be effectively addressed.

Plan for Learning Collaborative: N/A

Project Valuation:

Estimated Local Funding, Project Investment, Project Size/Scope, Community Need, Community Benefit, etc. This project will achieve waiver goals because it will provide primary care services to improve patient access to care, thereby improving outcomes and lowering the overall costs of healthcare delivery. As healthcare services become more affordable, patients will find it easier to take advantage of health care services that will improve their overall health. The community will benefit from this project in several different ways. Easier access to preventive screenings and health care services will mean that more people in our community receive intervention sooner. As patients take advantage of greater capacity with Primary Care Providers, lifestyle behaviors can be addressed before they have resulted in adverse health outcomes. The presence of more Primary Care Providers in Wichita Falls will help over 76% of the population in the RHP access much needed health care services with less effort. As has been shown, this project will be a fairly large investment and will serve many people that desperately need Primary Care services that can't get it anywhere else in the community. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and prioritizes community need.

The value of the project is based on two parts:

- Expand primary care clinic hours: Extend the Primary Care Walk-In Clinic hours, and establish a Pediatric Walk-In Clinic to alleviate the non-emergent pediatric population we are seeing in our Emergency Department. This in turn should decrease wait times in our Emergency Department and improve patient satisfaction. Investigate establishing an urgent care clinic.
- Expand primary care clinic staffing: In 2012, Primary Care provided 18,247 visits, with approximately 43% Medicare, Medicaid, or uninsured/underinsured; also in 2012, our Emergency Department provided 65,782 visits, with approximately 57.3% Medicare, Medicaid, or uninsured/underinsured. Our goal includes hiring additional clinic staff to increase primary clinic volume; increasing visits by 9,000 visits in DY4, and by 13,000 visits in DY5.

135237906.1.1	**PROJECT OPTION 1.1.2**	**1.1.2 A, B, C**	**EXPAND PRIMARY CARE CAPACITY**	
United Regional Health Care System				135237906
Related Category 3 Outcome Measure(s):	IT-3.5	135237906.3.1	AMI 30 Day Readmission Rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 3 [P-1]: Establish additional/expand existing primary care clinics Metric [P-1.1.]: Expanded hours or space. Baseline/Goal: Expansion plans of clinic space for providers who are recruited over the course of this project; approximately doubling clinic space. Data Source [P-1.1.b.]: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. Milestone 3 Estimated Incentive Payment (maximum amount): $905,756	

135237906.1.1	**PROJECT OPTION 1.1.2**	**1.1.2 A, B, C**	**EXPAND PRIMARY CARE CAPACITY**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-3.5	135237906.3.1	AMI 30 Day Readmission Rate

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Train / Hire additional primary care providers and staff. Metric [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal: Hire two new Primary Care Providers per year Data Source [P-5.1.a]: Administrative documentation. Milestone 1 Estimated Incentive Payment (maximum amount): $2,621,497	**Milestone 2** [P-5]: Train / Hire additional primary care providers and staff. Metric [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal**:** Hire two new Primary Care Providers per year Data Source [P-5.1.a]: Administrative documentation. Milestone 3 Estimated Incentive Payment (maximum amount): $2,709,390	**Milestone 4** [P-5]: Train / Hire additional primary care providers and staff Metric [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal: Hire two new Primary Care Providers per year Data Source [P-5.1.a]: Administrative documentation. Milestone 4 Estimated Incentive Payment (maximum amount): $905,755	**Milestone 6** [P-5]: Train / Hire additional primary care providers and staff Metric [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal: Hire two new Primary Care Providers per year Data Source [P-5.1.a]: Administrative documentation Milestone 6 Estimated Incentive Payment (maximum amount): $1,122,34

135237906.1.1	**PROJECT OPTION 1.1.2**	**1.1.2 A, B, C**	**EXPAND PRIMARY CARE CAPACITY**	
United Regional Health Care System				135237906
Related Category 3 Outcome Measure(s):	IT-3.5	135237906.3.1	AMI 30 Day Readmission Rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric [I-12.1]: Documentation of increased number of visits Baseline/Goal: Increase primary care clinic volume of visits by 9,000 from DY1 of 18,247 Primary Care visits to 27,247 Primary Care visits. Data Source [I-12.1.a]: EHR and other Administrative documentation Milestone 5 Estimated Incentive Payment (maximum amount): $905,755	**Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric [I-12.1]: Documentation of increased number of visits Baseline/Goal: Increase primary care clinic volume of visits by 13,000 from DY1 of 18,247 Primary Care visits to 31,247 Primary Care visits. Data Source [I-12.1.a]: EHR and other Administrative documentation Milestone 7 Estimated Incentive Payment (maximum amount): $1,122,349

135237906.1.1	**PROJECT OPTION 1.1.2**	**1.1.2 A, B, C**	**EXPAND PRIMARY CARE CAPACITY**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-3.5	135237906.3.1	AMI 30 Day Readmission Rate

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount:: $2,621,497	Year 3 Estimated Milestone Bundle Amount: $2,709,390	Year 4 Estimated Milestone Bundle Amount: $2,717,267	Year 5 Estimated Milestone Bundle Amount: $2,244,698
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $10,292,852			

Summary Information: Wilbarger General Hospital

Pass 1 Project 112707803.1.1

- Provider: Wilbarger General Hospital (WGH) is a 47-bed Sole Community Hospital in Vernon serving the counties of Wilbarger and Foard with a combined population of 15,874.

- Intervention(s): This project will recruit and retain two new family practice physicians.

    - One will allow us to expand the hours of our Walk In Clinic

    - Second will increase access to primary care by taking new patients with the expectation that a portion of their patient population is Medicaid or uninsured.

    - The expected result of this will be expansion and optimization of access to primary care in Wilbarger County.

- Need for the project: We currently have six family practice physicians in Vernon, however only one of six is accepting new patients. This project will address CN.5 respective to the need to overcome patient access to care barriers. The barrier to access is secondary to inability to pay and scheduling of time flexibility due to the patients work schedule.

- Medicaid and Uninsured Target population: WGH is targeting the Medicaid and uninsured population. Based on data from Health Facts Profile 2009, 23% of the population is on Medicaid and 21% are completely without any form of insurance. Collectively, this is 44% of the local population. (http://www.dshs.state.tx.us/chs/)

- Category 1 or 2 expected patient benefits: Recruit and retain two new family practice physicians over the next three years. The result of this initiative should be a significant increase in access to care in our county by providing the right care (family practice) in the right setting (physician office rather than the emergency department). Through this new venue we expect to see an additional 100 new patients.

- Category 3 outcomes: IT-9.2: Our goal is to decrease the number on patients accessing the emergency department for non-emergent needs.

Category 1

Project Title: 1.1 Expand Primary Care Capacity

Project Option: 1.1.2: Expand existing Primary Care Capacity

RHP Project Number: 112707803.1.1

RHP Performing Provider: Wilbarger General Hospital-112707803

Project Description:

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Project Goal:

Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Projects plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care.

Starting Point/Baseline:

Starting Point: January 1, 2012 and baseline is 3,249 (annualized) patient encounters from January – September of 2012.
Baseline: 3,249 pt visits (annualized)

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. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients experience barriers in accessing primary care services as referenced in CN.5 of the Needs Assessment that are secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting 112707803.3.1

OD-9; Right Care, Right Setting. This selection is secondary to the fact that access to primary care in Wilbarger County is /has been difficult since most physicians currently are not accepting new patients. Subsequently, the disparate patient population was being managed through the emergency department or opting to go to primary care services outside of the primary or secondary service area.

IT-9.2 ED Appropriate Utilization. This selection is secondary to the fact that many of our patients that were unable to access primary care in the office setting were showing up in our emergency department. Unfortunately, this venue does not adequately manage post visit needs of the patient the potential for post acute anomalies to be overlooked. Additionally, the National Association of Community Health Centers estimated that greater than $18 million dollars are spent annually on emergency department visits that are non emergent and could have been treated in the physician office of health clinic. (J.Greene, Trustee Magazine, Oct. 2012)

Relationship to other Projects:

RHP 19 recognizes considerable disparities related to access to care as noted in CN.5 of the Needs Assessment, and as such are working both independently and collectively to bridge the gaps in care. This project relates to the Category 3 project, 112707803.3 to optimize and more appropriately utilize the emergency department for truly emergent care while having subacute and more benign health care needs managed through the clinic. Additionally, as a sole community hospital we are not exempt from the Category 4 reporting and believe that this new clinic venue will enhance our abilities to improve our scores in the core measures.

Relationship to Other Performing Providers' Projects in the RHP:

While other Performing Providers in RHP 19 may be doing similar projects in their local areas, there are not any others in our local community. It is well known that the national supply of primary care does not meet the demand for primary care services, as noted in CN.3 of the Needs Assessment. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHP 19 is in real need of expanding primary care capacity in the entire region in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

Outcome Measure Valuation: $647,633

Access to primary care is the foundation to building and improving patient health outcomes, improving preventive health and screenings and achieving patient access in low cost settings. We seek to provide the approximately 20,000 residents in our primary and secondary service area access to primary and preventive care. Based on this population we expect to see 100 new patients and increase number of visits by 250. As evidenced in the Department of State Health Services 2009 County Report , 29% of children 0 - 17 live below poverty with limited access to healthcare and almost 19% of the total population in Wilbarger and Foard County live below the poverty level. In Texas as a whole, 24% of children and 17% of the total population live below poverty. This further identifies the need for access to appropriate levels of care as populations below poverty typically are uninsured and have chronic conditions. Additionally, through Medicaid eligibility, we are able to provide access to insurance for patients who would otherwise remain uninsured and have fragmented care. With the backing of Wilbarger County and/or Wilbarger General Hospital District we have approximately $200,000 in local funds to be invested each year for all of our DSRIP projects.

In year one of this project we will work collaboratively with all key stakeholders (mainly current solo practitioner offices) to assure support of this physician recruitment initiative. This will be critical to the long term success of this project because it will assure appropriate support and buy-in to the project.

112707803.1.1	1.1.2	1.1.2.A 1.1.2.B 1.1.2.C	EXPAND PRIMARY CARE CAPACITY
Wilbarger General Hospital			112707803
Related Category 3 Outcome Measure(s): OD-1	IT-1.10	112707803.3.1	[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 1P-X. Contract with Recruiting CompanyP-X.1 Metric: Signed contract with recruitment company. Baseline/Goal: Begin Recruitment / Contract with new family practice physician. Data Source: Signed contract with new family practice physician. Milestone 1 Estimated Incentive Payment $149,456	**Milestone 2** P-5. Recruit additional primary care providers and staff Metric 1 P-5.1. Documentation of increased number of providers and staff. Baseline/Goal: Contract with one new family practice physician to establish clinic in community. Data Source: New physician contract Milestone 2 Estimated Incentive Payment: $177,217	**Milestone 3** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Data Source: Registry Goal: See 50 new patients. Milestone 3 Estimated Incentive Payment: $177, 825	**Milestone 4** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Data Source: Registry Goal: See 100 new patients. Milestone 4 Estimated Incentive Payment: $143,135
Year 2 Estimated Milestone Bundle Amount: $149,456	Year 3 Estimated Milestone Bundle Amount: $177,217	Year 4 Estimated Milestone Bundle Amount: $177,825	Year 5 Estimated Milestone Bundle Amount: $143,135
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $647,633			

Section V. Category 2

Summary Information: Bowie Memorial Hospital

Pass 3B Project New 127305405.2.2
Old 127305405.2.1

Provider: Bowie Memorial Hospital is a 49-bed community hospital in Bowie, Texas on the, serving a rural population of approximately 20,000, in a 930 square mile area.

Intervention(s): This project will provide resources to establish a chronic disease management program and coordinate transitions to continuing care when necessary for patient care.

Need for the project: We are striving to create an innovative method/project for the community needs of increased education, support, and chronic disease management to assist the population, avoid hospitalization, as well as complications, and to provide services a more appropriate environment than the emergency setting.

Medicaid and Uninsured Target population: The target population is our patients that seek primary care in the emergency room. Approximately 53%of our patients are either Medicaid eligible, uninsured or county indigent, and we expect they will benefit from the availability of a chronic disease management program.

Category 1 or 2 expected patient benefits: The project seeks to provide an increased percentage of 25% year to year, in DY4 and DY5, of the population reached by the chronic care management team, and consequently to assist in the reduction of readmissions and promote improved health and decreased complications. The project will increase the number of patient encounters by DY4 to approximately 1500 encounters (approximately 42/mo) and by 1875 encounters (approximately 52/mo) in DY5. These numbers are based on a small group (35/mo) of diabetic patients in a program that is very limited in scope.

Category 3 outcomes: OD-1, IT-1.10 The identification of poor control of the HbA1c, will indicate patient issues with dietary or exercise compliance, education, or medication regimes. Promoting early interventions through establishment of a systematic chronic care management team will lend support to those diabetic patients through determination of causative agents of the elevated HbA1c.

Category 3B: Program Innovation and Redesign

Project Option: 2.2 Expand Chronic Care Management Models

RHP Project Number: 127305405.2.2

RHP Performing Provider: Bowie Memorial Hospital TPI 127305405

- ***Project Description*:**
- **Expand Chronic Care Management Models.**
- The *goals* of the project, to establish chronic disease management initiatives, such as patient education, self-management support, improved patient-provider communication techniques, and coordination of transition resources, will help to provide evidence based interactions and interventions between providers and patients. The early identification of chronic disease related problems, will help to reduce complications, hospitalizations, and will promote healthcare resource conservation. *Challenges* in a rural setting include patient access to a post hospitalization continuum of care forum, and educational resources, as well as a lack of understanding of the need for self-monitoring. Primary care resources are essentially limited to acute care visits. Rural population groups are more unaware of the complications resulting from chronic diseases not being managed on a continuing basis. According to Deloitte (2008), 9 of 15 diagnoses for hospital admissions are directly related to chronic conditions. To help *resolve the challenges*, a program to provide increased patient education, increased use of self-monitoring, and early awareness of potential complications will hopefully encourage healthier habits, better adherence to medication regimes, and improved behaviors to help manage the chronic disease and keep the patients out of the emergency room and hospital beds. Project option 2.2.1 promotes a redesign in the outpatient sector for those patients with a chronic disease. Care teams, of non-physician health professionals, will be utilized in conjunction with care providers to promote a more thorough outpatient experience. This particular option promotes provision of patient specific services, adequate access to outpatient resources, increased patient involvement, and quality patient impact for chronic disease management. *In 5 years* a chronic care management program could potentially reduce potentially preventable admissions and readmissions and improve the HbA1c of patients involved in the program. The selected project is reflective of the community needs assessment for RHP 19 indicating a need for improving the rates of preventable hospitalization admissions and readmissions. *(Community Index CN.2*) Between 2001-2010 emergency room visits increased by 28.6% and inpatient days increased by 6.9% for RHP 19, while population grew by less than 1% during that same time period. This project *is related to the regional goals* of building an infrastructure for improving the coordination of care in the rural environment. One of the goals for RHP 19 is to transform health care in the total population, and it is our belief that individuals will experience more success in maintaining healthy lives with the help of chronic care management and readily available personalized assistance. The region as a whole has high rates of chronic

diseases, such as heart disease, respiratory diseases, and obesity related issues, according to the Texas Department of Health and Human Services statistics. **(**Summary of Community Needs, RHP 19 document, 2012). These chronic diseases are known for resulting in costly admissions to acute care facilities, as well as transfers to tertiary facilities from the rural settings. RHP 19 contributed to the Public Health Region 2 statistic of 571 inpatient days per 1,000 of population, as compared to an average of 546 inpatient days for the state. (Texas Hospitals; Utilization and Financial Trends. 2001-2010). Diabetes, itself, affects approximately 20.8 million Americans and complications account for almost $100 billion of the annual costs of the country for medical assistance.

- **Starting Point/Baseline:** There is no current program in Montague County for chronic care management, however Bowie Memorial Hospital has a limited program of diabetic education and will benefit from an expanded chronic care management program. Therefore the baseline will be determined in DY2, from the outpatient program statistics for diabetic patients. The current program consists of monthly contact/encounter of 35 patients, or one monthly encounter. The new chronic care management would increase the encounters to a minimum of three, and increase the number of program patients by 25% DY4 and DY5. This increase represents a total of 42 patients in DY4 and in DY5 52 patients, with respectively 1512 encounters and 1872 encounters in those years.
- **Rationale:**

  Promoting effective changes in provider groups, to support evidence-based clinical and quality improvement across a wide variety of health care settings, became the basis and *reason* for improving the acute care readmissions, *Community Index CN.2,* and provide patients with increased knowledge for improved self-management. There are many definitions of "chronic condition", some more expansive than others. We characterize it as any condition that requires ongoing adjustments by the affected person and interactions with the health care system. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

  - 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. To speed the transition, Improving Chronic Illness Care created the Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. Evidence on the effectiveness of the Chronic Care Model has recently been summarized. (Health Affairs, Ref 86 in RHP planning protocol).

The *project option*, Redesign the outpatient delivery system to coordinate care for patients with chronic diseases, was chosen because of several issues. There is a shortage of primary care in Texas, evidenced by a national ranking of 42nd in ratio of physicians to population; because Texas is the state with the highest uninsured rate in the nation; and finally RHP 19 has a higher death rate for heart disease and respiratory/lung illnesses than the average in Texas.

Required QI consists of: Rapid cycle improvement processes will be utilized as the method for ongoing quality review components of the new chronic care management program. Quality improvement projects will test the effectiveness and improve the processes involved in the program. The rapid cycle improvement will be instrumental in achieving the metric associated with the Improvement Milestone 2, as listed in the table. Participation in learning initiatives within the RHP 19 will allow for sharing of ideas and will enhance the knowledge of the chronic care team members.

The project components consist of:

2.2.1.a- Design and implement care teams tailored to the patient's health care needs.

2.2.1.b- Ensure that patients can access their care teams in person or by phone or email.

2.2.1.c- Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources.

2.2.1.d- Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.

2.2.1.e- Conduct quality improvement for project using methods such as rapid cycle improvement.

- **Related Category 3 *Outcome Measure(s):***
  ***OD-1* Primary Care and**
  Chronic Disease Management
  I.T.- 1.10.
  This particular measure is indication of a comprehensive program creating the desired outcome of helping patients stay healthier and reduce complications from a sustained poor HbA1c value. The project 2.2 Expand the Chronic Care Management Model should assist in improving clinical indicators for chronic diabetic disease management, as well as promoting enhanced personal health through lowering the HbA1c.

- **Relationship to other Projects:** In the RHP 19 region, while several entities are proposing Category 2.2 Expand Chronic Care Management Models, in Montague County the need for these services will be provided by Bowie Memorial Hospital's project. Expanding Chronic Care Management in Montague County reinforces support for education resources and follow up to reduce emergency room visits and hospitalizations.
- **Relationship to Other Performing Providers' Projects in the RHP:** In Montague County there is no other provider proposing to expand chronic care management; therefore Bowie Memorial Hospital Category 2 project will potentially serve the entire county to

provide the necessary education resources and follow up to deliver adequate support for the safety net hospital of the region.

- **Plan for Learning Collaborative: N/A** at this time.
- **Project Valuation:** The project 2.2 Expand Chronic Management Models has significant value for the community assisting in the identification of chronic disease related problems, will help to reduce complications, hospitalizations, and will promote heath care resource conservation. The valuation of this project gave consideration to several influencing factors: increase patient education, increase use of self-monitoring and early awareness of potential complications, encouraging healthier habits, better adherence to medication regimes, and improved behaviors to help manage the chronic disease and keep the patients out of the emergency room and hospital beds. Currently there is no local funding available to this facility to meet these challenges. Each of the Demonstration Years was included in the valuation process, based upon the planning process: DY2 came to an estimated value of $243,500 (allowing for organizational equipment/supplies purchasing and consulting expertise); DY 3 estimated to be a value of $339,500 (allowing for increased staff of 2, dedicated to the program); DY4 (with an increase in performance of 25% or 1500 patient encounters) was $434,500 and finally DY 5 estimated at $444,500 (with a continued increase in performance of 25% or 1875 patient encounters). The average acute care admission results in a $15,000 payer cost, whereas outpatient charges for education and management are approximately $500. Respectively, the distribution of available funding ($917,400) will be under the project value to the facility and the community; however it is felt that this is a viable project with a positive impact for this community, and will be necessary for promoting the future health of residents of this county.

PROJECT 127305405.2.2	***PROJECT OPTION 2.2.1***	***PROJECT COMPONENTS 2.2.1A;2.2.1B;2.2.1C ; 2.2.1D;2.2.1E***	***EXPAND CHRONIC CARE MANAGEMENT MODEL***	
Bowie Memorial Hospital				*TPI 127305405*
OD-1	*I.T. 1.10*	*127305405.2.2* **1**	*Diabetes care: HbA1c poor control (greater than 9.0%)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-3 Develop a comprehensive care management program. *Metric 1* *P-3.1* Documentation of comprehensive Care management program. Baseline/Goal: Development of plan for chronic care management program. Data Source: Documentation of care program to be utilized. Milestone 1 Estimated Incentive Payment : $165,067	**Process Milestone 2** P-4 Designate/hire personnel or teams to support and/or manage the chronic care management program. *Metric 1 P-4. 1* Establish the support team for the chronic care management program. (2 staff dedicated to program) Baseline/Goal: Number of relevant staff prepared/trained for the chronic care management implementation. Data Source: HR records. Milestone 2 Estimated Incentive Amount $ 178,934		**Process Milestone 3** P-10. Expand and document interaction types between patient and health care team beyond one to one visits to include group visits, telephone visits, and other interaction types. *Metric 1 P-10.1* Increase the number of group visits and/or telephone visits and/or other interaction types. Baseline: Approximately 35 patients annually are currently followed by diabetic educator. Goal: Increase the number of chronic care management encounters with diverse interactions by care team by 20%.	**Improvement Milestone 2** **I-18** *Metric I-18.1 Goal:* Increase the percentage of patients with self-management goals in the program. Baseline: Goal: Increase the number of program participants with diverse types of interactions with care team by 25% from prior measurement (of 42 patients or 1875 encounters). Data Source: E.H.R., program interaction documentation Estimated Incentive Payment: $148,248

Project 127305405.2.2	***Project Option 2.2.1***	***Project Components 2.2.1a;2.2.1b;2.2.1c ; 2.2.1d;2.2.1e***	***Expand Chronic Care Management Model***	
Bowie Memorial Hospital				*TPI 127305405*
OD-1	*I.T. 1.10*	*127305405.2.2* **1**	*Diabetes care: HbA1c poor control (greater than 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)**
			Data Source: E.H.R., registration documentation, program interaction documentation. **Improvement Milestone 1** **I-18** Improve the percentage of patients with self-management goals in the program. *Metric 1* *I-18.1* Goal: Increase the number of patients in the program by 25% of baseline (of 35 patients or 1500 patient encounters). Data Source: E.H.R. and Program Registry Estimated Incentive Payment: $ 89,810	
Year 2 Estimated Milestone Bundle Amount:: $165,067		Year 3 Estimated Milestone Bundle Amount: $178,934	Year 4 Estimated Milestone Bundle Amount: $179,620	Year 5 Estimated Milestone Bundle Amount: $148,248
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $671,869				

Summary Information: Clay County Memorial Hospital

Pass 1 Project 094138703.2.1

Summary Information: Clay County Memorial Hospital

Pass 3B Project 094138703.2.2
Old Pass 3B Project 094138703.2.1

- Provider: Clay County Memorial Hospital is a 25-bed Critical Access Hospital in Henrietta serving a 1,000 square mile area and a population of over 11,000.

- Intervention(s): This project will redesign our Primary Care model to improve patient experience and reduce no-show rates

- Need for the project: We currently have four family practice physicians in Henrietta, but none of the four are accepting new patients. We will be adding another primary care provider and improving efficiencies through the redesign of our primary care model to provide better access to patients

- Medicaid and Uninsured Target population: The target population is our patients that don't have insurance or have Medicare/Medicaid. Over 75% of our patients are either Medicare or Medicaid or uninsured.

- Category 1 or 2 expected patient benefits: The project seeks to redesign the primary care utilizing the newly recruited new family practice physician over the next three years. Care capacity will expand by 200 patients.

- Category 3 outcomes: IT-6.1 Our goal is to decrease inappropriate Emergency Department usage by providing the right care in the right place.

Category 2: Program Innovation and Redesign

Project Option: 2.3 Redesign Primary Care

RHP Project Number: 094138703.2.2
Old project 094138703.2.1

RHP Performing Provider: Clay County Memorial Hospital TPI 094138703

Project Description:

Our project to redesign primary care in Clay County complements our Category 1 project to recruit an additional family practice physician to meet the needs of our 11,000 plus residents, where over 75% are Medicaid/Medicare eligible or uninsured. The use of patient-centered scheduling models in the clinic, a new access point for patients, and redesigning the whole patient visit are challenges and a solution to the challenge.

Starting Point/Baseline:

The starting point is zero, due to the fact that none of the four physicians in Clay County are currently accepting new patients. This includes Medicare, Medicaid and uninsured patients.

Rationale:

By recruiting a family practice physician, the increase in patient satisfaction and efficiency in access to care will happen as a result. The core components of patient-centered scheduling, patient visit redesign and quality improvement will be fulfilled.

<u>Required core project components:</u>
a) Implement the patient-centered scheduling model in primary care clinics
b) Implement patient visit redesign
c) 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.

As the additional physician is brought on board, the components of patient-centered scheduling and patient visit redesign will be implemented in this new clinical access point for this target population. We have selected a redesign project because we need a new, more efficient system to provide care for our Medicaid, Indigent and other low or no pay patients. This redesign will open a new patient access point for patients. Additionally, because we will employ the physician, the provider will have the ability to focus on evidence based care and not reimbursement rates.

As no show rates often limit access to care, we also intend to reduce no show rates by utilizing patient reminders via Texting and Facebook. As this is a new access port for primary and preventative care specifically designed for our Medicaid and uninsured population, we will monitor the scale of the project and the available appointments, and identify key challenges which may arise as we open this new access point. We will seek to address any issues through lessons learned here and/or by other providers seeking to increase primary care access points and reduce inappropriate ED utilization. The community need identification number that this project addresses is CN.3, shortage of health care professionals.

Related Category 3 Outcome Measure:

OD-9 Right Care, Right Setting

IT-9.2 ED Appropriate Utilization

By recruiting an additional family practice physicians to our community, the residents of Clay County won't have to go to the Emergency Department for basic care. Patients can be seen at the doctors clinic after hours and on weekends instead.

Relationship to other Projects:

The category 2 project is indelibly linked with our Category 1 project, which is Expanding Primary Care Capacity #094138703.1.2 (Old 094138703.1.1)

By recruiting another doctor, we will achieve improvements in efficiency, access, continuity of care and patient experiences.

Project Valuation

Clay County Memorial Hospital is a County Hospital. The Clay County Commissioners and the Hospital Board of Managers have heard many times over the last two years from residents that they cannot get in to see a local physician. The process to find physicians to work in a rural area is a tedious and grinding one. The physician will expect a bonus to relocate and a monthly guarantee to maintain their standard of living. Typically, finding a physician who will also focus on the Medicaid and uninsured population further exacerbates this search and recruitment process. By redesigning the primary care model in Henrietta, we believe we will be able to hire a physician who will be able to focus on providing care to Medicaid and uninsured/indigent patients. Through this redesign, we will establish a new model of patient-centered care and incorporate efficient ways to manage the clinic setting. We will be able to increase new patient visits by 200. We will review this change and new access point to evaluate lessons learned and to further improve efficiencies. The total value for this project is $474,025.

NEW 094138703.2.2 (094138703.2.1)	**2.3.1**	**2.3.1 A, B, C**	**REDESIGN PRIMARY CARE**	
Clay County Memorial Hospital				094138703
OD-9	IT-6.1	**094138703.3.4. ((094138703.3.2)87 (03.2.23.2**	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 Establish baseline data for each: patient appointment "no-show" rates, Metric 1 P-1.1 Establish baseline patient "no-show" rates. Baseline/Goal: Establish baseline rate. Data Source: Scheduling system Milestone 1 Estimated Incentive Payment : $109,382	**Milestone 2** I-11 Improve patient access to primary care as measured by reducing no-show baseline rate by 3%. **Milestone 2** I-12 Reduce patient appointment no-show rates by 3% of current level. Metric 2 Baseline patient "no-show" rates. Baseline/Goal: Decrease no-show rate by 54 patients. Data Source: Scheduling system Milestone 2 Estimated Incentive Payment: $126,789		**Milestone 3** I-11 Improve patient access to primary care as measured by reducing no-show baseline rate by 4%. **Milestone3** I-12 Reduce patient appointment no-show rates by 4% of current level. Metric 2 Baseline patient "no-show" rates. Baseline/Goal: Decrease no-show rate by 72 patients. Data Source: Scheduling system Milestone 3 Estimated Incentive Payment: $128,101	**Milestone 4** I-11 Improve patient access to primary care as measured by reducing baseline rate by 5%. **Milestone 4** I-12 Reduce patient appointment no-show rates by 5% of current level. Metric 2 Baseline patient "no-show" rates. Baseline/Goal: Decrease no-show rate by 90 patients. Data Source: Scheduling system Milestone 4 Estimated Incentive Payment: $109,753
Year 2 Estimated Milestone Bundle Amount: $109,382	Year 3 Estimated Milestone Bundle Amount: $126,789		Year 4 Estimated Milestone Bundle Amount: 128,101	Year 5 Estimated Milestone Bundle Amount: $109,753
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $474,025				

Summary Information: Electra Memorial Hospital

Pass 1 Project 135034009.2.1
Summary Information: Electra Memorial Hospital

Pass 3B Project 135034009.2.2
(Old Pass 1 Project 135034009.2.1)

- Provider: Electra Memorial Hospital is the anchor hospital for RHP 19 that serves a population of approximately 260,000. The hospital is located in Electra, Texas on the western edge of Wichita County.

- Intervention(s): This is a regional project that focuses on care transitions in RHP 19. We will work in cooperation with United Regional Health Care Center, the tertiary and safety net hospital for all but one hospital in the region, and all other providers in the region, to assure that patients are transitioned from acute care to the most appropriate post-acute setting as well as to their family physician in the community where they reside. ED case managers will be designated or placed in each outlying hospital to assure smoother transitions.

- Need for the project: As the tertiary hub for the region, URHCS receives numerous transfers from the outlying facilities. When those patients are dismissed from the hospital, they often do not get proper follow-up care. With many physicians no longer accepting Medicaid patients, this project should facilitate better follow-up care and the establishment of medical homes for patients that often aren't treated until their illnesses are serious enough to require hospitalization.

- Medicaid and Uninsured Target population: The target population is the approximately 260,000 people that reside in RHP 19. Only 52% of the patients in RHP 19 have commercial insurance. 15% are Medicare recipients, and the remaining 33% are covered by either Medicaid, CHIP or are uninsured. That 33% equates to approximately 85,000 potential patients.

- Category 1 or 2 expected patient benefits: This project seeks to increase the number of ED case managers and provide new care transition education, care and services to the 260,000 people residing in RHP 19, 85,000 of which are Medicaid or uninsured. We hope to provide services for at least 1,500 Medicaid discharges in RHP 19 by DY 5.

- Category 3 outcomes: IT-3.2. Our goal is to reduce the all-cause 30-day readmission rate in RHP 19 by the end of DY 5.

Category 2: Program Innovation and Redesign

Project Option: 2.12 Implement/Expand Care Transitions Programs

RHP Project Number: NEW ID: 135034009.2.2
(**OLD ID:** 135034009.2.1)

RHP Performing Provider: Electra Memorial Hospital-135034009

- **Project Description:** Implement/Expand Care Transitions Programs, project 2.12, is one that will help promote the Triple Aim goals of RHP 19. Providing the right care in the right place, at the right time is critical to preventing increased health care costs and hospital readmissions. Many patients, including Medicaid clients and the uninsured, often do not follow up with their primary care physician post discharge. Pediatrician visits, as well as other specialty care visits, may be difficult for patients outside Wichita Falls because of economic factors. Transitioning care to a primary care physician in the patient's local area could facilitate contact with the specialist and encourage seeking preventative services on a regular basis. We expect that it will also decrease the number of patients seeking post-acute care in the emergency department. Our goal will be to transform coordination of care efforts and implement improvements in care transitions from inpatient to outpatient, post-acute care and home care settings. According to the Journal of the American Geriatrics Society's article, "Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs.", transitions from one health care provider setting to another can be prone to errors. By implementing a well-planned transition program, those errors can be avoided and potentially prevent readmissions. The major challenge will be engaging stakeholders across the region and developing a program that will create the collaboration needed to affect the readmission rate. This project will require cooperation among medical providers, social services, community support services and long-term care facilities across RHP 19. United Regional Health Care System in Wichita Falls is the tertiary hub for this region. Our care transitions will allow practitioners to learn and develop effective ways to successfully manage patients' diseases. By ensuring that patients discharged from the inpatient hospital setting are appropriately transitioned effectively and safely back to their communities or the appropriate post-acute setting, all patients, and particularly those with serious conditions, can receive the care they need to avoid a possible readmission. By the end of the Waiver, we expect that readmission rates across the entire RHP will decline, thereby improving the health of the patients in the region.
- **Starting Point/Baseline:** The baseline for readmission will be established in DY 3 by compiling data from DY 2 on readmission rates.
- **Rationale:** The Community Needs Assessment for RHP 19 identifies the high rates of chronic disease, CN.1, the high costs associated with preventable hospitalization admissions and readmissions, CN.2, and the need to overcome patient access to care

barriers, as significant needs throughout RHP 19. As a method of achieving delivery system transformation, we have chosen milestones that develop a plan and policies and procedures that will assure patients are receiving the Triple Aim goals of RHP 19, right care, right time and right setting. Poorly designed discharge processes create unnecessary stress for medical staff, causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Regional providers will collaborate to develop protocols for discharge planning and post discharge follow-up from United Regional Health Care System (URHCS) which is the Safety Net hospital and tertiary hub for RHP 19. In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. Patient education around discharge and transitional care will ensure that patients, family members and other care givers are empowered and better able to self-manage follow-up care. It is also important to try to coordinate care with facilities outside URHCS's own delivery system so that patients can receive optimal care, again, at the right time in the right place. We plan to employ or designate ED case managers throughout the regional which will allow for better access for those patients using ED services for post-discharge care, but also to assist those patients in identifying a more appropriate setting and identify diseases for which patients are seeking care in the ED. Assessing the most prevalent conditions and factors that lead to readmissions will allow the providers to address the needs of the patient population more effectively. **Required QI:** By investing in a learning collaborative, providers in RHP 19 can share ideas, promote continuous learning and exchange of best practices, determine the impact of the project, in turn deciding collectively how to "raise the floor" for performance across the region. Milestone 12 below in the table reflects initiatives that will include "raise the floor" and the face-to-face meeting to improve the project.

- **Related Category 3 Outcome Measure(s):**
    - **OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)**
        - **IT-3.1 All cause 30 day readmission rate *(Standalone measure)***

135034009.3.7 (135034009.3.3) IT-3.1. Electra Memorial Hospital/135034009.
This outcome measure was chosen based on data in the appendix of the CNA, specifically Table Y illustrating potentially preventable admissions. We believe that providing the Triple Aim of right care, right time, right setting, these types of admissions and readmissions can be reduced for all types of patients, not just those with specific diagnoses. No baseline data has been established, but we believe by establishing protocols for discharge and post-discharge follow up throughout the entire region, we can reduce readmissions and transition patients into the appropriate care setting. By establishing baselines and collecting current data to identify admission and readmission diagnoses and then analyzing that data on a collective basis to determine the cause, potentially preventable readmissions can be avoided. This will assist us in estimating the hospital-level, risk standardized rate of unplanned, all-cause readmission after

admission for any eligible condition (http://www.qualityforum.org/QPS/) within 30 days of hospital discharge (RSRR) for patients ages 18 and older.

- **Relationship to other Projects:** This project directly relates to our other projects of Expanding Primary Care 135034009.1.4 (135034009.1.1), 135034009.1.3 and Expanding Specialty Care 135034009.1.5 (135034009.1.2) because of its regional focus and scope. Meeting the Triple Aim goals of RHP 19 will be achieved through a true transformation of the delivery system in the region. Providing the right care at the right time in the right setting by expanding primary care at the local level, specialty care for the entire region in a timely manner and in the most appropriate setting, and assuring that patients are transitioned from inpatient into the post-acute setting that will best meet their needs, is essential to the region and the overall patient experience.
- **Relationship to Other Performing Providers' Projects in the RHP:** As a regional project for RHP 19, this project will involve all performing providers in the region, except for North Texas Regional Medical Center, who will be doing a care transitions project 121777003.2.2 (121777003.2.1) for the Gainesville area. Other RHP 19 provider's projects will be enhanced by the transition of patients from the tertiary/safety net hospital in Wichita Falls, into the appropriate post-acute setting. Specialty physicians collaborating with rural primary care physicians will make the transitions smoother and improve patient satisfaction. By placing ED case managers in rural facilities and sharing information and best practices among the region's providers, lessons can be learned and methods for "raising the floor" for performance can be implemented across the region.
- **Plan for Learning Collaborative:** We expect to conduct a learning collaborative in DY 5 to share ideas, promote continuous learning and exchange best practices in order to improve performance. Providers from the entire region will be included and collective actions are expected to be formulated.
- **Project Valuation:** The value of this project was based upon the direct savings to payers of potentially preventable readmissions. There were 17,596 potentially preventable admissions in RHP 19 from 2005-2010. If only 2%, or approximately 350, of those avoided each year, charges of $1.25 million to payers will be eliminated. The cost of ED case managers in facilities throughout the region was considered, along with the cost of plan development, implementation, monitoring and support staff. We estimate that this will require at least 10 new case managers and 2 new support staff positions. The intrinsic value to patients of returning to a post-acute setting that best meets their needs is paramount, as well as the value of keeping patients healthy and out of the inpatient setting. Low income and uninsured patients staying healthy alleviates the burden to taxpayers in the entire region, but also improves the patient experience and promotes wellness. We plan to provide new care transition education, care and services to the 260,000 people residing in RHP 19, 85,000 of which are Medicaid or uninsured. We hope to provide services for at least 1,500 Medicaid discharges in RHP 19 by DY 5. Using these assumptions and estimates, we have valued 2.1 at $8,925,464 over DY 2 – DY 5. This includes the value of additional staff, space, and of providing transitional care services. Each year we have at least one milestone, and in years with more than one, each is valued equally per the PFM Protocol.

135034009.2.2 (135034009.2.1)	***PROJECT OPTION 2.12.2***	***2.12.2***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Electra Memorial Hospital				***135034009***
Related Category 3 Outcome Measure(s): OD-3	**IT-3.1**	**135034009.3.7 (135034009.3.3)**	**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. 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. P-1.1 Metric: Care transitions protocols Baseline: Submission of protocols Data Source: Care transitions program materials Milestone 1 Estimated Incentive Payment *(maximum amount):* Payment: $727,617.33	**Milestone 4: P-2**. Implement standardized care transition processes P-2.1 Metric: Care transitions policies and procedures. Baseline/Goal: Implement standardized care transition processes and establish the baseline number of patient transitions (currently 0) from the tertiary safety net hospital. Data Source: Policies and procedures of care transitions program materials Milestone 4 Estimated Incentive Payment: $793,791.33		**Milestone 7: I-11**. Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. I-11.1 Metric: Number over time of those patients in target population receiving standardized care according to the approved clinical protocols and care transitions policies. Goal: Increase the number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines by 500 over DY 3. Data Source: EHR reports or	**Milestone 10: I-11**. Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. I-11.1 Metric: Number over time of those patients in target population receiving standardized care according to the approved clinical protocols and care transitions policies. Goal: Increase the number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines by 1,500 over DY 3. Data Source: EHR reports or

135034009.2.2 (135034009.2.1)	*PROJECT OPTION 2.12.2*	*2.12.2*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
Electra Memorial Hospital				*135034009*
Related Category 3 Outcome Measure(s): OD-3	**IT-3.1**	**135034009.3.7 (135034009.3.3)**	**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 2: **P-3**. Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instruction 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. P-3.1 Metric: Care transitions protocols. Goal: Establish a process that	**Milestone 5: P-6.** Train and/or designate more ED case managers throughout the region P-6.1. Metric: Number of trained and/or designated ED case managers in region Baseline: Number of trained and/or designated ED case managers for care transitions in DY 2 (0) in RHP 19 Goal: 2 trained and/or designated ED case managers in DY 3 Data Source: HR records, job descriptions or other documentation as appropriate		other documentation Milestone 7 Estimated Incentive Payment: $796,099 **Milestone 8: P-6.** Train and/or designate more ED case managers throughout the region P-6.1. Metric: Number of trained and/or designated ED case managers in region over baseline Goal: 6 trained and/or designated ED case managers in DY 3 Data Source: HR records, job descriptions or other documentation as appropriate	other documentation Milestone 10 Estimated Incentive Payment: $657,647 **Milestone 11: P-6.** Train and/or designate more ED case managers throughout the region P-6.1. Metric: Number of trained and/or designated ED case managers in region over baseline Goal: 10 trained and/or designated ED case managers in DY 4 Data Source: HR records, job descriptions or other documentation as appropriate

135034009.2.2 (135034009.2.1)	*PROJECT OPTION 2.12.2*	*2.12.2*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
Electra Memorial Hospital				*135034009*
Related Category 3 Outcome Measure(s): OD-3	**IT-3.1**	**135034009.3.7 (135034009.3.3)**	**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)**
provides for a regional case manager at URHCS that would collaborate with rural case managers to follow up with identified patients regarding post discharge instructions and education. Data Source: Care transitions program materials. Milestone 2 Estimated Incentive Payment: $727,617.33 **Milestone 3: P-4**. Conduct an assessment and establish linkages with community-based organizations to create a support network for target patients post-discharge. <u>P-4.1 Metric</u>: Care transitions	Milestone 5 Estimated Incentive Payment: $793,791.33 **Milestone 6: P-7.** Develop a staffing and implementation plan to accomplish the goals/ objectives of the care transitions program <u>P-7.1 Metric:</u> Documentation of the staffing plan Goal: Establish the necessary staff to successfully implement the care transitions program Data source: Staffing and implementation plan.		Milestone 8 Estimated Incentive Payment: $796,099 **Milestone 9: I-10.** 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 <u>P-10.1 Metric:</u> Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-	Milestone 11 Estimated Incentive Payment: Payment: $657,647 **Milestone 12: P-12.** Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. 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.

135034009.2.2 (135034009.2.1)	***PROJECT OPTION 2.12.2***	***2.12.2***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Electra Memorial Hospital				***135034009***
Related Category 3 Outcome Measure(s): OD-3	**IT-3.1**	**135034009.3.7 (135034009.3.3)**	**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)**
assessment Goal: Conduct assessment Data Source: Care transitions assessment and resource planning documents Milestone 3 Estimated Incentive Payment: $727,617.34	Milestone 6 Estimated Incentive Payment: $793,791.34		admissions. Goal: Documentation of frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates. Data source: EHR reports or other appropriate documentation Milestone 9 Estimated Incentive Payment: $796,099	<u>P-12.1 Metric:</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participation of all RHP 19 providers in learning collaborative Data source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <u>P-12.2 Metric:</u> Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Goal: Sharing of best practices in RHP 19 with peers

135034009.2.2 (135034009.2.1)	***PROJECT OPTION 2.12.2***	***2.12.2***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Electra Memorial Hospital				***135034009***
Related Category 3 Outcome Measure(s): OD-3	**IT-3.1**	**135034009.3.7 (135034009.3.3)**	**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)**
				Data source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 12 Estimated Incentive Payment: Payment: $657,647
Year 2 Estimated Milestone Bundle Amount: $2,182,852	Year 3 Estimated Milestone Bundle Amount: $2,381,374		Year 4 Estimated Milestone Bundle Amount: $2,388,297	Year 5 Estimated Milestone Bundle Amount: $1,972,941
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $8,925,464				

Summary Information: Faith Community Hospital

Pass 1 Project: 119874904.2.1
Summary Information: Faith Community Hospital

Pass 3B Project: New ID: 119874904.2.3
Old ID: 119874904.2.1

Provider: Faith Community Hospital is a 40-bed county hospital in Jacksboro, Texas, serving a 920 square mile area and a population of approximately 9,044. The population of Jacksboro was approximately 4,506 in 2011.

Intervention(s): Health Promotion Program to address identified disparities in the areas of physical activity, nutrition, health behaviors, and preventative health screenings across the lifespan. Programming will be featured in a dedicated Facebook page. There is no other federal funding being used for this program. This program is solely managed by Faith Community Hospital and is not a collaborative effort with any other entity.

This program aligns with the RHP 19 goal to transform healthcare for the total population through health promotion and wellness initiatives. These new partnerships reflect a paradigm shift in the hospital's approach to health care. This program reaches beyond the hospital walls and into the community to lead the way to improved health. As of this writing, four of the seven primary programs have been initiated with a total participation of 212. Three of the seven programs remain in development and baseline data will be forthcoming.

Need for the project: According to the County Health Rankings conducted by the University of Wisconsin in 2011, Jack County residents ranked 76th percentile in clinical care and 53rd percentile (1 being the best) in health behaviors.

Medicaid and Uninsured Target population: Fifteen percent of people in Jack County fall below the poverty line. Sixteen percent of people are poor, defined as living below two times the national poverty level. In Jack County, 1672 residents were enrolled in Medicaid as of December 2011. Compared to Texas as a whole, Jack County has similar percentages of people who lack access to healthcare.

Category 1 or 2 expected patient benefits: According to a study by Scott, Gazmararian, Williams, and Baker (2002) persons with limited health literacy are less likely to seek preventive care[1]. Our goal is to provide Health Promotion programs and activities and demonstrate an increase in participation in order to impact health literacy. Participants will complete a Health Literacy assessment form after attending health promotion programming. Gaps in literacy will be identified and included in future programming. Participants providing a name and contact information will receive individual follow up to assist them in improving health literacy. Valuation assumes Health Promotion activities will be attended by up to 400 participants by the end of the waiver. Activities will be advertised throughout Jack County, but it is anticipated

that the majority of attendees will be residents of the city of Jacksboro. The plan projects an increase of 35 additional participants from baseline in DY2; 70 additional participants from baseline in DY4; and 105 additional participants from baseline in DY5. The age of the target population for Health Promotion activities will be parents and other adult family members. The aim is to empower adult family members to make healthier choices for themselves and their children/grandchildren. In this way, the actual number of lives affected by this effort will far outweigh the number of program participants.

Category 3 outcomes: The study by Scott, et al, specifically addressed a tendency among populations with low health literacy levels toward not receiving mammography, cervical screening or flu shots. Applying waiver protocol outcome measures and based upon pro-rated Healthy People 2020 goals, we aim to achieve the following: Increased breast Cancer screening: DY2 – Program planning; DY3 – Establish baseline; DY4 - Increase breast cancer screening by 20 patients over baseline; DY 5 Increase breast cancer screening by 40 patients over baseline. Increased cervical Cancer screening: DY2 – Program planning; DY3 – Establish baseline; DY4 - Increase cervical cancer screening by 20 patients over baseline; DY 5 Increase cervical cancer screening by 40 patients over baseline. Increased pneumonia vaccinations for older adults: DY2 – Program planning; DY3 – Establish baseline. DY4 – Increase vaccinations by 30 patients over baseline. DY5 – Increase vaccinations by 50 patients over baseline. These improvement estimates are based upon a percentage of the current clinic census. If these goals are met, the clinic could experience a 26% increase in utilization.

There is no other federal funding for this program. This program is solely managed by Faith Community Hospital and is not a collaborative effort with any other entity.

The clinic is currently using a new electronic finance system and reorganizing patient flow processes. Program planning for screenings will be part of this reorganization. During DY2 a primary care physician will leave the clinic practice after 20+ years of service and many patients may transfer to his private practice. Baseline data for Category 3 will not be determined until DY3 due to this restructuring.

[1]Scott TL, Gazmararian JA, Williams MV, Baker DW. 2002. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Medical Care.* 40(5): 395-404.

Category 2: Program Innovation and Redesign

Project Title: Health Literacy by Faith

Project Option: Project 2.1 Option 2.6.3

RHP Project Number: 119874904.2.3
(OLD I.D. 119874904.2.1)

RHP Performing Provider: Faith Community Hospital - 119874904

Project Description

Faith Community Hospital is developing a Health Promotion Program which will impact multiple health conditions. This is a new program that will address identified disparities in the areas of physical activity, nutrition, health behavior and health screenings across the lifespan. Faith Community Hospital aims to extend its reach as a local leader in health care by working to teach tools necessary to establish healthy lifestyles and improve access to local Medicaid and Indigent Care services.

Prior to January 2011, Faith Community Hospital was not focused on providing services to patients with Medicaid or establishing Indigent Care contracts with uninsured residents. This resulted in most members of the Jack County population eligible for Medicaid travelling a minimum of 30 miles to receive primary care. Many of the uninsured used the Emergency Department for care. A new administrator and rural health clinic provider have been instrumental during 2012 in the Rural Health Clinic becoming participating providers for Texas Health Steps and the Texas Women's Health Program. The Rural Health Clinic seeks to become the primary care source for patients with Medicaid and the uninsured through our Indigent Care Program.

The Health Promotion Program marketing staff will employ a variety of methods to educate the community on how to access Medicaid and Indigent Care resources in Jack County. The Faith Community Hospital Rural Health Clinic currently has approximately 500 active patients. Of these, an estimated 25% are Medicaid patients and <5% are indigent. In Jack County, 1672 residents were enrolled in Medicaid as of December 2011. This translates to over 1500 Jack County Medicaid patients commuting to receive primary care. The economic impact of lost wages and travel costs may result in either delaying care or using the Emergency Department rather than receiving regular, scheduled care from a primary care provider.

This effort is very timely for Jack County, Texas, as several local programs that benefit Medicaid and uninsured for children's nutrition, Head Start, the pregnant teen population, senior programs, and others are losing funding or donation sources. This Health Promotion program can be instrumental to developing partnerships with community health workers to bridge the gap through fundraising efforts, community education, and teaching tools such as monthly health promotion seminars, Diabetic teaching, and Life Skills classes. The Health Promotion Program intends to help community members seek the right care, at the right time, in the right setting by providing them with the right tools to make better care and health decisions by improving health literacy.

Health literacy is defined by the Institute of Medicine as the "degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions". Health literacy projects currently in place or in the planning stages are partnering with the Extension Agent to demonstrate healthy meal preparation, monthly seminars addressing health issues, partnering with Child Protective Services to present Life Skills classes for parents, partnering with the local food closet to teach healthy meal preparation, and partnering with the local Lions Club to increase diabetes awareness. Health Promotion projects currently in place or in the planning stages are creating a walking path near the senior citizens center, after school activity program, employee wellness program, and Reindeer Run fundraiser to provide food for needy families during the holidays.

Faith Community Hospital will partner with local physician clinics and community health workers as well as state and regional health workers that routinely visit Jacksboro. These stakeholders include the Jacksboro Independent School District, Concerned Citizens (senior center), Learning Center, Texas Department of Aging and Disability, Relay for Life, and others. Hospital staff members have interviewed area health workers to gather input into ways the Health Promotion program can best serve the community. These new partnerships reflect a paradigm shift in a hospital approach to health care. This program reaches beyond the hospital walls and into the community to lead the way to improved health.

Program staff will conduct ongoing surveys and use available statistics to identify gaps and potential barriers to accessing services and resources throughout the course of the waiver. These needs will be analyzed to form the basis of project plans to meet those needs. It is the aim of the program to build on the objectives of Healthy People 2020 to address identified priority interventions.

Program staff will partner with local health care workers to develop and present an annual Wellness Fair. The event will focus on Healthy People 2020 objectives to promote healthy lifestyle changes and increase awareness within the community about the health benefits of and ways to increase physical activity, improve diet and decrease health risks. According to the US Department of Health and Human Services and US Department of Agriculture dietary guidelines maintaining a healthy weight and diet can reduce the risk of a number of health conditions including diabetes, heart disease and some cancers. These conditions often represent a significant cost to consumers and the hospital.

Program staff will develop and promote a series of monthly presentations addressing health topics based upon Healthy People 2020 objectives and learning needs identified by surveys. Area health professionals will lead presentations and answer questions posed by or submitted by participants. The Ladies of Faith presentations will focus on women's health issues and promote The Texas Women's Health Program. The presentations will be free and open to the public.

Challenges/Issues

Internal factors that present challenges to the implementation of this program are:

- the time element of providing the training necessary to educate staff to provide, teach, and promote new services
- physical space to conduct structured classes and support group meetings

External factors intrinsic to health promotion opportunities are the challenges of patient compliance and sustained participation in programs intended to create lifestyle changes.

Some members of the community may feel disenfranchised or not welcome to attend health promotion seminars. Follow-up, marketing and promotion and quality improvement efforts will need to be continuous to eliminate barriers to participation.

Follow-up, marketing and promotion efforts will need to be continuous to both maintain participation and generate new interest in programs.

Marketing and promotion efforts will need to be continuous to inform Jack County residents of enhanced access to Medicaid services at the Rural Health Clinic.

Starting Point/Baseline

All health promotion programs are new during DY2 and baselines will be established with each new program initiated. As of this writing, four of the seven primary programs have been initiated with a total participation of 212. Three of the seven programs remain in development and baseline data will be forthcoming.

Required Quality Improvement

The Health Promotion program will be monitored using the principles of continuous quality improvement. Participants will complete a Health Literacy assessment form after attending health promotion programming. Gaps in literacy will be identified and included in future programming. Participants providing a name and contact information will receive further follow up to assist them in improving health literacy. Health Promotion program staff will use Plan, Do, Study, Act worksheets to evaluate programming and make improvements as needed.

Rationale

CN.4 Low utilization of preventative care services, including sigmoidoscopy, colonoscopy, and immunizations (Texas Behavioral Risk Factors Surveillance System). Due to the lack of primary care services available to Medicaid and uninsured patients in Jack County and the lack of demand for them, we believe that education and literacy for the over 1,500 targeted patients will improve their utilization of primary and preventive services, such as screenings and vaccinations.

According to the County Health Rankings conducted by the University of Wisconsin in 2011, Jack County residents ranked 76th percentile in clinical care and 53rd percentile (1 being the best) in health behaviors. It is the aim of Faith Community Hospital to take a broad approach to promoting improved focus on and access to wellness interventions across the lifespan. To achieve this goal, the hospital is establishing a Health Promotion Program through which a number of programs and initiatives will be made available to the general public as well as persons enrolled in Medicaid, the uninsured or those identified as requiring additional resources (e.g. school lunch program, learning center, Head Start, etc.)

It is the goal of the program to increase access to facilities, services and programs to improve health behaviors and teach healthy lifestyle changes.

Relation to Category 3 Outcome Measures

A study by Scott, et al[1], specifically addressed a tendency among populations with low health literacy levels toward not receiving mammography, cervical screening or flu shots. Applying waiver protocol outcome measures we aim to improve the following:

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 to 69 in the patient or target population. (Women who have had a bilateral mastectomy are excluded)

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.
IT-12.4 Pneumonia vaccination status for older adults
Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine
Denominator: Number of adults aged 64 and older in the patient or target population.

Relationship to Other Performing Providers' Projects in the RHP:

Other Performing Providers in RHP 19 that are doing similar projects in their local areas are:

Hamilton 110856504.2.2 (110856504.2.1)
Seymour 138353107.2.2 (138353107.2.1)
None of these address health promotion in the Jacksboro community.

Project Valuation
Valuation assumes Health Promotion activities will be attended by up to 400 participants by the end of the waiver. Activities will be advertised throughout Jack County, but it is anticipated that the majority of attendees will be residents of the city of Jacksboro. The plan projects an increase of 35 additional participants from baseline in DY2; 70 additional participants from baseline in DY4; and 105 additional participants from baseline in DY5. The age of the target population for Health Promotion activities will be parents and other adult family members. The aim is to empower adult family members to make healthier choices for themselves and their children/grandchildren. In this way, the actual number of lives affected by this effort will far outweigh the number of program participants.

Valuation also assumes required program planning documentation using Health Promotion Planning Worksheets to ensure that programming is aligned with Healthy People 2020 objectives and shows progress toward waiver goals. Programming will be evaluated using Plan, Do, Study, Act worksheets that document the ongoing quality improvement process.

Old ID: 119874904.2.1 NEW ID: 119874904.2.3	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct an assessment of health promotion programs that involve community health workers at local and regional level **Metric [P-1.1]:** Document regional assessment **Goal**: 200 assessments **Data Source**: Performing Provider assessment and	**Milestone 4 [P-5]:** Execution of evaluation process for project innovation **Metric [P-5.1]:** Document evaluative process, tools and analytics **Goal**: 7 - Minimum of 1 Plan, Do, Study, Act worksheet for each health promotion	**Milestone 7 [P-5]:** Execution of evaluation process for project innovation **Metric [P-5.1]**: Document evaluative process, tools and analytics **Goal**: 7 - Minimum of 1 Plan, Do, Study, Act worksheet for	**Milestone 10 [P-5]:** Execution of evaluation process for project innovation **Metric [P-5.1]:** Document evaluative process, tools and analytics **Goal**: 7 - Minimum of 1 Plan, Do, Study, Act worksheet for each health promotion

Old ID: 119874904.2.1 *NEW ID: 119874904.2.3*	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
summary of findings **Milestone 2 [P-2]:** Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community **Metric [P-2.1]**: Document	program conducted during DY3 **Data Source**: Plan, Do, Study, Act worksheets **Milestone 5 [P-2]:** Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of	each health promotion program conducted during DY4 **Data Source**: Plan, Do, Study, Act worksheets **Milestone 8 [P-2]**: Development of evidence-based projects for targeted population based on distilling the needs assessment	program conducted during DY5 **Data Source**: Plan, Do, Study, Act worksheets **Milestone 11 [P-2]:** Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of

Old ID: 119874904.2.1 *NEW ID: 119874904.2.3*	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
innovational strategy and plan **Goal:** 7 - one completed Health Promotion Planning worksheet for each program planned in DY 2. **Data Source**: Health Promotion Program Worksheet **Milestone 3 [I-8]:** Establish	interventions for the community **Metric [P-2.1]**: Document innovational strategy and plan **Goal:** 7 - one completed Health Promotion Planning worksheet for each program planned in DY 2.	and determining priority of interventions for the community **Metric [P-2.1]**: Document innovational strategy and plan **Goal:** 7 - one completed Health Promotion Planning worksheet for each program planned in DY 2.	interventions for the community **Metric [P-2.1]**: Document innovational strategy and plan **Goal:** 7 - one completed Health Promotion Planning worksheet for each program planned in DY 2.

Old ID: 119874904.2.1 *NEW ID: 119874904.2.3*	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
baseline access to health promotion programs and activities using innovative project option. **Metric [I-8]**: Increase percentage of target population reached. Numerator: Number of individuals of target population reached by the innovative	**Data Source**: Health Promotion Program Worksheet **Milestone 6 [I-8]:** Increase access to health promotion programs and activities using innovative project option. **Metric [I-8]**: Increased percentage of target population reached.	**Data Source**: Health Promotion Program Worksheet **Milestone 9 [I-8]:** Increase access to health promotion programs and activities using innovative project option. **Metric [I-8]**: Increased percentage of target	**Data Source**: Health Promotion Planning Worksheet **Milestone 12 [I-8]:** Increase access to health promotion programs and activities using innovative project option. **Metric [I-8]**: Increased percentage of target population reached.

Old ID: 119874904.2.1 *NEW ID: 119874904.2.3*	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
project. Denominator: Number of individuals in the target population. **Goal:** Established baseline **Data Source**: Documentation of baseline	Numerator: Number of individuals of target population reached by the innovative project. Denominator: Number of individuals in the target population. **Goal:** 35 person over baseline increase in program	population reached. Numerator: Number of individuals of target population reached by the innovative project. Denominator: Number of individuals in the target population. **Goal:** 70 person over baseline	Numerator: Number of individuals of target population reached by the innovative project. Denominator: Number of individuals in the target population. **Goal:** 105 person over baseline increase in program

Old ID: 119874904.2.1 NEW ID: 119874904.2.3	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.	
Faith Community Hospital, Jacksboro, Texas				*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment (maximum amount):	attendance **Data Source**: Health Promotion program attendance records **Milestone 4** Estimated Incentive Payment (maximum amount): *$ 219,777.00* **Milestone 5** Estimated		increase in program attendance **Data Source**: Health Promotion program attendance records **Milestone 7** Estimated Incentive Payment (maximum amount): *$ 222,025.00*	attendance **Data Source**: Health Promotion program attendance records **Milestone 10** Estimated Incentive Payment (maximum amount): $ 190,220.33 **Milestone 11** Estimated

Old ID: 119874904.2.1 *NEW ID: 119874904.2.3*	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
$ 189,620.67 **Milestone 2** Estimated Incentive Payment (maximum amount): *$ 189,620.67* **Milestone 3** Estimated Incentive Payment (maximum amount): *$ 189,620.66*	Incentive Payment (maximum amount): *$ 219,777.00* **Milestone 6** Estimated Incentive Payment (maximum amount): *$ 219,777.00*	**Milestone 8** Estimated Incentive Payment (maximum amount): *$ 222,025.00* **Milestone 9** Estimated Incentive Payment (maximum amount): *$ 222,025.00*	Incentive Payment (maximum amount): $ 190,220.33 **Milestone 12** Estimated Incentive Payment (maximum amount): $ 190,220.34

Old ID: 119874904.2.1 NEW ID: 119874904.2.3	**2.6.3**	**2.6.3**	*Health Literacy by Faith* Engage community health workers in an evidence-based program to increase health literacy of a targeted population.
Faith Community Hospital, Jacksboro, Texas			*119874904*
OD-12: Primary Care and Primary Prevention *119874904.3*	*IT-12.1* *IT-12.2* *IT-12.4*	*New I.D. 119874904.3.5* *Old I.D. 119874904.3.1* *New I.D. 119874904.3.6* *Old I.D. 119874904.3. 2* *New I.D. 119874904.3.7* *Old I.D. 119874904.3.3*	*Health Promotion by Faith* **Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ ***568,862.00***	Year 3 Estimated Milestone Bundle Amount: ***$ 659,331.00***	Year 4 Estimated Milestone Bundle Amount: ***$ 666,075.00***	Year 5 Estimated Milestone Bundle Amount: ***$570,661.00***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: ***2,464,929.00***			

Summary Information: Faith Community Hospital

Pass 3 Project: 119874904.2.2

Provider: Faith Community Hospital is a 40-bed hospital in Jacksboro, Texas, serving a 920 square mile area and a population of approximately 9,044.

Intervention(s): ED Care Transitions staff will provide patient follow up after ED use applying elements of the Care Transitions Program by Dr Eric Coleman. There is no other federal funding being used for this program. This program is solely managed by Faith Community Hospital and is not a collaborative effort with any other entity. This program aligns with the RHP 19 goal to transform healthcare for the total population through patient education regarding appropriate ED use to receive the right care, at the right time, and in the right setting.

Need for the project: According to the County Health Rankings conducted by the University of Wisconsin in 2011, Jack County residents ranked 76th percentile in clinical care and 53rd percentile (1 being the best) in health behaviors. Medicaid and Uninsured Target population: Fifteen percent of people in Jack County fall below the poverty line. Sixteen percent of people are poor, defined as living below two times the national poverty level. In Jack County, 1672 residents were enrolled in Medicaid as of December 2011. Compared to Texas as a whole, Jack County has similar percentages of people who lack access to healthcare.

Category 1 or 2 expected patient benefits: The goal of ED Care Transitions is to improve care level transition after ED use by providing assistance linking patients to resources necessary to manage care safely at home and prevent high use of ED services. The target populations will be all patients with Medicaid, uninsured, and those with ambulatory care sensitive conditions regardless of payer source. Our aim is to assist patients in obtaining the resources (medication, equipment, transportation, interpretation, further teaching, etc.) necessary to achieve successful care at home and with a primary care provider.

Our goal is to reduce the number of patients with ambulatory care sensitive conditions returning frequently to the ED. We are currently determining our baseline and estimate that approximately 80% of an average 2400 ED visits per year are uninsured or Medicaid patients. The plan projects a decrease from baseline of 50 high users of ED services with ambulatory care sensitive conditions in DY3; decrease from baseline of 100 patients in DY4 and a decrease from baseline of 200 patients in DY5. Annual non-emergent emergency department visits are approximately 2,400 visits per year. A potential limitation to this program is that there is not a local urgent care clinic level of care to divert patients to from the ED. Faith Community Hospital does not have the space or resources to establish such a clinic.

Category 3 outcomes: The majority of our non-emergent visits were patients with Medicaid or were uninsured. During follow up care transitions phone calls, patient teaching will also be provided regarding appropriate ED use, assistance offered how to change to a local Medicaid provider if the patient elects to do so, and how to apply for the hospital's indigent care program if patients meet criteria. This program is solely managed by Faith Community Hospital and is not a collaborative effort with any other entity. This RHP 19 goal to transform healthcare for the total population through patient program aligns with education regarding appropriate ED use to receive the right care at the right time in the right setting. Through the care transition intervention our goal is to develop the care transition program in DY2, and refine the program using Plan, Do, Study, Act system during DY3, and program improvement as evidenced by 100 fewer non-emergent patients seen in DY4 and 200 fewer non-emergent patients in DY5. A potential limitation to this program is that there not a local urgent care clinic level of care to divert patients to from the ED. Faith Community Hospital does not have the space or resources to establish such a clinic.

Emergency Room Care Transitions Category 2.12.2
Faith Community Hospital 119874904.2.2

Project Description

Faith Community Hospital will provide care transition follow up of Emergency Department patients using the evidence-based Care Transitions Program developed by Dr. Eric Coleman. The Emergency Department Care Transition program seeks to reduce future, avoidable emergency department visits by Medicaid and uninsured patients without a primary care provider and all patients that meet ambulatory care sensitive conditions criteria.
The program is based upon four pillars:

1. Medication self-management
2. Use of a dynamic patient-centered record (Personal Health Record)
3. Primary Care and Specialist Follow-Up
4. Knowledge of Red Flags

Patients will be surveyed to determine their access to care needs as part of a series of three (3) weekly follow up calls to determine whether they have acquired prescribed medications or equipment, have any questions regarding discharge instructions, assess understanding of red flags for their condition, and have scheduled a follow up appointment. Upon request, the Transition team will assist the patient to develop a Personal Health Record that they will update and be encouraged to bring with them to appointments.
A Spanish speaking staff member will assist the Transition Coach to translate clinical information for non-English speaking patients and will make the weekly phone calls to all patients. The staff member will meet with the Transition Coach to discuss issues discovered during the phone visits and to review general findings.
Uninsured patients will receive education regarding ways to afford care in area clinics and an evaluation of local and federal programs they may qualify for. Medicaid patients without local primary care providers will be queried whether they need assistance to change to a local provider and information provided upon request.

Challenges/Issues

Internal factors that present challenges to the implementation of this program are:

- the time element of providing the training necessary to educate select staff to provide new services
- the need for a staff member fluent in Spanish
- EHR system requirements necessary to identify and track emergency room patients

A part-time, Spanish speaking employee will be hired and trained to participate in this program. A database will be developed to track patients and their access to the hospital system.
External factors intrinsic to patient access to care are the challenges of patient compliance with instructions and overcoming financial barriers that may prevent the patient from receiving the medication and follow up recommended. Follow up phone call may serve to remind and encourage patients to participate more fully in their post emergency department care.

Starting Point/Baseline

The baseline will be determined during DY2 for this pass 3 project.

Required Quality Improvement

The Emergency Room Care Transitions program will be monitored using the principles of continuous quality improvement. Plan Do Study Act worksheets will be completed at regular intervals to analyze effectiveness of all programs and modifications explored, implemented, and analyzed as needed.

Rationale

CN.5 Need to overcome patient access to care barriers

The ratio of non-emergent to urgent/emergent patients presenting to Faith Community Hospital Emergency Department is approximately 15:3. Many of these non-emergent patients are uninsured, do not have a primary care provider, or may benefit from teaching regarding local health care resources available. According to recent census data, 1in 4 Texans are uninsured. The Healthy People 2020 baseline of persons without a primary care provider is 76.3%.

Misuse of the emergency department results in increased costs for the consumer and potential losses for the hospital in delinquent billing. There is also inappropriate diversion of resources of time and personnel away from urgent/emergent patients in order to meet the needs of patients presenting for routine care.

Relation to Category 3 Outcome Measures

The goal of the Emergency Department Care Transition Program is to reduce the number of all Emergency Department visits, especially patients with ambulatory care sensitive conditions. Patients will be better prepared to seek the right care at the right time and in the right setting through assessment, follow up, and education.

IT-9.2 Reduce all ER visits (including Ambulatory Care Sensitive Conditions)

a.Numerator: Number of high users with ambulatory sensitive conditions identified for care transitions program

b. Denominator: Number of high users with ambulatory sensitive conditions

Relationship to other Projects

Faith Community Hospital is participating in a Health Promotion program. Patients identified through care transition follow up may be linked to various programs available through our health community worker network of programs and volunteers. This project is not related to any other projects within RHP 19.

Project Valuation

Valuation assumes the ER care transition team will establish outreach to over 1,000 patients per year that are at high risk for lack of primary care services and/or are high users of ED services with ambulatory care sensitive conditions. The plan projects a decrease from baseline of 50 high users of ED services with ambulatory care sensitive conditions in DY3; decrease from baseline of 100 patients in DY4 and a decrease from baseline of 200 patients in DY5. Annual

non-emergent emergency department visits are approximately 2,400 visits per year. A potential limitation to this program is that there is not a local urgent care clinic level of care to divert patients to from the ED. Faith Community Hospital does not have the space or resources to establish such a clinic.

IMPLEMENT CARE TRANSITIONS PROGRAM 119874904.2.2	**2.12.2** Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.	**P-1** DEVELOP PROTOCOL **P-2** IMPLEMENT **P-4** ESTABLISH LINKS **P-7** DEVELOP STAFFING **P-11** WEEKLY REVIEWS	*Emergency Room Care Transitions*
Faith Community Hospital, Jacksboro, Texas			*119874904*
Related Category 3 Outcome Measure(s): *119874904.3.4*	*IT-9.2*	*119874904.3.4*	Reduce all ER visits (including Ambulatory Care Sensitive Conditions)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions **Metric [P-1.1]**: Establish care transitions protocols	**Milestone 5 [P-2]**: Implement standardized care transition processes **Metric [P-2.1]**: Care transitions policies and procedures **Data Source**: Policies and procedures of care transitions program materials **Goal**: 1 care transitions policy and procedure manual	**Milestone 8 [P-2]**: Implement standardized care transition processes **Metric [P-2.1]**: Care transitions policies and procedures **Data Source**: Policies and procedures of care transitions program materials **Goal**: 1 annual review of care transitions policy and procedure manual	**Milestone 11 [P-2]**: Implement standardized care transition processes **Metric [P-2.1]**: Care transitions policies and procedures **Data Source**: Policies and procedures of care transitions program materials **Goal**: 1 annual review of care transitions policy and procedure manual

Data Source: Submission of protocols, Care transitions program materials **Goal**: 1 protocol set based upon the Care Transitions Program **Milestone 2 [P-4]**: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge **Metric [P-4.1.]**: Care transitions assessment **Data Source**: Care transitions assessment and resource planning documents **Goal**: 1 comprehensive listing of local support network **Milestone 3 [P-7]**: Develop a staffing and implementation plan to accomplish the goals/ objectives of the care transitions program **Metric [P-7.1.]**:	**Milestone 6 [P-11]**: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric [P-11.1.]**: Number of new ideas, practices, tools, or solutions tested by each provider. **Data Source**: Plan, Do, Study, Act worksheets **Goal**: 3 quarterly Plan, Do, Study, Act worksheets **Milestone 7 [I-12]**: Reduce the percentage of high users of ED services with ambulatory care sensitive conditions **Metric [I-12.1.]**: Identify high users with ambulatory care sensitive conditions.	**Milestone 9 [P-11]**: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric [P-11.1.]**: Number of new ideas, practices, tools, or solutions tested by each provider. **Data Source**: Plan, Do, Study, Act worksheets **Goal**: 3 quarterly Plan, Do, Study, Act worksheets **Milestone 10 [I-12]**: Reduce the percentage of high users of ED services with ambulatory care sensitive conditions **Metric [I-12.1.]**: Identify high users with ambulatory care	**Milestone 12 [P-11]**: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric [P-11.1.]**: Number of new ideas, practices, tools, or solutions tested by each provider. **Data Source**: Plan, Do, Study, Act worksheets **Goal**: 3 quarterly Plan, Do, Study, Act worksheets **Milestone 13 [I-12]**: Reduce the percentage of high users of ED services with ambulatory care sensitive conditions **Metric [I-12.1.]**: Identify high users with ambulatory care sensitive conditions.

Documentation of the staffing plan. **Data Source**: Staffing and implementation plan. **Goal:** 1 staffing and implementation plan **Milestone 4 [I-12]**: Reduce the percentage of high users of ED services with ambulatory care sensitive conditions **Metric [I-12.1.]**: Identify high users with ambulatory care sensitive conditions. a.Numerator: Number of high users with ambulatory sensitive conditions identified for care transitions program b. Denominator: Number of high users with ambulatory sensitive conditions **Data source**: care transitions program registry, claims, EHR or other provider records.	a.Numerator: Number of high users with ambulatory sensitive conditions identified for care transitions program b. Denominator: Number of high users with ambulatory sensitive conditions **Data source**: care transitions program registry, claims, EHR or other provider records. **Goal**: 50 patient from baseline decrease in high use of ED by users with ambulatory care sensitive conditions **Milestone 5** Estimated Incentive Payment (maximum amount): **$ 100,768.34**	sensitive conditions. a. Numerator: Number of high users with ambulatory sensitive conditions identified for care transitions program b. Denominator: Number of high users with ambulatory sensitive conditions **Data source**: care transitions program registry, claims, EHR or other provider records. **Goal**: 100 patient from baseline decrease in high use of ED by users with ambulatory care sensitive conditions **Milestone 8** Estimated Incentive Payment (maximum amount): **$ 101,154.68**	a. Numerator: Number of high users with ambulatory sensitive conditions identified for care transitions program b. Denominator: Number of high users with ambulatory sensitive conditions **Data source**: care transitions program registry, claims, EHR or other provider records. **Goal**: 200 patient from baseline decrease in high use of ED by users with ambulatory care sensitive conditions **Milestone 11** Estimated Incentive Payment (maximum amount): **$ 83,487.34** **Milestone 12** Estimated Incentive Payment (maximum amount): **$ 83,487.33**

Goal: Baseline number of high users with ambulatory sensitive conditions established **Milestone 1** Estimated Incentive Payment (maximum amount): **$ 69,719.25** **Milestone 2** Estimated Incentive Payment (maximum amount): **$ 69,719.25** **Milestone 3** Estimated Incentive Payment (maximum amount): **$ 69,719.25** **Milestone 4** Estimated Incentive Payment (maximum amount): **$ 69,719.25**	**Milestone 6** Estimated Incentive Payment (maximum amount): **$ 100,768.33** **Milestone 7** Estimated Incentive Payment (maximum amount): **$ 100,768.33**	**Milestone 9** Estimated Incentive Payment (maximum amount): **$ 101,154.66** **Milestone 10** Estimated Incentive Payment (maximum amount): **$ 101,154.66**	**Milestone 13** Estimated Incentive Payment (maximum amount): **$ 83,487.33**
Year 1 Estimated Milestone Bundle Amount: **$278,877**	Year 2 Estimated Milestone Bundle Amount: **$302,305**	Year 4 Estimated Milestone Bundle Amount: **$ 303,464**	Year 5 Estimated Milestone Bundle Amount: **$ 250,462**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: ***$ 1,135,108***			

Summary Information: Hamilton Hospital 110856504

Pass 3B Project 110856504.2.2 (110856504.2.1)

- Provider: Hamilton Hospital is a 25-bed Critical Access Hospital in Olney, Texas serving a 25 square mile radius, including Archer City, with an approximate population of 7,000.

- Intervention(s): We plan to enhance our Physical Therapy area to offer a Wellness program to teach self-management programs. Also we plan to provide fitness classes, including nutrition, to improve and or prevent complications from obesity in teens and adults in rural America. Olney and surrounding areas will benefit health wise from a structured fitness, wellness facility consequently improving health and prevention.

- Need for the project: The need to prevent hospital admissions alone for rural Americans with weight problems is reason enough to want to provide these self-management programs. The next reason is to prevent clinical health issues in our rural teen and adult citizens which are over 10% of our recurring patients, or 180.

- Medicaid and Uninsured Target population: The target population is our citizens that are in need of an organized wellness plan to improve our clinical indicator of obesity. Approximately 25% of our patients are either Medicaid eligible or indigent, so we expect they will all benefit from the program if they participate.

- Category 1 or 2 expected patient benefits: The project seeks to have 7 clients enrolled in our Wellness program in DY4 and 9 in DY5 out of the 180 recurring patients we see each year from our obese population.

- Category 3 outcomes: IT-11.1 Our goal is to address obesity in Minority Populations by increasing participation in a Wellness program from 0% currently to 5% by DY5.

Category 2: Program Innovation and Redesign

Project Option: 2.6.2 Establish Self-Management Programs and Wellness Using Evidence-Based Designs

RHP Project Number: 110856504.2.2 (110856504.2.1)

RHP Performing Provider: Hamilton Hospital-110856504

- **Project Description:** We plan to enhance our Physical Therapy area to offer a Wellness program to teach self-management programs. Also we plan to provide fitness classes, including nutrition, to improve and or prevent complications from obesity in teens and adults in rural America. Olney and surrounding areas will benefit health wise from a structured fitness, wellness facility consequently improving health and prevention. There are currently no programs offered like this to citizens of Olney and surrounding communities. Also, local employers have requested such a place to help maintain healthier staff. Consequently we will be offering nutrition and diabetes classes along with circuit type fitness classes.
  In fact we have read that "in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care." according to Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient Self-management of Chronic Disease in Primary Care. JAMA. 2002; 288(19):2469-2475.
  Lack of equipment, space and personnel for Wellness and fitness programs is hindering us from providing this much needed service. Other lack of resources includes the means to hire and educate staff in the programs needed to accomplish our goal of a healthier community.
- **Starting Point/Baseline:** We will start our Wellness program in January 2013. We currently have 0 client's enrolled and 0 staff hired.
- **Rationale:** We want to establish self-management programs and wellness using evidence-based designs. We want to educate our local community and surrounding service areas on the health benefits of a Wellness program and education to prevent possible admissions and readmissions. CN. 2, High costs associated with preventable hospitalization admissions and readmissions, supports the need for community access to self-management programs and wellness throughout RHP 19. If we can prevent just 1 admission per year we would generate cost savings of at least $5,000; this does not include the savings of outpatient visits that are estimated at over $10,000 per year. During the first quarter of 2012 we had 5 hospital admissions due to complications from obesity; this is why we want to establish this program. Currently, found at http://www.city-data.com/city/Olney-Texas.html, our Adult obesity rate is 26.4% and our low-income preschool obesity rate is at 13.7%.
  - **Required QI:** We will review all charts with obesity diagnosis to trend improvements in health and decrease in admissions.

- **Related Category 3 Outcome Measure(s):** 110856504.3.3 (110856504.3.2)
  This project will address Category 3 OD-11 Addressing Health Disparities in Minority Populations; specifically IT-11.1 Improvement in Clinical Indicator in identified disparity group. As mentioned in my rationale, the need to prevent hospital admissions alone for rural Americans with weight problems is reason enough to want to provide these self-management programs. The next reason is to prevent clinical health issues in our rural teen and adult citizens which are over 10% of our clients. Also, by offering a place locally for people to exercise and enroll in fitness and or nutrition classes we believe that the low-income people will benefit by not having to have the expense of travel to accomplish this and consequently by being healthier will not be burdened by preventable health costs.
    - The indicator we will use will be clients BMI, or Body Mass Index. We will measure clients BMI using their height and weight to determine if they fall within our target population of being obese.

- **Relationship to other Projects:** This will also aid in decreasing ED utilization from our other projects by promoting healthier lifestyles.
- **Project Valuation:** We recently did a strategic plan where we listened to our community leaders express the desire for a wellness center to promote healthy employees. We are answering this by establishing a self-management program with a wellness center and education opportunities. Like mentioned above, the value will be by saving at least $10,000 per year for each obese person that changes their life style through our wellness center. Our baseline is 0 but we will plan on increasing participation each year until DY5 where we plan to have 9 minority or obese patients enrolled. This increase will be monitored by wellness center enrollment. We also value the project by monitoring each client enrolled that has previous hospital admissions to see if hospital usage is decreased.

110856504.2.2 (110856504.2.1)	***2.6***	***2.6.2***	***ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS***	
HAMILTON HOSPITAL				***110856504***
Related Category 3 Outcome Measure(s):	***IT-11.1***	**110856504.3.3 (110856504.3.2)**	***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-3: Implement, document and test an evidence-based innovative project for targeted population. We will offer exercise programs and education classes to the minority and diseased population. <u>Metric 1</u> P-3.1: Document implementation strategy and testing outcomes. Baseline/Goal: We have a baseline of 0 programs or clients/our goal is to prove development of program through contracts and policies. Another goal is to have at least 2 enrollments by end of year 2. The 2 enrollments must be enrolled in an exercise program or education class at the Wellness Center.	**Milestone 2** I-6: Identify 5% of patients in defined population; any obesity related disease and or minority. Offer them the opportunity to receive innovative intervention consistent with evidence-based model. The model will be exercise programs and education classes developed by our Wellness Director. <u>Metric 1</u> I-6.1: 3% of patients will be identified and enrolled in wellness program are being monitored to make sure they are receiving innovative intervention consistent with evidence-based model. (mentioned above) Baseline/Goal: Our baseline is 0/ our goal is 3%, or 5 clients enrolled from the targeted		**Milestone 3** I-8: Increase access to health promotion programs and activities using innovative project option. We will increase availability of the mentioned programs. <u>Metric 1</u> I-8.1: Increase percentage of target population reached. Goal: 4%, or 7 clients. Data Source: Use statistics obtained through school, hospitals, clinics and local health offices to determine number of target population then use the number enrolled to get the percentage. Milestone 3 Estimated Incentive Payment: $140,836	**Milestone 4** I-8: Increase access to health promotion programs and activities using innovative project option. We will increase availability of the mentioned programs. <u>Metric 1</u> I-8.1: Increase percentage of target population reached. Goal: 5%, or 9 clients. Data Source: Use statistics obtained through school, hospitals, clinics and local health offices to determine number of target population then use the number enrolled to get the percentage. Milestone 4 Estimated Incentive Payment: $116,237

110856504.2.2 (110856504.2.1)	***2.6***	***2.6.2***	***ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS***	
HAMILTON HOSPITAL				***110856504***
Related Category 3 Outcome Measure(s):	***IT-11.1***	**110856504.3.3 (110856504.3.2)**	***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)**
Data Source: Contracts with staff and policies of programs. Copies of enrollment applications to verify signed up for exercise and or education classes. Milestone 1 Estimated Incentive Payment : $129,425	population. Data Source: Client charts Milestone 2 Estimated Incentive Payment: $140,297			
Year 2 Estimated Milestone Bundle Amount: $129,425	Year 3 Estimated Milestone Bundle Amount: $140,297		Year 4 Estimated Milestone Bundle Amount: $140,836	Year 5 Estimated Milestone Bundle Amount: $116,237
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIO*:* $526,795				

Summary Information (RHP19): Helen Farabee Center

Pass 3 Project 127373205.2.1

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

- Intervention(s): The goal is to expand the Peer Provider staffing to better meet the needs of the patient population in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties.

- Need for the project: Currently, Peer Provider services are provided by one Peer Provider staff member located in Wichita County who also attempts to provide the services in eighteen additional counties.

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

- Category 1 or 2 expected patient benefits:

    - Complete health risk assessments for 90 clients.

    - Provide peer services to 45 clients.

    - Improve health measures for at least 50% of participants (DY4).

    - Improve health measures for at least 60% of participants (DY5).

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

Pass 3

Project Title: Implement whole health peer support (Peer Support).

Project Option: 2.18.c, 2.18.d, 2.18.e, 2.18.f, 2.18.g

RHP Project Number: 127373205.2.1

RHP Performing Provider: Helen Farabee Center-127373205

1. **Identifying Project and Provider Information:**
    a. **Title of Project:** Implement whole health peer support (Peer Support).
    b. **Unique RHP Project Identification Number (new):** Project [TPI].[Category].[Unique Project Identification Number] 127373205.2.1

2. **Project Description:**
    a. **Describe the project** and how it fits the Project Area and Intervention:

    Currently, Peer Provider services are provided by one Peer Provider staff member located in Wichita County who also attempts to provide the services in eighteen additional counties. The goal is to expand the Peer Provider staffing to better meet the needs of the patient population in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The target population for this project is Adults who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Major Depression, Bipolar Disorder, and Schizophrenia). The project fits within the Project Area in that it involves recruiting and training potential peer providers. The project fits within the Intervention in that the new staff will be implementing peer support services.

    b. **Describe the project goals,** including the purpose of performing a project in this project area

    The goal is to expand the Peer Provider staffing by hiring three Peer Providers in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties to better meet the needs of the patient population in that region. These Peer Providers will use Whole Health Planning and health risk assessment tools in order to improve standardized health measures. The purpose of performing the project within this project area is that recruiting and training are integral to completing the goal.

    c. **Describe any challenges or issues** faced by the performing provider and how the project addressed those challenges

According to the National Alliance on Mental Illness (NAMI)[32], one in 4 people will experience some sort of diagnosable mental illness. One in seventeen people in the United States suffers from a *severe persistent* mental illness. Mental health interventions for these individuals have evolved over the years to include more evidence-based practices such as Peer Service Provision. Peer provision is a new shift in the way mental health centers can provide skills training and rehabilitative services to individuals with mental health needs. For the past few years this service has been provided in a limited capacity by a single Peer Provider employed by the Helen Farabee Center. More Peer Providers are needed to serve more of the Helen Farabee Service area. This project addresses these challenges by hiring and training the staff required to provide Peer Services in an area with limited Peer service.

d. **Describe the 5-year expected outcome** for the performing provider and patients:

The 5-year outcome is to have hired three peer providers for Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties and implement whole health planning for identified consumers resulting in improved standardized health measures for those consumers.

e. **Describe how the project is related to regional goals. (new)**

Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project adds an additional layer of care coordination by providing peers as access points for clients in care. The Peer Model also serves as an important education source for patients (Right Service). The services are provided at community access points and in individual or group settings that meet the needs of consumers (Right Setting). Finally, the services are provided upon an individual's enrollment into services and throughout their treatment period as indicated (Right Time). This project improves patient experience by providing access to providers who have a lived-experience with mental health conditions and who can offer valuable guidance. It improves health by helping identify individuals who require ongoing behavioral health education and/or who have concurrent physical health issues requiring additional coordination efforts. It is designed to reduce costs by utilizing non-degreed specialists who can provide billable services that are designed to improve overall health, thus impacting emergency department or crisis services utilization.

3. **Describe the project's starting point/baseline** [e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.]

There is currently one full time Peer Provider center-wide. There are no consumers receiving Whole Health Planning interventions at any location. The goal is to provide services initially to 45 people.

[32] The High Costs of Cutting Mental Health (www.nami.org)

4. **Rationale:** Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community). With this in mind, please develop narratives that address the following:
    a. **Describe the reason(s) for selecting this project option:**
    On August 15, 2007 the Center for Medicare & Medicaid Services (CMS) issued a statement as part of a letter to state Medicaid offices encouraging the use of State certified peer specialists[33]. Currently, the Texas Department of State Health Services includes Peer Support among other best practices as part of the Texas Resilience and Recovery treatment model[34]. The corresponding milestones and metrics track the changes necessary to place, train, and equip Peer Providers in a location that currently lacks the service.
    b. **Describe the reason(s) for selecting these project components** (if the selected project option includes required core project components, all required core components must included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components were not included)
    Core Component a) was not included since the administrators and key clinical staff at the mental health center have already acknowledged peer specialists as a key component of the Texas Recover and Resiliency mental health system. Core Component b) was not included because the organization has already integrated peer specialist services into its network. This project is an expansion of those services.
    Projects c) through i) were selected since they are integral to the whole health system of care and are areas that have not yet been fulfilled. They will require recruiting of additional peer specialists, training, implementing health risk assessments, identifying patients who have health risk factors, implementing the whole health peer support model, connecting patients to primary car or preventative services, and tracking outcomes.
    c. **Reasons for selecting the milestones and metrics** based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point (new).
    The milestones and metrics were chosen based on the elements required to be in place in order to provide peer-provided whole health services at a new location where none had been provided before. The process requires the recruitment and training of peer specialists, implementing health risk assessments, identifying

[33] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf
[34] http://www.dshs.state.tx.us/mhprograms/RDM.shtm

consumers with modifiable health risks, developing person-centered wellness plans, and tracking improvements in standardized health measures.

d. **Specify the unique community need identification number the project addresses (new)**: [Please refer to the CHNA Needs Table]

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

e. **Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative,** including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services.

   Using Peer Service Provision in our service area an initiative started through the Texas Department of State Health Services and continues within its Texas Resiliency and Recovery model of care. Since specific funding for peer initiatives is absent in the DSHS model, this project enhances the Peer Services model by specifically funding additional peer positions to more effectively meet consumer needs across the service area.

   Required QI: Category 3 Milestones 1 and 2 require dissemination of findings, lessons learned, and best practices to stakeholders. Outcome Improvement targets in years 4 and 5 require increased improvement in quality of life measures for the target population.

5. **Related Category 3 Outcome Measures. (new)** Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures. Explain the reasons/rationale in the narrative below, which should be data-driven, including:
   - Data supporting why these outcomes are a priority for the RHP;
   - Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the outcome measure selected; and/or
   - Explanation of how focusing on the outcomes will help improve the health of low-income populations.

   Outcome Measure #1: IT-10.1 Quality of Life. This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that 1 in 8 of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a Substance Abuse problem. Nearly 41% of these mental disorder and/or Substance Abuse-related visits resulted in hospitalization.

[35]Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate peer support intervention were available. The outcome also reflects any impact peer support services will have in ensuring patients remain in the community. Expansion of the Peer Provider program can foster recovery having a subsequent improvement on an individual's health overall well- being. Peer Service Provision is identified as a clinical Best Practice by the Texas Department of State Health services. Certified Peer Specialists are trained using a curriculum developed by the Appalachian Consulting Group, the leading provider of Peer Specialist training in the United States. Non-degreed, certified Peer Specialists can provide engagement and rehabilitative services which were previously limited only to degreed professionals. The resulting impact is that a Peer Provider network represents valuable clinical interventions at a lower cost to mental health authorities. In a 2004 research review, the Psychiatric Rehabilitation Journal noted studies showing little difference in outcomes resulting from professional versus non-professional (peer) providers. Other studies reviewed in this journal showed a decrease in hospitalizations and shorter hospital stays for clients connected to peer interventions[36]. Given the consistent findings of decreased hospitalization and shortened length of stay combined with the low cost of utilizing paraprofessionals and self-help groups, peer provided services are likely to result in cost savings. A 2008 policy briefing at the National Conference of State Legislatures described an expansion of the health care system through using Community Health Workers (including peer service provision). This briefing described current research which found the Community Health Worker model to be cost-effective, resulting in improved health, more preventative and primary care visits as opposed to urgent care, and fewer hospitalizations[37]. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at 3 months with assessments at 6 months, as measured by the ANSA for 5% of adults receiving peer support services in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

6. **Relationship to other Projects:** Describe how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan.
    a. **Describe the related Category 1 and 2 projects** with the unique RHP project identification number based on the requirements above:
    N/A

[35] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.
[36] Solomon, P. (2004). Peer Support/Peer Provided Services: Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.
[37] Goodwin, K (2008). Community Health Workers: Expanding the Scope of the Health Care Delivery System. *Presentation to National Conference of State Legislators, 2008 Policy Brief.*

b. **Describe the related Category 4 Population-focused improvements** with the unique RHP project identification number based on the requirements above:
N/A

7. **Relationship to Other Performing Providers' Projects in the RHP.** If applicable, list other providers in the RHP proposing similar projects and who will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.
TBD
The target population for this project is Adults who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia). Part of this eligibility includes geographic location limited to Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. We do not believe the project duplicates another provider's intervention for the same target population.

8. **Plan for Learning Collaborative (new):** If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.
N/A
9. **Project Valuation (new):** Describe the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums]. ***Please let us know what information should be included in the addendum.***

We applied a benefit-cost ratio of $3.71 per dollar invested. The closest studies relating to valuation of peer support programs came from Sari et al. (2008)[38] who found the benefit-cost ratio for a peer support program related to preventing adolescent suicide was $3.71 for each dollar invested. Kuyken et al. (2008)[39], in another peer-support program for prevention of adolescent suicide, found a benefit cost ratio of $43 for each dollar invested for Native American Youth. The average benefit cost ratio between these two studies is $23.36, however since our target population contains little or no Native American representation,

[38] Sari, N., de Castro, S., Newman, F.L., & Mills, G. (2008). Should we invest in suicide prevention programs? *The Journal of Socio-Economics 37 (2008),* 262–275.
[39] Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., . . . Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *J Consult Clin Psychol, 76(6)*, 966-978.

we chose the conservative amount of $3.71. We estimate Completing health risk assessments for 90 clients in DY2 and providing peer services to 45 clients in DY3.

127373205.2.1	***2.18.1***	***2.18.C*** ***2.18.D*** ***2.18.E*** ***2.18.F*** ***2.18.G*** ***2.18.H*** ***2.18.I***	**Implement whole health peer support (Peer Support).**	
[The Helen Farabee Center/ Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties]				***[127373205]***
Related Category 3 Outcome Measure(s):	***127373205.3.4***	***3.IT-10.1***	***Quality of Life (Peer Support)***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]:Identify and train peer specialists to conduct whole health classes Metric 1 [P-3.1]:Number of peers trained in whole health planning Baseline/Goal: baseline of 0 peers trained in Whole Health peer support with a goal of 100% Data Source: Training records Milestone 1 Estimated Incentive Payment*:* $221,196.50	**Milestone 3** [P-5]: Identify health risks of consumers with serious mental illness Metric 1 [P-5.1]: Number of consumers identified with modifiable health risks Baseline/Goal: To determine the number of consumers with modifiable health risks so that Whole Health services can be offered and provided Data Source: Internal data base Milestone 3 Estimated		**Milestone** 5 [I-18]: Health Outcomes Metric 1 [I-18.1]: Improvements in standardized health measures for consumers who participate in whole health peer support Numerator: The number of people who participate in whole health peer support and experience improvement in standardized health measures Denominator: The number of people who participate in whole health peer support in the RHP Sites.	**Milestone 6** [I-18]: Health Outcomes Metric 1 [I-18.1]: Improvements in standardized health measures for consumers who participate in whole health peer support. Numerator: The number of people who participate in whole health peer support and experience improvement in standardized health measures Denominator: The number of people who participate in whole health peer support in the RHP Sites.

127373205.2.1	***2.18.1***	***2.18.C*** ***2.18.D*** ***2.18.E*** ***2.18.F*** ***2.18.G*** ***2.18.H*** ***2.18.I***	**Implement whole health peer support (Peer Support).**	
[The Helen Farabee Center/ Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties]				***[127373205]***
Related Category 3 Outcome Measure(s):	***127373205.3.4***	***3.IT-10.1***	***Quality of Life (Peer Support)***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-4]: Select and implement a health risk assessment (HRA) tool Metric 1 [P-4.1]:Number of HRAs completed by consumers Baseline/Goal: baseline of 0 consumers who have completed the HRA tool with a goal of 90 Data Source: Internal data base Milestone 2 Estimated Incentive Payment: $221,196.50	Incentive Payment: $241,356 **Milestone 4** [P-6]: Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors Metric 1 [P-6.1]: Number of participants receiving peer services Baseline/Goal: Baseline of 0 participants receiving services and goal of 45 Data source: Internal records and clinical records		Goal: Improved standardized health measures for at least 50% of identified participants. Data Source: Project Data; Medical Record Data; Participant Surveys Milestone 5 Estimated Incentive Payment: $516,868	Goal: Improved standardized health measures for at least 60% of identified participants. Data Source: Project Data; Medical Record Data; Participant Surveys Milestone 6 Estimated Incentive Payment: $498,941

127373205.2.1	***2.18.1***	***2.18.C*** ***2.18.D*** ***2.18.E*** ***2.18.F*** ***2.18.G*** ***2.18.H*** ***2.18.I***	**Implement whole health peer support (Peer Support).**	
[The Helen Farabee Center/ Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties]				***[127373205]***
Related Category 3 Outcome Measure(s):	***127373205.3.4***	***3.IT-10.1***	***Quality of Life (Peer Support)***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 2 [P-6.2]: Number and quality of person centered wellness plans Baseline/Goal: Baseline of 0 participants receiving services and goal of 45, each with a wellness plan meeting Whole Health program criteria. Data Source: Internal records and clinical records Milestone 4 Estimated Incentive Payment: $241,356			
Year 2 Estimated Milestone Bundle Amount: $442,393	Year 3 Estimated Milestone Bundle Amount: $482,712		Year 4 Estimated Milestone Bundle Amount: $516,868	Year 5 Estimated Milestone Bundle Amount: $498,941

127373205.2.1	***2.18.1***	***2.18.C*** ***2.18.D*** ***2.18.E*** ***2.18.F*** ***2.18.G*** ***2.18.H*** ***2.18.I***	**Implement whole health peer support (Peer Support).**	
[The Helen Farabee Center/ Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties]				***[127373205]***
Related Category 3 Outcome Measure(s):	***127373205.3.4***	***3.IT-10.1***	***Quality of Life (Peer Support)***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,940,914				

Summary Information: Nocona General Hospital

Pass 2 Project 127310404.2.1

- Provider: Nocona General Hospital is a 38 bed acute care hospital located in Nocona, Texas. The hospital currently serves the northern part of Montague County. The county wide population is approximately 19,710. The county currently has 13.2% of its population living below the poverty level with approximately 20% of its residents 65 years and older and approximately 22% under 18 years of age. Charity care for the district runs approximately $400,000 to $500,000 per year.

- Intervention(s): This project will engage the patient to take ownership of his or her healthcare to reduce costly readmissions and reduce potentially preventable events.

- Need for the project: Rural healthcare presents many challenges. One such challenge is the inability to accurately gauge patient understanding of discharge orders and the proper steps to take once at home. The ability to ascertain this information and properly train hospital personnel will not only enable patients to manage their conditions more properly but also reduce the healthcare expense associated with it.

- Medicaid and Uninsured Target population: Approximately 50% of the hospital's emergency room visits are from Medicaid and uninsured patients. By targeting this population with education and empowering them to own their healthcare the hospital fully expects a reduction in the usage of the emergency room for primary care.

- Category 1 or 2 expected patient benefits: The project seeks to improve the patient experience by educating both the patient and provider on the needs of the patient at discharge. The patient will benefit by reduced healthcare expense and the avoidance of future hospitalizations or emergency room visits. Ensuring the number of patients receiving a satisfaction survey is a least: 63 patients in DY2, 127 patients in DY3, 190 patients in DY4 and 317 patients in DY5.

- Category 3 outcomes: Our goal is to improve patient satisfaction scores year over year through increased awareness of patient needs and conditions thus allowing the hospital to meet the future goals of pay for performance programs.

Category 2: Program Innovation and Redesign

Project Option: 2.4 Redesign to improve patient experience
2.4.3 Increased patient satisfaction

RHP Project Number: 127310404.2.1

RHP Performing Provider: Nocona General Hospital-127310404

NOCONA GENERAL HOSPITAL CATEGORY 2 NARRATIVE

- **Project Description:** In order to meet the documented needs of its patient base as reported by the RHP community needs assessment, Nocona General Hospital plans to enhance and expand its patient satisfaction program. By doing so the hospital's goal is to better understand the needs of its unique patient base in order to better care for and provide higher quality of care to those patients. As a small hospital many services are referred to larger urban providers with the capability to provide a more robust patient experience; experiences due to cost constraints NGH is unable to provide at this time. By expanding its satisfaction tools to: 63 patients in DY2, 127 patients in DY3, 190 patients in DY4 and 317 patients in DY5, the hospital plans to elicit comments in order to provide better continuum of care and meet this challenge. Additionally, a system wide patient satisfaction program will be implemented from the top down emphasizing its importance including new employee orientation, public reporting of the hospital scores, individual recognition of documented employee patient satisfaction efforts, and the implementation of needed upgrades based on patient comments. The hospital expected outcomes include an expanded patient base, an improved continuum of care, and improved quality of care. It is the hospital's belief that patient experience is transformational; the goals of which are to engage the patient and create a more patient centered care process. The surveys to be utilized will measure and account for educating patients about his or her treatment options, how to achieve better health outcomes and how to be more engaged and responsible for their own healthcare. It is these transformational goals which tie back to RHP 19's goal of transforming health care in the total population and further advancing the goals of right care, right place, and right time.
- **Starting Point/Baseline:** Currently the hospital has no system in place to adequately document the patient experience. Although patient satisfaction surveys are used, and scores are recorded, documented follow up is not common and the number of patients surveyed is unknown. Therefore, there is no way of knowing who is being reached with the surveys and how best to improve their individual healthcare. Additionally employees are not adequately trained to enhance the patient experience.

- **Rationale:** The community needs assessment for RHP 19 has identified high costs associated with preventable hospital admissions and readmissions (CN.2). The selection of this project will enable a better identification of the needs of patients upon discharge from the hospital. Based on this new collection of information new patient education tools can be developed which can assist in preventing future admissions. Additionally the community needs assessment identified low utilization of preventative services in our region (CN.4). Again, information is power and if the hospital is better able to ascertain through surveys the preventative needs of its patient base, the better suited it will be to provide and offer these services. Moreover, the regional community needs assessment also showed high emergency room utilization (CN.8). This need is also met by identifying the needs of the patient through surveys in order to better prepare the patient for post discharge conditions that might arise and when left uncheck may lead to unnecessary emergency room visits.

  Required QI: The hospital currently tracks 30 day readmissions and non-urgent emergency room visits. Once the project is implemented the hospital will easily be able to track the success of the new processes against historical numbers. The hospital would like to be able to track the number of readmissions and unnecessary ER visits. We believe part of the problem with these types of visits is due to patient satisfaction. When a patient is dissatisfied with service this causes a communication breakdown potentially causing a breakdown in the healthcare process, and resulting in ER visits or readmission simply due to not following education due to dissatisfaction.

- As evidenced by the continued push to move to a pay for quality system by most payers, Nocona General believes an initial step to a successful transition is the ability to ascertain and act upon the needs of its patients. Over the course of this project, as identified in Project Option 2.4.3, increased patient satisfaction, we expect to implement innovative processes that will lead to a better understanding of the patient experience thus leading to better patient satisfaction and the ultimately to the region's goal of transforming healthcare.

- **Related Category 3 Outcome Measure(s):** OD-6 Patient Satisfaction
  IT-6.1 Percent improvement over baseline of patient satisfaction scores
  These measures were chosen due to the priority being placed on quality of care outcomes and the coordination of care between providers especially between the RHP providers. Additionally, as stated, payment systems are moving towards this type of system. Focusing on a top down and fully integrated quality driven program, focusing on the needs of the patient while as a patient and post discharge will not only increase patient satisfaction but should also reduce the cost of healthcare by reducing the number of readmissions. This is especially true with the low income population as members of that group may not have the ability to adequately follow up on discharge instructions on their own.

- **Project Valuation:** The valuation of the project was based on the consideration of adding key executive staff to efficiently and effectively install a successful patient satisfaction program. Additionally, the cost of implementing the process such as new survey questions and follow up personnel has been considered for the disbursement of surveys to 63 patients in DY2, 127 patients in DY3, 190 patients in DY4 and 317 patients in DY5. Moreover, once the program has established the requirements to successfully increase patient satisfaction, a valuation has been assigned to these. As a taxing hospital district, the community benefit of such a project will most certainly reduce the cost of healthcare to the taxpayers by reducing the number of readmissions, identifying preventative care needs, and reducing the most costly healthcare, emergency room utilization. Healthcare is a regional issue, and as such, a significant valuation must be placed on the project in order to better educate and serve not only the patient base of Nocona General, but also, the regional population.

127310404.2.1	***2.4.3***	***2.4.3***	***REDESIGN TO IMPROVE PATIENT EXPERIENCE***
Nocona General Hospital			***127310404***
Related Category 3 Outcome Measure(s):	***IT-6.1***	***127310404.3.1***	***Patient Satisfaction***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1. Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance P-1.1. Metric: Documentation of an executive assigned responsibility experience performance Data Source: Org Chart or job description (if percentage of time) Baseline/Goal: Establish which executive position will be responsible for experience performance and update job description to match. Executive will review 63 patient satisfaction surveys and compile results.	**Milestone 2** P-3. Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. P-3.1. Metric: Documentation of committee proceedings and list of committee members Baseline/Goal: Establish the necessary committee members to effectively implement improvements in experience. Committee will review 127 patient satisfaction surveys and compile results.	**Milestone 3:** P-8. Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data. P-8.1. Metric: Develop a new patient experience survey tool or revise and improve the current ones. Baseline/Goal: Develop one new inquiry method/question. Data Source: Documentation of inquiry materials. Milestone 3 Estimated incentive amount payment: $55,289.50 **Milestone 4:**	**Milestone 5:** I-16: Improve patient satisfaction/experience scores Metric 1-16.1 Percent improvement of patient satisfaction scores for a specific tool over baseline Baseline/Goal: Administer 317 patient satisfaction surveys and tabulate scores to compare baseline results of DY 4. Milestone 5 Estimated incentive payment (maximum amount): $94,741

127310404.2.1	***2.4.3***	***2.4.3***	***REDESIGN TO IMPROVE PATIENT EXPERIENCE***	
Nocona General Hospital				***127310404***
Related Category 3 Outcome Measure(s):	***IT-6.1***	***127310404.3.1***	***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: Updated job description. Milestone 1 Estimated Incentive Payment (maximum amount): $94,422	Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members Milestone 2 Estimated Incentive Payment: $109,448		I-16: Improve patient satisfaction/experience scores Metric 1-16.1 Percent improvement of patient satisfaction scores for a specific tool over baseline. Baseline/Goal: Administer 190 patient satisfaction surveys and tabulate scores to compare to results from DY3. Milestone 4 Estimated incentive amount payment: $55,289.50	
Year 2 Estimated Milestone Bundle Amount $94,422	Year 3 Estimated Milestone Bundle Amount: $109,448		Year 4 Estimated Milestone Bundle Amount: $110,579	Year 5 Estimated Milestone Bundle Amount: $94,741
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $409,190				

Summary Information: North Texas Medical Center

Pass Anchor Project 121777003.2.1

- Provider: North Texas Medical Center is a 60 bed Hospital in Gainesville Texas serving a 583 square mile area and a population of approximately 40,000.

- Intervention(s): NTMC will assemble a dedicated care transitions team including representation from the following disciplines; case managers/discharge advocates, dietitians, pharmacists, and social workers. This team will serve both hospital inpatients and emergency department patients. Through this care transitions program we will implement a discharge planning program and post discharge support program to assist patients make smooth changeover from the ED/inpatient setting to the appropriate non-hospital setting. Services provided will include;
  - Medication reconciliation and training
  - Follow-up appointments with an appropriate provider soon after discharge
  - Nutrition counseling
  - Post-discharge phone support
  - Connections to appropriate social agencies in the community

- Need for the project: North Texas Medical Center along with Denton hospitals face major challenges with readmissions as evidenced by a position in lowest 10% statewide of 30 day readmissions during fiscal year 2010. Texas Medical Foundation Health Quality Institute as the Quality Improvement Organization for Texas invited NTMC to participate in a regional (Gainesville & Denton) effort to improve readmission rates of NTMC, Denton Presbyterian, and Denton Regional hospitals. We have no case managers and no staff with experience in case management and discharge planning.

- Medicaid and Uninsured Target population: The target population will be patients with the top three conditions - that result in 30-day readmissions at NTMC. Since our inpatients are approximately 20% Medicaid and uninsured and our ED patients are approximately 55% we expect they will benefit from 20% of the inpatient and 55% of the ED care transitions interventions. With these interventions we expect that the Medicaid and uninsured patients will see less frequent readmissions and ED visits.

- Category 1 or 2 expected patient benefits: The project seeks to provide care transitions services to a minimum of 200 inpatients in DY4 and 300 inpatients in DY5 with the top three conditions (determined in DY2) that result in 30-day readmissions at NTMC. Additionally the care transitions program will serve 150 ED patients in DY4 and 250 ED patients in DY5.

- Category 3 outcomes: IT-3.1 All Cause 30-day readmission rate will be decrease by a TBD amount by DY5.

Project Option 2.12.1 : Implement Care Transitions Program

Unique Project ID#: 121777003.2.1
Performing Provider Name/TPI: North Texas Medical Center, TPI: 121777003

Project Description:
NTMC would like to implement a care transitions program to target patients with high risk of readmission.

The time period between the inpatient and outpatient setting following hospital discharge is a critical period for patients due to discontinuities in health care. NTMC would like to implement/expand a care transition program to create a smooth transfer of care from the ED and/or inpatient to outpatient or other alternative settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable admission following an ED visit and inpatient readmissions.

North Texas Medical Center along with Denton hospitals face major challenges with readmissions as evidenced by a position in lowest 10% statewide of 30 day readmissions during fiscal year 2010. Texas Medical Foundation Health Quality Institute as the Quality Improvement Organization for Texas invited NTMC to participate in a regional (Gainesville & Denton) effort to improve readmission rates of NTMC, Denton Presbyterian, and Denton Regional hospitals. This effort is based primarily on components of Project Red. These efforts began in fall of 2011. We have tried to implement the program by spreading out the duties among existing pharmacy, nursing, and quality management staff that are already overburdened with tasks and cannot give this the priority it deserves. We have no case managers and no staff with experience in case management and discharge planning. Additionally, our original conception did not include ED patients.

Goals & Relationship to Regional Goals:
NTMC will assemble a dedicated care transitions team including representation from the following disciplines; case managers/discharge advocates, dietitians, pharmacists, and social workers. This team will serve both hospital inpatients and emergency department patients. Through this care transitions program we will implement a discharge planning program and post discharge support program to assist patients make smooth changeover from the ED/inpatient setting to the appropriate non-hospital setting.

Project Goals:
- Increase the number of patients served by a care transitions program
- Decrease all cause readmissions

This project meets the following regional goals:
- Transform healthcare for the total population
- Further advance the goals of the Triple Aim: right care, right place, right setting.

Challenges:
Poor communication among outside facilities, home care agencies, and the hospital; very few primary care practices accepting new Medicaid or uninsured patients; and the lack of personnel infrastructure to implement post discharge planning and follow-up from ED or inpatient settings are all barriers to improving care transitions for our patients. This project will address these challenges by;

- Improving communications among outside facilities, home care agencies, and the hospital via a cross continuum team.
- Increasing personnel infrastructure to include case managers, social worker(s), a dietitian, and a pharmacist to implement post discharge planning and ED follow up.
- NTMCs other project, expanding primary care will provide a primary care home for patients who are unable to get into other local primary care practices.

5-Year Expected Outcome for Provider and Patients:
By DY4 we expect to serve a minimum of 200 patients with the top three conditions (determined in DY2) that result in 30-day readmissions at NTMC, through the care transitions program. In DY5 we expect to serve an additional 100 patients for a total of 300 patients in DY5. The care transitions program will serve 150 ED patients in DY4 and 250 ED patients in DY5.

Starting Point/Baseline:
NTMC began planning a care transitions program early in 2012; however it has not yet been fully developed or implemented. Therefore the baseline for number of target population served by a care transitions program at NTMC is zero.

Rationale:
Case Managers/Discharge advocates will help patients and their families make a smooth transition from the ED or inpatient to the services they will need after discharge. Services provided by the Care Transitions team will include:

- Medication reconciliation and training
- Follow-up appointments with an appropriate provider soon after discharge
- Nutrition counseling
- Post-discharge phone support
- Connections to appropriate social agencies in the community

A project to develop a strong care transitions team is needed in Cooke County. A project of this kind is the first and best step in reducing the high percentage of readmissions (17.8% overall 2011) at NTMC. Elderly patients are often less health literate and need help navigating the healthcare system. The increased elderly population (16% Cooke County, 10% Texas) and high rates of chronic conditions such as diabetes, heart disease, and pulmonary conditions make this doubly important.

Project Components:

- **Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc)** – NTMC will take a step back and review best practices to ensure that we are using methods best suited to our patient population, both inpatients and ED patients.
- **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 State Action on Avoidable Re-hospitalizations (STAAR tool) and patient interviews.** – NTMC has done an initial chart analysis of 30 charts and identified some areas for intervention. Chart review continues on a monthly basis to evaluate program performance and opportunities for improvement.
- **Integrate information Systems so that continuity of care for patients is enabled** – NTMC will explore the gap of information regarding the patient's care in the hospital and then back in the clinic, home health, skilled nursing units, and nursing homes. We will identify barriers to access to this information and work with a patient's provider mix to combine/create a care record which would increase the quality and appropriate care post discharge.
- **Develop a system to identify patients being discharged potentially at risk of needing acute services within 30-60 days.** – We currently are using the LACE tool to identify patients at risk of needing acute services within 30-60 days. We have been unable to see that all patients identified are getting appropriate discharge planning and post discharge support. As part of our review of best practices we will verify that this is the best tool for us or pick a more appropriate tool and develop an algorithm of how to appropriately respond to a given score.
- **Implement a discharge planning program and post discharge support program** – NTMC had developed a plan but virtually no implementation has occurred due to staffing constraints. NTMC will put together a care transitions team whose job is to review what was planned, make any needed changes, document needed procedures, train as needed, and implement the program.
- **Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers**. – We have begun this process, but have not connected with all key organizations (most importantly pharmacies & DME companies) . We will continue this process.

Required QI

- **Conduct quality improvement for project using methods such as rapid cycle improvement**. – We will conduct QI projects to test the effectiveness and improve the quality of our program.
- **Learning collaborative** - North Texas Medical Center is expecting to participate in learning collaborative with United Regional Healthcare System and Faith Community Hospital to share ideas, promote continuous learning and exchange best practices in

order to improve performance. The collaborative will invite all interested providers from region to be included and collective actions are expected to be formulated.

Unique community need identification numbers the project addresses:

- CN.1 High rates of chronic disease including cancer, diabetes, heart disease, respiratory diseases, and obesity,
- CN.2 High costs associated with preventable hospital admissions and readmissions, and
- CN.5 Need to overcome patient access to care barriers

all support the need for a robust care transitions program at North Texas Medical Center.

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

Although it is possible to say we are expanding an existing program we think it should be more correctly viewed as a program development and implementation.

Related Category 3 Outcome Measure(s):

OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs):
IT-3.1 All Cause 30 day readmission rate – NQF 1789

- Rate 1: Unplanned all-cause 30-day readmission.

Reasons/rationale for selecting the outcome measure:

During fiscal year ending 2010 NTMC had a 40% readmission rate for DRG code 291(Heart failure & shock with MCC) and a 23.5% readmission rate for DRG code 292 (heart failure & shock with cc), these rates included readmission to NTMC and downstream providers. This was our poorest DRG 30 day readmission score. Fortunately many common interventional themes run throughout literature demonstrating successful programs to improve transitions.[40],[41],[42] Further review of NTMCs readmission rate (specifically in "Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2011 Confidential Results for Gainesville Hosp District (d/b/a NTMC) revealed that there are not enough CHF admits or any other single condition at NTMC to support choosing reducing CHF or any other single condition readmission reduction. NTMC would like to replace the CHF readmission reduction project with IT-3.1, all cause 30 day readmission reduction.

Relationship to other Projects:

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[40] Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. Annals of Internal Medicine. 2009; 150:178-187

[41] Balaban RB, Weissman JS, Samuel PA, Woodhandler S. Redefining and redesigning hospital discharge to enhance patient care: a randomized controlled study. JGIM: Journal of General Internal Medicine. 2008;23(8):1228-1233

[42] Hostetter M. Case Study: Reducing Hospital Readmissions Among Heart Failure Patients at Catholic Healthcare Partners. Quality Matters Newletter. 2008: March/April Issue.

Expanding the primary care capacity (unique project ID 121777003.1.1) will provide a place for the care transitions team to refer both ED and inpatients needing primary care.

Category 4 Population-focused Improvement Measures:
NTMC is exempt from category 4 reporting. However we expect that improvements will occur in the following measures.

- RD-2 30 day readmissions
- RD-4 Patient-centered Healthcare

Relationship to Other Performing Providers' Projects and plan for Learning Collaborative:
North Texas Medical Center is at the eastern edge of the region and our care transitions project is focused on North Texas Medical Center emergency department and inpatients to provide additional access care with dedicated care transitions team including representation from the following disciplines; case managers/discharge advocates, dietitians, pharmacists, and social workers. United Regional Healthcare System in Wichita Falls and Faith Community Hospital are the other providers in RHP 19 that have a care transitions project. North Texas Medical Center is expecting to participate in learning collaborative with United Regional Healthcare System and Faith Community Hospital to share ideas, promote continuous learning and exchange best practices in order to improve performance. The collaborative will invite all interested providers from region to be included and collective actions are expected to be formulated.

Project Valuation:
NTMC is the second largest provider of services to the Medicaid and underinsured population of RHP 19. Our performance in the lower tier of hospital readmissions highlights the urgent need for a wide reaching care transitions program. The lack of a care transitions program is resulting in more frequent readmissions, and ED visits, a cost both to our community and beyond. The Agency for Healthcare Research and Quality estimates the mean emergency room expense per visit for 2009 to be $1318.[43] The average hospital charge in Texas for an adult preventable hospitalization is $27,625, certainly a significant portion of these are readmissions. There are ample references in literature with significant saving achievements with the implementation of care transitions programs. Examples include; one readmission or ED visit prevented for every 7.3 subjects receiving project RED interventions,[44] Eric Coleman's care transitions program yielded an mean hospital decrease in patient cost of $2058 per intervention patients vs controls,[45] and Naylor's intervention group showed total Medicare reimbursements for health services of about $0.6 million vs the control group reimbursement

[43] http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?
[44] Jack BW, et al. The Re-Engineered Discharge: A RCT of a Comprehensive Discharge Program. ***Annals of Internal Medicine*** 2009;150: In Press- Feb 2009
[45] Coleman, EA, et al. The Care Transitions Intervention: Results of a Randomized Controlled Trial***. Arch Intern Med***. 2006; Sep 25; 166 (17): 1822-8

of $1.2 million at 24 weeks post discharge.[46] Lack of the program also contributes to increased complications in chronic diseases such as diabetes, heart disease and respiratory disease.

We envision case managers that target the top three readmission conditions primarily for inpatients. In the ED case managers would focus on patients with chronic conditions and without a primary care physician, patients using the ED for nonemergent conditions, and patients using the ED without financial resources. These case managers would be augmented with a dietitian for nutrition consults. We also plan for the dietitian to provide consults to high risk outpatients (diabetics, CHF, pregnant) and nutrition education throughout Cooke County. A pharmacist would also be part of the care transitions team to facilitate medication reconciliation, again both within the hospital and the community. Lastly a social worker would be the conduit to needed services in the community. This care transitions team would bridge the gap between the hospital and community health services such as clinics, home health agencies, and nursing homes. Patients who need help accessing the appropriate medical care would be served by the team, and with their help get the support they need to manage their chronic conditions leading to overall better health, fewer readmissions, and lower costs. The project will provide care transitions services to a minimum of 200 inpatients in DY4 and 300 inpatients in DY5 with the top three conditions (determined in DY2) that result in 30-day readmissions at NTMC. Additionally the care transitions program will serve 150 ED patients in DY4 and 250 ED patients in DY5.

[46] Naylor MD, et al. Comprehensive Discharge Planning and Home Followup of Hospitalized Elders: A Randomized Clinical Trial. ***JAMA***. 1999 Feb 17;281(7): 613-20

121777003.2.1	***2.12.1***	***2.12.1 (A-G)***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***
North Texas Medical Center			*121777003*
Related Category 3 Outcome Measure(s):	*121777003.3.2*	*IT 3.1*	*Decrease All Cause Readmission*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [I-10]: Identify the top chronic conditions (e.g., heart attack, heart failure, and pneumonia) & other patient characteristics (e.g. medical home assignment &demographics such as age) or socioeconomic factors (e.g. homelessness) that are common causes of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of readmissions. Baseline: Currently we think heart failure is our biggest problem. We need to verify that and ascertain what other conditions we need to focus on. Goal: Determine top 3 conditions resulting in highest rate of readmission. Data Source: EHR report/analysis	**Milestone 4[P-2]:** Implement standardized care transitions processes Metric1[P-2.1] : Implement care transitions policies & procedures Baseline: At the beginning of DY2 documented policies and procedures did not exist. Goal: Develop as needed and implement standardized care transitions processes Data Source: Policies & procedures of care transitions program materials Milestone 4 Estimated Incentive Payment: $159,279 Milestone 5 [P-3]: Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address	**Milestone 7** [I-14]: Implement standard care transition care processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to care transitions processes for inpatients Goal: Minimum of 200 patients in target population (top 3 conditions resulting in 30-day readmissions receiving care according to standard protocol. Data Source: Hospital administrative data and the patient medical record Metric 2[I-14.1]: Measure adherence to care transitions processes for ED patients. Goal: Minimum of 150 ED patients receiving care according to standard protocol. Data Source: Hospital	**Milestone 8** [I-14]: Implement standard care transition care processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to care transitions processes for inpatients. Goal: Minimum of 300 patients in target population (top 3 conditions resulting in 30-day readmissions receiving care according to standard protocol. Data Source: Hospital administrative data and the patient medical record Metric 2[I-14.1]: Measure adherence to care transitions processes for ED patients. Goal: Minimum of 250 ED patients receiving care according to standard protocol. Data Source: Hospital administrative data and the patient medical record

121777003.2.1	***2.12.1***	***2.12.1 (A-G)***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***
North Texas Medical Center			*121777003*
Related Category 3 Outcome Measure(s):	*121777003.3.2*	*IT 3.1*	*Decrease All Cause Readmission*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment: $146,935 **Milestone 2** [P-5] Using a validated risk assessment tool, create a patient identification system. Metric1 [P-5.1]:Develop a patient Stratification System Baseline: currently there is no stratification of the LACE tool Goal: Assign protocols to scores of the tool. Data Source: Submission of the risk assessment tool and patient stratification support & description of provider utilization of report findings. Milestone 2 Estimated incentive payment: $ 146,935 **Milestone 3**[P-7]: Develop a staffing and implementation	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] Develop Patient Education protocols Baseline: At the beginning of DY2 no protocols were in existence Goal: Develop patient education materials Data Source: standardized discharge instructions, patient education, & follow-up care Milestone 5 Estimated Incentive Payment: $ 159,279 **Milestone 6** [P-12]: Quality Improvement Milestone:	administrative data and the patient medical record Milestone 7 Estimated Incentive Payment: $ 479, 670	Milestone 8 Estimated Incentive Payment: $ 395,892

121777003.2.1	***2.12.1***	***2.12.1 (A-G)***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***
North Texas Medical Center			*121777003*
Related Category 3 Outcome Measure(s):	*121777003.3.2*	*IT 3.1*	*Decrease All Cause Readmission*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
plan to accomplish the goals/objectives of the care transitions program. Metric 1[P-7.1]: Documentation of staffing plan. Baseline: Currently there is not staffing or implementation plan. Goal: Develop & document staffing and implementation plan. Data Source: Staffing and implementation plan. Milestone 3 Estimated incentive payment: $ 146,935	Participate in face-to-face learning (i.e. meetings or seminars) at least twice yearly 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 provider should publicly commit to implementing these improvements. Metric 1 [P-12.1]: Participate in semiannual 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. Metric 2[P-12.2]: Implement the "raise the floor" improvement		

121777003.2.1	***2.12.1***	***2.12.1 (A-G)***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
North Texas Medical Center				*121777003*
Related Category 3 Outcome Measure(s):	*121777003.3.2*	*IT 3.1*	*Decrease All Cause Readmission*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	initiatives established at the semiannual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented "raise the floor" improvement initiative after the semiannual meeting. Milestone 6 Estimated Incentive Payment: $ 159,279			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 440,806	Year 3 Estimated Milestone Bundle Amount: $ 477,837		Year 4 Estimated Milestone Bundle Amount: $ 479,670	Year 5 Estimated Milestone Bundle Amount: $ 395,892
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,794,205				

Summary Information: Seymour Hospital

Pass 3B Project 138353107.2.2
(Old Pass 1 Project 138353107.2.1)

- Provider: Seymour Hospital is a 49-bed hospital located in Seymour, Texas. We are located within the central portion of Baylor County at the crossroads of seven major highways and have a population of approximately 3,741 people.

- Intervention(s): Our project involves the implementation of a Community Wellness Program

- Need for the project: Our community does not have currently have access to any comprehensive exercise and fitness programs. Additionally, we do not have access to nutritional analysis or educational programs which would highlight the importance of living a healthy lifestyle and reducing risk factors which often lead to chronic illness.

- Medicaid and Uninsured Target population: The target population for this project will be the underserved members of our community which include the elderly, indigent/charity populations, Medicaid/Medicare recipients, uninsured/underinsured and those who face financial or geographical barriers to adequate and appropriate care. Additionally, we plan to target those with diabetes, hypertension and a sedentary lifestyle as well as those who are obese or who would benefit from smoking cessation.

- Category 1 or 2 expected patient benefits: We estimate the patient benefit for our project based upon having at least 10 patients enrolled in our Wellness Center Program by the end of DY5. The expected outcomes for this project will be a measurable decrease in the number of patients with health risks such as obesity, smoking, high blood pressure and a sedentary lifestyle. Additionally, we expect to see an improvement in the control of chronic conditions such as diabetes and CHF.

- Category 3 outcomes: IT-1.7 Controlling High Blood Pressure

J. Category 2: Program Innovation and Redesign

Project Option: *2.6.1 Implement Evidence Based Health Promotion Programs*

RHP Project Number: NEW ID: *138353107.2.2*
*(**OLD ID:** 138353107.2.1)*

RHP Performing Provider: *Seymour Hospital/138353107*

- **Project Description:** *Seymour Hospital plans to implement a Community Wellness Program. This program will be open to the general public with special emphasis on the underserved members of our community which include the elderly, indigent, and charity populations, as well as Medicare/Medicaid recipients, the uninsured/underinsured and those who face financial or geographical barriers to care. Our five county service area includes the counties of Baylor, Foard, Haskell, Knox and Throckmorton counties in North Central Texas and has a cumulative population of approximately 17,179 people. Our project addresses the immediate needs of our community as identified by the Needs Assessment for RHP 19 and will provide a professionally supervised health and fitness program that is designed to optimize healthy lifestyle practices. The first goal of our project is to offer our patients wellness activities to encompass general health, nutrition and exercise in addition to programs which address targeted health issues and chronic conditions such as weight management, diabetes, hypertension, and smoking cessation. The second goal of our project is to provide a documented improvement in the general health of our community through the utilization of our community wellness center. The primary challenge that our facility faces in the implementation of our project is the current lack of community involvement in their own health and fitness. We will need to enhance outreach efforts to our community in order to increase interest and attendance to our wellness center and therefore improve the general health of those we serve. The 5-year expected outcome for our project is a measurable decrease in the number of patients with health risks such as obesity, smoking, high blood pressure and a sedentary lifestyle. This will be documented through patient evaluations both prior to enrollment and then periodically as the patient's recommended plan is completed.*
- **Starting Point/Baseline:** *We do not currently offer any type of wellness program or wellness facility to the members of our community. Health risk factors such as obesity, diabetes, smoking, hypertension and a sedentary lifestyle all contribute to the general decline in the health of our population.*
    - **Rationale:** *Our project was chosen due to the fact that it directly addresses community need CN.1 (High Rates of Chronic Disease, Including Cancer, Heart Disease, Respiratory Diseases and Obesity), which was identified in the Community Needs Assessment for RHP 19 that was conducted in July 2012. By implementing a comprehensive community wellness program, we will be offering our patients and our community increased access to preventative services such as*

physical exercise and fitness, nutritional analysis, educational information on living a healthy lifestyle and reducing risk factors which often lead to chronic illness. Baylor County, which has a population of 3,781, is designated by HRSA as a Medically Underserved Area (MUA) and a Healthcare Professional Shortage Area (HPSA). **Required QI:** *We will review project data and respond to it every week with tests of new ideas, practices, tools or solutions. The 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.*

- **Related Category 3 Outcome Measure(s):**
  - *OD-1 Primary Care and Chronic Disease Management*
    - *IT-1.7, Controlling High Blood Pressure (Standalone Measure)*
    - *138353107.3.5 (138353107.3.2), Seymour Hospital/138353107*
      - *We have chosen this outcome measure due to the fact that monitoring the prevalence of high blood pressure is directly related to the reduction in the mortality rate from heart disease, stroke and renal failure, especially in the elderly population. High blood pressure is often referred to as the "silent killer" due to its lack of symptoms and warning signs. High blood pressure is a significant risk factor for developing cardiovascular disease, which is the leading cause of death in Texas. The higher one's blood pressure is, the greater the risk of heart attack, heart failure, stroke, and kidney disease. A number of actions can be taken to control high blood pressure, including diet, exercise, reduction of salt and alcohol intake and taking medications. Through the implementation of our community Wellness Program, we will have the ability to advise our at-risk patients on effectively combining these activities in order to achieve the greatest impact on their general health and wellbeing.*
- **Relationship to other Projects:** *Each of our projects address the needs of our community, as identified by the Community Needs Assessment for Region 19, which was completed in July 2012.*
- **Relationship to Other Performing Providers' Projects in the RHP:** *N/A*
- **Plan for Learning Collaborative:** *N/A*
- **Project Valuation:** *Through the successful implementation of a community wellness center, we will be able to increase the overall health status of not only our patients, but also our community. We will be able to document measurable improvements in blood pressure, body weight and blood sugar, which will in turn greatly reduce the health risk to those who participate in our wellness program. Healthy living reduces the likelihood of the need for emergent, acute episodic care, which can be more costly when care is delayed for chronic conditions.* We estimate the patient benefit for our project based

upon having at least 10 patients enrolled in our Wellness Center Program by the end of DY5. The total valuation for our project is $841,991.

Project: 138353107.2.2 (138353107.2.1)	***PROJECT OPTION:*** ***2.6.1***	***2.6.1***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS***	
Seymour Hospital				*138353107*
Related Category 3 Outcome Measure(s): *OD-1*	*IT-1.7*	138353107.3.5 (138353107.3.2)	*Primary Care and Chronic Disease Management (Controlling High Blood Pressure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: *P-3* *Implement, Document and Test an Evidence-Based Innovative Strategy and Plan* *Metric P-3.1: Document Implementation Strategy and Testing Outcomes* *a. Data Source: Performing Provider Contract or Other Documentation of Implementation* *b. Rationale/Evidence: Documentation of Implementation Strategy and Testing Outcomes.*	**Milestone 2**: *I-8* *Increase Access to Health Promotion Programs and Activities Using Innovative Project Option.* *Metric I-8.1: Increase Percentage of Target Population Reached* *a. Numerator: Number of Individuals of Target Population Reached by the Innovative Project* *b. Denominator: Number of Individuals in the Target Population* *c. Data Source: Documentation of Target Population*		**Milestone 3**: I-8 Increase Access to Health Promotion Programs and Activities Using Innovative Project Option. Metric I-8.1: Increase Percentage of Target Population Reached a. Numerator: Number of Individuals of Target Population Reached by the Innovative Project b. Denominator: Number of Individuals in the Target Population c. Data Source: Documentation of Target Population	**Milestone 4:** I-8 Increase Access to Health Promotion Programs and Activities Using Innovative Project Option. Metric I-8.1: Increase Percentage of Target Population Reached a. Numerator: Number of Individuals of Target Population Reached by the Innovative Project b. Denominator: Number of Individuals in the Target Population c. Data Source: Documentation of Target Population

Project: 138353107.2.2 (138353107.2.1)	***PROJECT OPTION:*** ***2.6.1***	***2.6.1***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS***	
Seymour Hospital				*138353107*
Related Category 3 Outcome Measure(s): *OD-1*	*IT-1.7*	138353107.3.5 (138353107.3.2)	*Primary Care and Chronic Disease Management (Controlling High Blood Pressure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Implementation of Plan for Community Wellness Center Milestone 1 Estimated Incentive Payment: *$205,921*	*Reached* *d. Rationale/Evidence: This Metric Speaks to the Efficacy of the Innovative Project in Reaching Target Population* Baseline/Goal: Implementation of Community Wellness Center and establishment of baseline of number of wellness center patients (currently 0). Milestone 2 Estimated Incentive Payment: *$224,649*		Reached as Designated in Project Plan d. Rationale/Evidence: This Metric Speaks to the Efficacy of the Innovative Project in Reaching Target Population Goal: Increase the Number of Patients Enrolled in the Wellness Center by 5 New Patients Over DY3. Milestone 3 Estimated Incentive Payment: *$225,302*	Reached as Designated in Project Plan d. Rationale/Evidence: This Metric Speaks to the Efficacy of the Innovative Project in Reaching Target Population Goal: Increase the Number of Patients Enrolled in the Wellness Center by 10 New Patients Over DY3. Milestone 4 Estimated Incentive Payment: *$186,119*
Year 2 Estimated Milestone Bundle Amount: *$205,921*	Year 3 Estimated Milestone Bundle Amount: *$224,649*		Year 4 Estimated Milestone Bundle Amount: *$225,302*	Year 5 Estimated Milestone Bundle Amount: *$186,119*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: *$841,991*				

SUMMARY PAGE: Texoma Community Center: Pass 1 Category 2 Project/084434201.2.1

Brief Description: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 874.76 square miles. TCC has a clinic in Cooke County which has a 2011 population of 33,396 representing a stable population from the previous year. (1a) TCC has four primary clinics providing 10,226 face to face patient encounters(1b) to over 1,200 adults, children, and families who range in age from birth to death with 200 of those patients in RHP 19. Less than 1% of TCC's patients have private insurance and 38% have Medicaid, and 81.34% of adult patients are at or below the federal poverty level.

Interventions: Project 084434201.2.1 will implement a new initiative for TCC by incorporating a primary health care provider into the TCC behavioral health system to create a "medical home" for the most "at risk" patients with mental illness and co-occurring chronic physical diseases, and who also have no primary care physician. The initial intervention will be for ½ day per week of integrated care.

Need for the Project: TCC selected this project to expand medical and behavior health services in RHP 19, which is identified by HRSA as an underserved behavioral health provider area. (1b) This project is essential to enhance access to comprehensive care. The WHO (2003) reports outcomes on blended care saying: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." (1h) Lawrence and Kisely (November, 2010) state that: "While much attention has been focused on suicide and homicide which are associated with higher rate ratios, the public health burden associated with major chronic diseases is much higher in people with SMI. The majority of excess deaths in this population are due to physical illnesses, in particular cardiovascular disease, respiratory illness and cancer (Kisely et al., 2005; Lawrence et al., 2001; Leucht et al., 2007)." (1h-a)

Target Population: Approximately 38% of TCC patients have Medicaid and almost 100% are low-income or indigent, which means 62% or 527 current TCC patients are the initial target population.

Category 2 Expected Patient Impact and Benefit: There are an average of 850 adult mental health patients served by TCC staff each month, and 527 (62%) need integrated primary and behavioral health services. Of these 527, 38% have Medicaid, leaving about 93 unfunded, uninsured adult patients (18%) who reside in RHP 19, specifically Cooke County. Since integrated care will be new to TCC, we initially intend to provide ½ day of primary/preventive care through this project, to be shared among three counties, allowing for about 48 patient encounters per month at an average of 17 minutes per patient which, according to a Medscape Physician Compensation Report (2011), is the time most physicians spend with patients.(h-b) Since the RHP 19 patients make up 18% of the total, and depending on frequency of return appointments, that allows for about 12 patient encounters per month for RHP 19 (104 per year) for Cooke County. DY 3 improvement target is for 104 patient encounters to occur (for approximately 93 targeted patients) which will then become the baseline for DY 4 and 5. Improvement targets in DY 4 and DY 5 are 25% (130) and 40% (146) increased encounters respectively for a total patient impact of 380 new integrated health care patient encounters for a valuation of $367,694.00.

Category 3 Outcomes: TCC's selected Category 3 IT-10.1 Quality of life- goal is to improve the quality of life for TCC's most "at risk" patients with co-occurring mental and physical health problems reducing the use of more expensive health services. QALY improvement targets will be determined for DY 3 after establishing a baseline in DY 2. It is expected that the savings to the region will be significant based on documented research.

Category 2: Program Innovation and Redesign

RHP Project Number: 084434201.2.1

RHP Performing Provider: Texoma Community Center-084434201
Category 2: Program Innovation and Redesign
Project Title: 2.19 – Develop Care Management Function that integrates primary and behavioral health needs of individuals.

Project Option: - 2.19.1 Project Options: Design, implement, and evaluate care management programs and that integrate primary and behavioral health needs of individual patients

Required core project components:

a) Conduct data matching to identify individuals with co-occurring disorders who are:

- not receiving routine primary care, not receiving specialty care according to professionally accepted practice guidelines,
- over-utilizing ER services based on analysis of comparative data on other populations
- over-utilizing crisis response services
- Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

b) Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation.

c) Identification of BH case managers and disease care managers to receive assignment of these individuals.

d) Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders.

f) Train staff in protocols and guidelines.

g) Develop registries to track client outcomes.

h) Review the intervention(s) impact on quality of care and integration of care and identify"lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Project Description:

Texoma Community Center (TCC) intends to implement a care management system that will integrate the primary physical health and behavioral health care for individuals served by TCC and to broaden the services array. By providing physical health care to those patients receiving behavior health treatment, TCC will address regional needs (CN.2, CN.3, CN.4, CN.5) and enhance regional goals to improve the health of populations in the region, reduce the cost of health care in the region, and improve access to health care in the region. TCC intends to do this by contracting with 1 primary care physician and 1 nurse for four hours per week specifically to treat chronic physical health issues that are co-occurring with TCC's most "at risk" patients. In doing so, TCC commits to researching, establishing protocols, supporting and providing the physical health treatment alongside the psychiatric treatment in an enhanced care management model. To do so, TCC will also need to additionally employ one full-time clerk to manage the medication acquisition through Patient Assistance Applications and other related duties. Providing this service will improve outcomes for behavioral health patients who have complications due to

chronic conditions and insufficient insurance coverage and insufficient support to meet those physical health needs. Accomplishing these goals will help meet regional goals to expand access and improve health care.

TCC patients have significant barriers and limited access to primary care physicians (CN.1) and case managers frequently have trouble finding physicians to prescribe physical health medications for Medicaid or low-income patients, at times putting patients at risk of not having essential medication. Integrating physical health care in this mental and behavioral health clinic will help solve this access problem and contribute to the regional goals to improve quality of care of regional populations, reduce the cost of health care and improve access to health care services.

To accomplish these goals, TCC will implement the **core components** including data matching to identify individuals with co-occurring disorders who are, as the core components describe:

- not receiving routine primary care, not receiving specialty care according to professionally accepted practice guidelines,
- over-utilizing ER services based on analysis of comparative data on other populations
- over-utilizing crisis response services
- becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

TCC will further explore and implement a chronic care management best practices protocol that is compatible with organizational readiness. BH case managers will be identified in order to receive assignment of these individuals. Protocols for coordinating care will be written and implemented and community resources and services that are available for supporting people with co-occurring disorders will be identified. Staff will be trained in protocols and guidelines and a registry to track client outcomes will be developed. As part of the continuing quality improvement strategies, intervention impact on quality of care and integration will identify the "lessons learned," explore opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety-net populations.

The five-year expected outcome is that current and new patients served by TCC will have quick access to both physical health treatment and psychiatric and behavioral health treatment at this center such that the most "at risk" patients will experience a quality of life improvement, improve their overall health and stabilize to reduce unnecessary emergency department visits and hospitalizations. Regional goals to expand access, improve health of individuals, reduce costs and improve quality of health care across the region will be met.

Baseline Data and Project Starting Point:

Currently TCC does not provide any physical health treatment except for vital sign monitoring at the time of psychiatrist visits, with the exception of the ACT patients, who have access to a RN at all times for assessing physical problems. However, when physical health issues are evident, the actual treatment must be referred out to area physicians who are rapidly opting out of providing services to Medicaid patients and more often don't provide services to indigent patients. Therefore, the initial baseline for treating physical health issues that are co-occurring with psychiatric issues for TCC's high utilizer patients would be zero. Being able to quickly and efficiently coordinate physical and psychiatric health care within the same facility for even a few "at risk" TCC patients, and establish that medical home, would be a significant improvement in service quality, accessibility and improve outcomes.

Rationale:

TCC chose this particular project because individuals with severe and persistent mental illness have difficulty accessing resources for all of their needs, including their basic health care needs. They encounter transportation problems, organizational problems and communication problems. They often have chronic medical conditions along with their mental illness; therefore their health and psychiatric stability is easily compromised. Coordinating and providing primary physical health care at the same facility where their behavioral health needs are treated will increase the care they receive for physical health issues as well. This endeavor is a completely new initiative for TCC. Individuals who are the most "at risk," where both the psychiatric issues and chronic physical issues are concerned tend to be high utilizers of emergency rooms, psychiatric hospitals and physical, acute care hospitals. Their overall level of functioning tends to be lower than the general population. Therefore, offering and supporting physical health treatment simultaneously with their psychiatric needs at TCC's behavioral health clinic would significantly reduce their risk factors and increase their overall stability, thus reducing their use of high dollar facilities. Texoma Community Center has already provided evidence and data with our own ACT patients showing increased support reduces hospitalizations and ER visits. The reduction of psychiatric hospitalization of these high utilizer patients from 1.8% being hospitalized in 2007 down to 0% in 2010 was in part due to the ACT team model including physical health awareness by: (1) having an RN on the case load who knows all ACT patients and regularly evaluates their physical health needs; (2) case manager's being made aware of physical health issues and supporting these clients in addressing physical health issues in addition to their psychiatric needs and then ensuring that they are transported to physical health appointments as needed. (32) The "wraparound" style of services for the ACT team has improved the psychiatric and physical health of these patients and supports the evidence that this ACT model of service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar utilization of ERs and hospitals. Having the opportunity through this Project to further broaden this style of service delivery to additional patients utilizing TCC's services would refine and enhance the cost reduction for area hospitals while improving patient outcomes, as well as overall global functioning and quality of life. (CN.1, CN.2, CN.3, CN.5).

It is specifically noted that one of the "Core Components" for this Project Option (2.19.1) has been omitted from TCC's Project Plan. The component omitted was "e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression and asthma." The reason for this omission is that TCC's medical staff's area of practice is specifically psychiatry and it is believed that trying to implement physical health guidelines at this point is beyond the scope of practice. While it is the purpose and intent of this project to expand the scope of practice to treating physical health issues "in house," it is further believed that initially, it will be important for the treatment primary care physician and nurse to have time to integrate into a new environment and treatment model and to focus the limited available hours to seeing patients rather than implementing new disease management guidelines. It is believed that in hiring a well-qualified primary care physician and nurse, the ability to adequately address disease management issues will be within their expertise brought to the center. This is not to diminish the value of developing evidence-based practices and implementing those best-practices guidelines in any way, but simply to be successful over time in making a paradigm shift away for a specialty practice of psychiatry to a more blended "whole person" treatment utilizing ALL best-practices guidelines. It is expected that as this blending of primary care and behavioral health care services is established and then expands, and potentially increasing physician and nurse time, then it will be the time to focus on identifying and implementing more refined disease management guidelines and protocols.

It is believed that by adopting and implementing all of the other Core Components, the groundwork will be established and supported for then incorporating more refined disease management protocols. TCC is committed to breaking new ground into this area of blending primary care and specialty care, and to researching best-practices guidelines in all areas of treatment. By implementing the other Core Components

in this project, this lays the groundwork for further growth into the identification and implementation of additional disease management guidelines as well as venturing into chronic disease registry data sharing in the future.

Related Category 3 Outcome Measure(s):

OD-10 Quality of Life/Functional Status
IT-10.1 Quality of life- (standalone measure)

d. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
e. Data source: Assessment of Quality of Life Tool Data Results
f. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life (QOL) and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

The Quality of Life/Functional Status outcome domain is appropriate for this projects because, again, mental/behavioral health is adversely impacted by physical health issues, and vice versa. Both reduce a patient's ability to function which adversely affects quality of life issues. Both physical and mental health problems negatively impact a person's independent living, relationships, sense of self-worth and lead to costly emergency treatment. By focusing on assessment of QOL and functional status, we will be able to determine the efficacy of combining primary care and behavioral health care treatment at one facility. The World Health Organization (WHO) issued a report called "Integrating mental health into primary care: A global perspective" and pointed out that by blending mental health treatment and primary care treatment, patients "avoid indirect costs associated with seeking specialist care in distant locations….. [and] integrating mental health services into primary care generates good health outcomes at reasonable costs."(33) Improving access to primary physical health while simultaneously providing mental health services will, indeed, help the low-income population served in Cooke County by TCC achieve a better quality of life, reduce high dollar hospital costs and achieve positive patient outcomes.

Relationship to other Projects:

This project supports, reinforces and relates to expanding telehealth services (084434201.1.1), expansion of substance abuse services (084434201.1.2) , and expanding counseling services to non-priority populations (084434201.1.3) in an integral way. Adding primary physical care to a more comprehensive behavioral health treatment program will create a complete wellness opportunity for those served (CN.1, CN.5). Successful development and implementation of this project will be facilitated by the other projects through streamlining information exchange and collaboration between the proposed projects. This will allow for a multi-modal

approach to comprehensive healthcare for unfunded, underfunded and underserved members of our community (CN.1, CN.2, CN.3, CN.4, CN.5) which will assist in meeting the regional health care goals to improve quality of care, improve patient satisfaction, improve the health of populations, reduce the cost of health care and improve access to health care services. Integrating primary and behavioral health care facilitates preventive treatment and a reduction in more costly and inefficient repetition of services, and supports regional goals.

Relationship to Other Performing Providers' Projects in the RHP:

The primary relationship this Project will have to the other Projects in RHP 19 is one of collaboration, sharing of data and information, and referrals as appropriate. While there are no specific TCC projects that are combined in implementation with other providers in the region, this project specifically lends itself to future collaboration as the potential to work with physical health providers blends into a holistic, patient-centered care model. Discussion has already begun with several health care providers in RHP 19, including health clinics and hospitals participating in the DSRIP service enhancement program, and a more formal collaboration is in the future. TCC will, indeed, be a part of collaboration and sharing data, knowledge and experiences with other with other stakeholders and providers in RHP 19 in order to enhance best practice models is a definite TCC goal. The need (CN.3) for additional behavioral health providers allows for service expansion, along with physical health providers, without duplicating provider services or even meeting the need fully. Helen Farabee Center and other LMHA's in the region as well as provider hospitals, all have similar goals to enhance services and improve overall health care of patient's across the region.

Plan for Learning Collaborative:

RHP 19 does have current plans to implement a Learning Collaborative within the region, but TCC will individually collaborate with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. Part of TCC's goal is to gather information and bring new knowledge back to the management table to help direct TCC's growth and expansion toward sound, cost-effective, evidence-based practices. Focus in the learning collaborative will be to identify project impacts, what has been learned within the Center and from other entities, and expanding the projects to a broader patient population. In the case of this project, TCC will be expanding, learning and growing into an entirely new territory of combining physical health care with behavioral health care. Addressing key challenges will be done internally and as part of the learning collaborative within the region because TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences. It is important to look for solid solutions that are backed up by evidence-based research, especially in a new area for this center, so that positive outcomes can spread across the region.

Project Valuation:

We have valued this project at $ 367,694.00 based on project size, scope, community benefit, cost avoidance, priority community need, and estimated local funding. According the World Health Organization/Organization of Family Doctors, 2000 publication entitled Integrating Mental Health and Primary Care: A Global Perspective, the lack of coordination of treatment on a world-wide scale is regretful because: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." **(34)** The article also points out that: "Primary care for mental health forms a necessary part of comprehensive mental health care, as well as an essential part of general primary care. However, in isolation, it is never sufficient to meet the full spectrum of mental health needs of the population." **(35)**

As documented in the American Journal of Psychiatry, June 1, 2008, medical costs are approaching 20% of the nation's Gross National Product, and 6.2% of those costs are directly related to mental health issues. **(36)** Persons with severe mental illness often have addictions, such as consuming 44% of all cigarettes smoked, that shorten their lifespan by 13 to 35 years. **(37)** The absence of integrated primary and medical care takes a toll on individuals, their families, their communities, and results in cost that could be greatly reduced if preventative or early medical treatment was used to avoid progression of illnesses to an acute care stage.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained. **(9g)** Using this methodology, 380 patient encounters would be funded through this project at a community health care savings value of about $1,000.00 per encounter and a total value of $367,694.00 to the community.

The patient impact is as follows: There are about 850 adult mental health patients served by TCC staff each month, and 527 (62%) need integrated primary and behavioral health services. Of these 527, 38% have Medicaid, leaving about 93 unfunded, uninsured adult patients (18%) who reside in RHP 19, specifically Cooke County. Since integrated care will be new to TCC, we initially intend to provide ½ day of primary/preventive care through this project, to be shared among three counties, allowing for about 48 patient encounters per month at an average of 17 minutes per patient which, according to a Medscape Physician Compensation Report (2011), is the time most physicians spend with patients.(h-b) Since the RHP 19 patients make up 18% of the total, and depending on frequency of return appointments, that allows for about 12 patient encounters per month for RHP 19 (104 per year) for Cooke County. DY 3 improvement target is for 104 patient encounters to occur (for approximately 93 targeted patients) which will then become the baseline for DY 4 and 5. Improvement targets in DY 4 and DY 5 are 25% (130) and 40% (146) increased encounters respectively for a total patient impact of 380 new integrated health care patient encounters.

Approximately 62% of the adult mental health patients served by TCC are without a third-party payer source for medical care, leaving them to manage illnesses through expensive "band aide" treatment in emergency rooms. **(38)** Additionally, many of the people receiving psychiatric services are placed on powerful psychotropic medications, and are at risk for adverse effects. Although the psychiatric staff do a good job in screening for critical conditions, such as pulmonary and circulatory problems, it is the absence of preventative or stabilizing primary medical care that prompts emergency room visits and hospital care at its highest cost end. TCC's employment of primary medical care staff to treat the most medically "at risk" individuals will create a community value with significant patient impact that far exceeds project costs.

084434201.2.1	PROJECT OPTION: 2.19.1	COMPONENTS: 2.19.1.A.C.D.F.G.H	DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS
Texoma Community Center		084434201	
Related Category 3 Outcome Measure(s): OD-10	084434201.3.5	IT-10.1	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-5 BH case managers are identified & trained for blended care coordination for "at risk" patients with co-occurring mental/physical health needs. P-5.1 Metric: Number of staff identified with the capacity to support the targeted population. Baseline: No staff identified Goal: Necessary number of staff are identified and trained to meet capacity for support of the targeted population. Data Source: Staff rosters and documents of caseloads/training rosters. Milestone 1 Estimated Incentive Payment (maximum amount): $83,442.00	Milestone 2: P-6 Care coordination protocols are developed. P-6.1 Metric - Written protocols are in place and easily available to staff. Data Source: Written protocols Milestone 2 Estimated Incentive Payment (maximum amount): $30,535.00 Milestone 3: P-8 Staff members (1 physician, 1 nurse, 1 clerical) are trained in care coordination protocols and practice guidelines for disorders identified in the data matching. P-8.1 Metric: Increase percentage of staff trained. Baseline: zero percent staff trained Goal: 100% staff trained Data Source: HR records/Training records Milestone 3 Estimated Incentive Payment (maximum amount): $30,535.00	Milestone 5: I-21 -Increase use of routine preventive and primary care visits. I-21.1 Metric - 25% increase in routine visits Baseline: 104 routine visits Goal: 130 or 25% increase in routine preventive and primary care patient encounters occur. Data Source: Encounter/ claims data Estimated 5 Incentive Payment (maximum amount): $ 98,000.00	Milestone 6: I-21 --Increase use of routine preventive and primary care. I-21.1 Metric – 40% Increase in routine visits Baseline: 104 routine visits Goal: 146 or 40% increase in routine preventive and primary care patient encounters occur. Data Source: Encounter/ claims data Milestone 6 Estimated Incentive Payment (maximum amount): $94,667.00

	Milestone 4: I-21 -Increase use of routine preventive and primary care visits. I-21.1 Metric - Increase in number of routine preventive and primary care visits Baseline: zero routine visits Goal: 104 routine preventive and primary care patient encounters occur establishing the baseline for DY 4 & DY 5. Data Source: Encounter/ claims data Milestone 4 Estimated Incentive Payment: $30,535.00 $		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $83,422.00	Year 3 Estimated Milestone Bundle Amount: $91,605.00	Year 4 Estimated Milestone Bundle Amount: $98,000.00	Year 5 Estimated Milestone Bundle Amount: $94,667.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $ 367,694.00			

SUMMARY PAGE: Texoma Community Center: Pass 3 Category 2 Project/084434201.2.2

Brief Description: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties in North Central Texas, including Cooke County that covers 874.76 square miles. Cooke County has a 2011 population of 38,396 reflecting a stable population from the year before. (1a) TCC has four primary clinics providing treatment to over 1,200 individuals, including the approximately 200 in Cooke County, and provides 10,226 face-to-face encounters with adults, children, and families ranging from zero to death. Less than 1% of TCC's patients have private insurance and 38% have Medicaid all close to or below the federal poverty level. (1b)

Interventions: This project will: "Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population," and represents both new initiatives and expanded current services for Texoma Community Center. The interventions are designed to develop and provide a comprehensive treatment modality that includes twelve different evidenced-based community-based intervention options to substantially stabilize individuals with severe and persistent mental illness and/or substance abuse issues who also are significantly functionally impaired and/or are homeless in Cooke County. The treatment components will be integrated into a SAMHSA-guided toolkit for permanent supported housing, with all other components acting as a "Wraparound" style of comprehensive treatments based on individual patient need.

Need for the Project: TCC selected this project to address a growing community problem of functionally impaired and often homeless mentally ill individuals and to expand successful specialized, comprehensive services that we already know help stabilize mentally ill individuals. The county population is growing and there is a significant need to address a broader patient base with more severe functional impairments. Cooke County is identified by HRSA as an underserved behavioral health provider area (1c) with no homeless shelters at all for mentally ill "at-risk" individuals.

Target Population: Project 084434201.2.2 targets the Medicaid eligible and indigent individuals among the 38,396 residents of Cooke County. The project targets those with mental illness and/or substance abuse issues with challenging functional impairments and significant community needs, who are the highest utilizers of emergency departments and jails. This project will target any low-income individual with these criteria in RHP 19 with or without Medicaid.

Category 2 Expected Patient Impact and Benefit: The patient impact will be guided by complex interventions for at least 436 individuals in RHP 19 by DY 5, including crisis services. TCC currently provides state-funded mental health services to about 135 individuals in Cooke County and has one contracted 16-bed residential facility for crisis respite that served additional RHP 19 residents but none received the comprehensive services outlined in this project. There currently are no resources in the county to address these complex needs beyond those already served by TCC. TCC expects to serve 75 RHP 19 patients with comprehensive community based services in DY 3, 161 in DY 4 and 200 in DY 5 for a total patient impact of at least 436. In addition, it is expected that 20% of the served individuals will demonstrate significant functional status improvement in DY 4 and 30% in DY 5. As outlined in our valuation, the overall financial impact to the community is valued at $705,787.00 by DY 5 **through reduced** psychiatric hospitalizations, health-related hospital admissions and re-admissions, homelessness, criminal behavior and incarcerations.

Category 3 Outcomes: The quality improvement outcome project is IT-9.2, appropriate utilization in order to reduce Emergency Department visits for target conditions related to behavioral health and substance abuse.

Since data has not already been gathered for a baseline to determine utilization, Category 3 outcome targets will be determined in DY 2 and implemented in DY 3, 4 and 5.

RHP 19 PASS 3 Category 2: Innovation and Redesign

RHP Project Number: 084434201.2.2

RHP Performing Provider: Texoma Community Center-084434201

Project Title: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting

Project Option: 2.13.1 -- Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Required core components:

a) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. 201 Lewis, D., Corporation for Supportive Housing, Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010.) Retrieved from http://www.caction.org/homeless/documents/AustinModelPresentation.pdf
Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.

b) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes/quality of life.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

d) Design models which include an appropriate range of community-based services and residential supports.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

RHP Project Number: 084434201.2.2

RHP Performing Provider: Texoma Community Center-084434201

Project Goal: Texoma Community Center (TCC) will provide specialized services to complex behavioral health populations, specifically people with severe mental illnesses and/or a combination of behavioral and physical health issues in order to avert potentially avoidable inpatient admissions and readmissions to a more

restrictive and expensive setting such as acute and/or psychiatric hospitals or the criminal justice system. The goal is to proactively promote wellness, medication compliance, improved functioning and recovery. TCC recognizes that the required core components will facilitate success. Therefore, the target population size, characteristics and needs will be assessed, a relative literature review will be conducted and a project evaluation plan will be developed that utilizes both qualitative and quantitative metrics. The outcome goals will be accomplished by developing and providing a comprehensive treatment modality that includes but is not limited to the following community-based interventions tailored to meet a patient's needs:

- Integrated medical and psychiatric care;
- Assisted living;
- Psychosocial Rehabilitation;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens, etc;
- Transportation to appointments and community-based activities;
- Specialized behavioral therapies:
- Cognitive Behavioral Therapy – An empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking or Cognitive Processing Therapy – An empirically supported treatment developed by the Veterans Administration that focuses on recovery from trauma-based injuries such as Post-Traumatic Stress Disorder and other related conditions.
- Prescription medications;
- Peer support service that models successful health and mental health behaviors provided by peer specialists who are in recovery from mental illness or substance use disorders and are supervised by mental health professionals;
- Respite care (short term);
- Substance abuse services;
- Employment supports

These treatment components will be integrated into a system guided by the SAMHSA evidence-based toolkit for permanent supported housing (1) (http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510). One primary goal is to significantly expand the assisted living and respite care facility in order to divert mentally ill individuals in this region who are homeless, in crisis, or needing long-term residential assistance from using emergency rooms, jails, and other high-cost publicly funded systems. As evidenced by the following chart outlining internal data (see reference 4), TCC's original 16 bed contracted facility has been extraordinarily successful in accomplishing this goal on a small scale. The intent is to broaden the scope of these services to facilitate the regional goals and keep these individuals out of high-cost facilities. Finally, the impact of the interventions will be assessed relative to the target population using research-based criteria.

TCC commits to developing initiatives based on process improvement methodologies appropriate to rapid communication, integrated system workflows, providing data to providers and patients, eliminating waste, enhancing provider performance and improving patient-centered care. TCC will use protocols and tools presented in the RHP Planning Protocol Manual (p. 301) designed to identify project impacts, and understand what "lessons have been learned" in order to "solve key challenges that address the special considerations for these target populations. (2)

TCC will accomplish the core components by engaging in outreach and coordination with stakeholders in the community impacted by this population. TCC will further (1) assess size, characteristics and needs of

target population(s); (2) review literature and experiences with target populations to determine effectiveness of community-based interventions; (3) develop project evaluation plans using qualitative and quantitative metrics; (4) Design an appropriate range of community-based services and residential supports; (5) assess the impact of interventions based using the accepted ANSA assessment tool while identifying "lessons learned," looking for opportunities to provide interventions to a broader patient populations, and identifying key challenges for safety-net populations. TCC will continue to address issues of safety, quality, and efficiency through continuous quality improvement. This will contribute to the overarching regional (RHP 19) goals of improving quality of care and patient satisfaction, reducing the cost of health care, and enhancing access to health services while improving preventive care. (RHP 19 Anchor Plan)

Texoma Community Center recognizes that project success requires essential quality improvement elements such as being open to change, problem solving, soliciting stakeholder feedback and engaging in continuous monitoring of performance in order to report and use those findings to direct and improve services. The patient impact will be complex interventions for 436 individuals in this region by DY 5, including crisis services. TCC currently provides state-funded mental health services to about 135 individuals in Cooke County and has one contracted 16-bed residential facility for crisis respite but none receiving the expected comprehensive services outlined in this project. There currently are no resources in the county to address these complex needs beyond those already served by TCC. In addition, it is expected that at least 20% of the served individuals will demonstrate significant functional status improvement in DY 4 and 30% in DY 5. TCC expects to serve 75 RHP 19 patients with comprehensive community based services in DY 3, 161 in DY 4 and 200 in DY 5 for total of 436 and an overall financial benefit to the community of $705,787.00 by DY 5 through **reduced** psychiatric hospitalizations, health-related hospital admissions and re-admissions, homelessness and criminal behavior and incarcerations.

The expected five-year outcome is to have a thriving, adaptive, well-organized, evidenced-based, comprehensive program that provides both transitional services from homelessness or crisis to independent living as well as supported assistive living for those in the community with more profound disabilities. This program will allow for the greatest measure of independence and self-direction possible for each individual. It is also expected that in five years the program will reduce health care costs, incarcerations and produce positive outcomes for the target populations. (CN.1, CN.2, CN.3, CN.5,).

Starting Point/Baseline: While TCC continuously provides appropriate interventions for about 150 patients in RHP 19 with severe and persistent mental illness or intellectual disability, it is recognized that expanding and refining these efforts will have a much greater positive impact on community health resources. While Quality Improvement has always been a priority, TCC has not had an organized set of evidenced-based strategies, tools or reporting capabilities in place. This will change within the next year to reflect the organization of rapid-cycle quality improvements. TCC has one contracted 16 bed residential facility for crisis respite only and no facilities for homeless mentally ill individuals. This facility served approximately 90 (18%) patients from Cooke County for crisis services, however, the baseline for **comprehensive** services including homelessness is zero, which is the baseline for these type of services. In addition, baseline functional status scores will be established for those individuals at the onset of intervention, and at least annually thereafter to assess progress of functional status. The person's initial ANSA will be the baseline for functional status.

Rationale: TCC selected this project in order to expand positive interventions across the region to further reduce unnecessary use of more expensive health services. TCC is starting this project with an established "track record" in stabilizing high utilizer patients in the area's medical community and seeks to improve on these accomplishments. The following "look back" at what TCC has accomplished during the past six years is <u>only</u> to connect TCC's existing accomplishments to the RHP 19 regional goals and the health care transformation goals, in order to exemplify what can be accomplished if these efforts are refined and

expanded to a regional level. Since 2006, TCC's management team has made comprehensive changes through an on-going process of consistent communication with patients and staff, solicitation of stakeholder feedback and through use of solutions-focused problem-solving responses. The management team has been aggressive in finding creative solutions that are clinically sound and consistent with "evidenced-based" treatment, and financially sound with continuous oversight and open disclosure. The changes and collaborations had a significant impact on improving the Center's financial stability and contributed to positive outcomes. The following internal data exemplify goals that are completely consistent with current regional transformation goals. TCC intends to continue this improvement model by expanding the intervention base, improving the range of community-based services and by engaging in performance improvement to reduce inefficiencies, waste, and barriers.

The first major change occurred with the Assertive Community Treatment Program (ACT) for those with the most severe and persistent mental illness. The result was a reduction of average psychiatric hospitalizations for this discreet population over a four-year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. (3) Also, other "high utilizer" patients are in TCC's out-patient psychosocial rehabilitation program. This group showed a reduction in crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, to 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (4) The following table also exemplifies how TCC already has expertise in reducing costs while improving services and TCC is poised to continue these accomplishments:

	FY06	FY 07	FY 08	FY 09	FY 10	FY 11	%
MEDICATION COSTS	$905,652	$191,491	$152,257	$132,072	$93,355	$72,511	-92%
HOSPITAL COSTS	$346,530	$126,575	$64,929	$40,197	$18,375	$12,600	-97%
OUTREACH EFFORTS	Began jail diversion; began med formulary	Began mobile crisis team & Crisis Residential unit; trained Judges; ↑Patient Assistant Medications	Began Mental Health Court in 1 county	Began Drug Court involvement& enhanced community training	Began telehealth services in all county offices & in 1 jail	Continued outreach efforts and increased trainings in community	

(5)

Medication costs were reduced by addressing prescribing practices and adhering to medication formulary and by aggressively pursuing Patient Assistance Program medications. This improvement trend has continued into 2012. Increased intervention by the Mobile Crisis Outreach Team (MCOT) in the five area emergency departments (EDs) has resulted in more appropriate dispositions of crisis events and fewer overall hospitalizations. There was a critical need in the community for an alternative to hospitalization for individuals in crisis but who did not REQUIRE hospitalization. It was determined that a 16-bed crisis residential unit (CRU) would be the most cost-effective option for TCC and this was implemented in 2007. This intervention dramatically reduces local psychiatric hospitalizations when TCC crisis staff is called for an assessment. It is important to note, though, that an identified barrier to hospital reduction costs was the need to educate local ED doctors to allow TCC crisis staff to make the outcome determination during a crisis. Internal data showed that when ED doctors dictated the outcome, hospitalizations were excessive, but when

TCC crisis staff made the determination for the least restrictive environment (LRE), patients were effectively stabilized in less costly environments, with continued follow up, and no increase in negative patient outcomes**.** This collaborative initiative resulted in state-funded local hospital costs being reduced to zero for the past 18 months. (6)

As demonstrated above, enhancing the intervention strategies to the target populations, as well as refining quality improvement and data management strategies, will significantly enhance health transformation goals to reduce high dollar hospitalizations and incarcerations. This enhancement is essential to continue TCC intervention endeavors, support the regional goals, and address the identified regional needs (CN.1, CN.2, CN.3, CN.5).

Related Category 3 Outcome Measure(s): OD-9 Right Care, Right Setting
IT-9.2 ED Appropriate utilization (standalone measure)

d. Reduce Emergency Department visits for target conditions
    - Behavioral Health//substance Abuse

The quality improvement outcome project (IT-9.2), which assesses for "ED appropriate utilization," was selected for this project in order to reduced crisis events and emergency room visits by mentally ill or substance abusing behavioral health patients who are functionally-impaired, possibly homeless, and who require significant, multiple-setting interventions to stabilize. It is believed that this Outcome Measure is appropriate in order assess patient impact specific to this target population (individuals who have mental illness, emotional disturbance and/or substance abuse issues and who live within the region). This Project will also discern the impact that interventions have in relation to reducing emergency department visits, incarcerations and hospitalizations for the patients served. It is recognized that positive improvement requires relentless focus on patient outcomes.

While the Right Care, Right Setting Domain seems to be a simple and single evaluation focus, directing attention and tracking the data for related hospitalizations and incarcerations will provide a more complete picture of the intervention impact on the behavioral health status of Cooke County's low-income population. Focus on tracking the reduction in hospitalizations is particularly important in reducing overall health-related costs. In fact, the US Department of Health & Human Services' *"2012 County Health Rankings"* shows that Cooke County hospitals have identified "89 preventable hospital stays, compared to the national average of 73 hospital stays."**(7)** Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment, especially if they lack health insurance because unfunded patients tend to use the ED as a primary care clinic for minor medical issues. They also are often incarcerated for minor infractions that do not occur when they are kept stable in adequate housing. With dedicated intervention strategies such as those described in this project, TCC will be able to focus on tracking, assessing and reducing emergency department use, hospitalizations, incarcerations and urgent care use. This focus will help accomplish the desired Category 3 goals for this underserved area (CN.1, CN.3, CN.4, CN.5).

Relationship to other Projects: This intervention project will contribute data relative to other projects submitted by TCC for health care transformation. Community–based interventions designed to stabilize additional low-income, mentally ill individuals in this region will impact the success of ALL other Pass 1 TCC projects (084434201.1.1, 084434201.1.2, 084434201.1.3, 084434201.2.1) as well as further regional health care goals, especially reducing health care cost.

Relationship to Other Performing Providers' Projects in the RHP: Several performing providers in this region are expanding their intervention strategies and goals**,** therefore, collaborating on experiences and processes will likely improve all outcomes. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other

providers in RHP 19 is a definite TCC goal. Lakes Regional MHMR Center and Helen Farabee Center plan to expand behavioral health care within this region so it is expected that strategy-sharing, data sharing and collaboration will occur. The need for additional behavioral health providers and additional services (CN.3) allows for all RHP 19 LMHA's to expand behavioral health services without duplicating services or even meeting the need fully.

Plan for Learning Collaborative: The RHP 19 Anchor has not yet committed to implementing Learning Collaborative opportunities for regional providers, but if that does occur, TCC will participate with other providers in the region in order to exchange knowledge and experiences about projects to facilitate success throughout the region. TCC will participate in the Learning Collaborative meetings in order to share knowledge, experience and outcomes across the region for quality improvement purposes. TCC will share expansion experiences as well as bring information back to the management table to help direct future growth toward even more cost-effective, evidence-based practices to further reduce health care costs.

Project Valuation: TCC's commitment to proving community-based interventions for the targeted health population is consistent with the U.S. Department of Health and Human Services' objective to "Reduce the growth of healthcare costs while promoting high-value effective care. "**(8)** Providing stabilizing services to a broader patient population who have severe and persistent mental illness will reduce high-cost hospital or jail interventions and save the health-care resources within the region. TCC recognize that: "From the perspective of a service provider or program manager, quality ensures effectiveness and efficiency. From the perspective of the policy maker, quality is the key to improving the mental health population, ensuring value for money expended and accountability." **(9)**
Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are value based on assigning a monetary value of $50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A cost-utility analysis by Holtgrave, (2012) was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life**. (9a, 9b)** A study by Jones, et. al. (2003) show that participants receiving the critical care intervention had 58 fewer homeless nights, compared with standard treatment participants. A night of homelessness was valued at $152.00 using a societal perspective which results in a value gain of $8,816 per participant. (9j) For supportive housing, Larimer, et. al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost offset of $2,449 per month per individual. (9k) Utilizing this methodology, this project's value to the community is $705,787.00 and will impact a minimum of 436 low-income individuals in this region who will receive a combination of the twelve recommended community-based interventions, depending on individual need, during DY3, DY4 and DY5. TCC expects to serve 75 RHP 19 patients in DY 3, 161 in DY 4 and 200 in DY 5 for an overall total of 436

and provide a financial benefit to the community of $705,787.00 by DY 5 through improved functioning and **reduced** emergency department visits psychiatric hospitalizations, health-related hospital admissions and re-admissions, homelessness, criminal behavior and incarcerations.

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-9	**084434201.3.6**	**IT-9.2**	**ED appropriate utilization (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-2 Design community-based specialized interventions for target populations, including significantly expanded respite & residential facility. P-2.1. Metric- Project plans which are based on evidence/experience and need which address the project goals. Baseline: No interventions in place. Goal: Community-based interventions well-developed and in place. Data Source: Project Documentation, Expansion Plans	Milestone 2: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, substance abuse, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric –Increase number of targeted individuals served Baseline: Zero served with	Milestone 4: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, substance abuse, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric –Increase number of targeted individuals served Baseline: Zero served with	Milestone 6: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, substance abuse, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric –Increase number of targeted individuals served Baseline: Zero served with

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-9	**084434201.3.6**	**IT-9.2**	**ED appropriate utilization (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 (maximum amount): $160,870.00	comprehensive services Goal: 75 Served Data Source: Related financial documents/lease agreements/ contracts in place/service encounter data and residential facility enrollment data. Milestone 2 Estimated Incentive Payment (maximum amount): $87,766 Milestone 3: P-4- Evaluate and continuously improve interventions P-4.1 Metric – Project planning and implementation documentation demonstrates	comprehensive services Goal: 161 served Data Source: Related financial documents/lease agreements/ contracts in place/service encounter data and residential facility enrollment data. Milestone 4 Estimated Incentive Payment (maximum amount): $93,976.00 Milestone 5: I-5 Functional Status I-5.1 Metric - Increase percentage of individuals receiving specialized interventions who	comprehensive services Goal: 200 served Data Source: Related financial documents/lease agreements/contracts in place/service encounter data and residential facility enrollment data. Milestone 6 Estimated Incentive Payment (maximum amount): $90,716.00 Milestone 7: I-5 – Functional Status I-5.1Metric Increase percentage of individuals receiving specialized interventions who

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-9	**084434201.3.6**	**IT-9.2**	**ED appropriate utilization (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)**
	plan, do, study act quality improvement cycles (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Baseline: Quality Improvement Cycle not in place and evident. Goal: Quality Improvement Cycle in place and evident through weekly reports/ dashboards. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality	demonstrate improved functional status on the ANSA or CANS assessment from the pre-intervention baseline on subsequent assessment. Baseline: zero improved individuals Numerator: Percent of individuals receiving specialized interventions demonstrating improvement from baseline on functional assessment. Denominator: The number of individuals receiving specialized interventions Goal: 20% show improved assessment scores Data Source: Pre-and-post-	demonstrate improved functional status on the ANSA or CANS assessment from the pre-intervention baseline to subsequent assessment. Baseline: zero improved individuals Numerator: Percent of individuals receiving specialized interventions demonstrating improvement from baseline on functional assessment. Denominator: The number of individuals receiving specialized interventions Goal: 30% show improved assessment scores Data Source: Pre-and-post-

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).
Texoma Community Center		**084434201**	
Related Category 3 Outcome Measure(s): OD-9	**084434201.3.6**	**IT-9.2**	**ED appropriate utilization (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 3 Estimated Incentive Payment (maximum amount): $87,766	treatment ANSA scores for target population Milestone 5 Estimated Incentive Payment (maximum amount): $93,976.00	treatment ANSA scores for target population Milestone 7 Estimated Incentive Payment (maximum amount): $90,717.00
Year 2 Estimated Milestone Bundle Amount: $160,870.00	Year 3 Estimated Milestone Bundle Amount: $175,532.00	Year 4 Estimated Milestone Bundle Amount: $187,952.00	Year 5 Estimated Milestone Bundle Amount: $181,433.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $705,787.00			

Summary Information: Throckmorton County Memorial Hospital

Pass 2 Project 088189803.2.1

Category 2: Program Innovation and Redesign

Project Option: 2.5 Redesign for Cost Containment with CT-Scan and Mobile X-Ray Imaging System

RHP Performing Provider: Throckmorton County Memorial Hospital-088189803

- Provider: TCMH is a 14-bed Critical Access Hospital and Medical Clinic in Throckmorton County, a county with a population of 1780. TCMH is located in the middle of four Acute Care Facilities, all approximately 30 to 35 miles away-to the North, West, East, and South. Throckmorton County has a population living at or below the poverty level of 14.3%, has a population with no insurance of 33%, adult obesity rates of 29%, heart disease is the second leading cause of death.

- Intervention(s): Throckmorton County Memorial Hospital (TCMH) plans to expand and improve access to the residents of Throckmorton County and the surrounding areas by adding a CT-Scan and replacing its' outdated Mobile X-Ray. The goal is to improve cost-effectiveness of care through improved care delivery of the CT-Scan and Mobile X-Ray for individuals, families, employers, and the government.

- Need for the project: TCMH has selected this innovative project to better serve the residents of Throckmorton County and the surrounding areas. As such, the patients of Throckmorton that now use our facility, have to travel or be transported via ambulance service to other facilities for a CT-Scan and Mobile X-Ray. This increases the cost to the patient because of ER and Transport charges incurred at TCMH and also charges incurred at another facility.

- Medicaid and Uninsured Target population: Throckmorton County has a population living at or below the poverty level of 14.3%, has a population with no insurance of 33%, adult obesity rates of 29%, heart disease is the second leading cause of death. In 2011, TCMH recorded approximately $40,000 in Medicaid and $91,500 in Charity Care, not including unpaid Self-Pay accounts of individuals that fell through the screening cracks.

- Category 2 expected patient benefits: This project will help the patient by allowing them to stay in our facility with their providing doctor and will decrease the cost that the patient will incur if transported to another facility. Enhance service availability for faster and prompt access to a CT-Scan and Mobile X-Ray for Throckmorton County residents and surrounding areas. The real time images produced by the new Mobile X-Ray will

allow doctors to make adjustments to breathing tubes, etc., to make their efforts more effective, efficient and beneficial to the patient.

Category 3 outcomes: Improved cost savings outcome measure; with a CT-Scan and updated Mobile X-Ray we can improve better health to our community which will decrease cost and increases the opportunity to diagnose and treat earlier without having to transport a patient. If the patient is seen in the ED and a CT-Scan is needed, the patient will need to be transported to another facility. We have discovered that this has been a problem due to the overall impact cost to the patient and decreased response time for immediate care. This outcome will help improve the overall health for all patients, including the Medicaid and/or indigent population. Therefore, this improves the value in emergency care to diagnose locally and treat immediately. Outcome and overall usage; for Y2 baseline is to service 100 patients and each year after to be determined.

Category 2: Program Innovation and Redesign

Project Option: 2.5 Redesign for Cost Containment with CT-Scan and Mobile X-Ray Imaging System

RHP Project Number: 088189803.2.1

RHP Performing Provider: Throckmorton County Memorial Hospital-088189803

Project Description:

Throckmorton County Memorial Hospital (TCMH) plans to expand and improve access to the residents of Throckmorton County and the surrounding areas by adding a CT-Scan and replacing its' outdated Mobile X-Ray. This goal is to improve cost-effectiveness of care through improved care delivery of the CT-Scan and Mobile X-Ray for individuals, families, employers, and the government. This project includes a specific focus on improving the Throckmorton population health inside and outside of the walls of the hospital. Therefore, this will provide the opportunity to examine important measures that will develop the capability to test methodologies for measuring cost containment. This will be used to determine outcomes subsequently applied to other projects or efforts so that the ability to measure the efficiency of these initiatives is in place, so integrated care models that use data-based cost and quality measures can be developed for the future.
As a provider within a Health Provider shortage area TCMH faces the following challenges for implementation:
Challenges:
Funding for a CT-Scan and Mobile X-Ray
Full-time employee with the proper credentials to operate CT-Scan equipment effectively and efficiently.
Patient awareness that Throckmorton County Memorial Hospital will provide CT-Scan and Mobile X-Ray's.
Preparing an exterior docking site for a full-time CT-Scan.
CT-Scan and Mobile X-Ray Maintenance and software updates.

Within the five years this project will help the patient by allowing them to stay in our facility with their providing doctor and to decrease the cost that the patient will incur if transported to another facility. Enhanced service availability for faster and prompt access to a CT-Scan and Mobile X-Ray for Throckmorton County residents and surrounding areas. The real time images produced by the new Mobile X-Ray will allow doctors to make adjustments to breathing tubes, etc., to make their efforts more effective, efficient and beneficial to the patient. Our overall goal is to improve quality, efficiency and to be more effective in how we provide care. We intend to improve cost effectiveness by alleviating, other incurring patient charges and transport services to other facilities.

Starting Point/Baseline:

TCMH currently does not serve any CT-Scan patients and a new Mobile x-ray will provide instant images for the providers to have immediate feedback on their patients. Therefore, this service is not provided and there has been no need for trained staff. There have been 0 encounters. All patients needing a CT-Scan had to either drive to another city or be transported at the patient's expense. With this information, our baseline starting point is zero for the first year. With this information, our baseline starting point is zero for the first year. DY2 TBD, DY3 TBD, DY4 100 and DY5 100.

Rationale:

TCMH has selected this innovative project to better serve the residents of Throckmorton County and the surrounding areas. As such, the patients of Throckmorton that now use our facility, have to travel or be transported via ambulance service to other facilities for a CT-Scan and Mobile X-Ray. This increases the cost to the patient because of ER and Transport charges incurred at TCMH and also charges incurred at another facility.

Milestone 1: To be achieved towards the improvement of cost containment utilizing this innovative project option is broken down below; Metric:
Total cost per member of the population per month;
Total cost of the project.
This will encompass the surrounding area of Throckmorton Population.
TCMH as the service provider will use, track and regulate regional data monthly according to CT-Scan and Mobile X-Ray patient visits and services.

Milestone 2: Will be used to track the cost per episode for the hospital and ER utilization rates for cost of care measurement; for the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures will be developed to track CT-Scan and Mobile X-Ray usage. Metrics:
Total cost for episode of care
Our goal is to increase CT-Scan and Mobile X-Ray visits per month
EHR software will be used to track regional data

TCMH realizes as health care costs rise – regulators, policymakers and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as well as society. TCMH hopes that in developing these cost-of-care measures, it will help those who get, give and pay for care. This will help them to understand how different providers use resources and compare them to national benchmarks.

Required CQI Core measure

Throckmorton County Memorial Hospital strives to provide high quality health care to our patients. Our aim is to provide Mobile X-ray and CT-Scans locally to reduce the cost of care to the patient and provide the results faster and to reduce emergency transport to another facility for results in minor treatments that could have been done in-house.

By adding a new mobile X-ray and CT-Scan our patients will see improved quality of care and significant cost saving. This will be achieved by establishing teamwork, collaboration and improved quality of care. Our areas of focus are the patient, planning, and decision making, train staff and educate the patient that we will provide the new services.

- Establish Leadership and team work
- Meet regularly to plan and collect data for decision making.
- Develop strategies for producing improvement
- Create and establish Policy & Procedure
- Enhance Service Availability

Unique community need identification numbers the project addresses: CNA.009 Improve Cost effectiveness of care.

Related Category 3 Outcome Measure(s):

OD-5 Cost of Care is selected to accommodate the Category 2 project for 2.5 to Redesign for Cost Containment. TCMH has selected Cost benefits analysis to determine the positive factors in implementing a CT-Scan and Mobile X-Ray Imaging System. This will decrease the cost to the patient by increasing the opportunity to diagnose and treat them at an earlier stage without having to transport. As a result this improves the value in emergency care to diagnose locally and treat immediately. The real time images produced by the new Mobile X-Ray will allow doctors to make adjustments to breathing tubes, etc., to make their efforts more effective, efficient and beneficial to the patient. If our doctors order a CT-Scan, the patient then has to travel to another facility to receive this service. This then accumulates more cost to the patient. Again, if the patient is seen in the ED and a CT-Scan is needed, the patient will need to be transported to another facility. We have discovered that this has been a problem due to the overall impact cost to the patient and decreased response time for immediate care. This outcome will help improve the overall health for all patients, including the low-income population.

Relationship to other Projects:

In relation to Throckmorton County Memorial Hospital Category 3 project 088189803.3.1

Relationship to Other Performing Providers' Projects in the RHP: N/A

Plan for Learning Collaborative:N/A

Project Valuation:

TCMH project scope is to reduce health care costs for the patients in our community. TCMH will develop cost-of-care measures by achieving high value to benefit the community. This will help those who get, give and pay for care. Value is our overall goal of health care delivery, with value defined as the health outcomes achieved per dollar spent. This goal is what matters for our patients served in our community.

TCMH is the only Acute Care Facility and Medical Clinic in Throckmorton County, a county with a population of 1780. TCMH is located in the middle of four Acute Care Facilities, all approximately 30 to 35 miles away-to the North, West, East, and South. Throckmorton County has a population living at or below the poverty level of 14.3%, has a population with no insurance of 33%, adult obesity rates of 29%, heart disease is the second leading cause of death. In 2011, TCMH recorded approximately $40,000 in Medicaid and $91,500 in Charity Care, not including unpaid Self-Pay accounts of individuals that fell through the screening cracks.

Our goal is to be the preferred provider for our residents in this area. With the ability to provide quicker and better service, to be more efficient in an effective way and lower cost to the patient we can meet any new challenges that may arise.

Community Needs: By providing a CT-Scan and an updated Mobile X-Ray at TCMH it will better serve the residents in the community. This project will provide easier and faster access to advanced diagnostic and specialty care locally. Therefore, allowing the needs of those that have no transportation for out of town travel to be easily accessed. With the CT-Scan and updated Mobile X-Ray available, it will provide lower costs for those with no health insurance.

TCMH understands that as health care costs rise that we will strive to find better ways to stay increasingly interested in developing accurate ways to measure outcomes. To be achieved towards the improvement of cost containment. This will be done by tracking the total cost per member of the population per month and to track the cost per episode for the hospital and ED utilization rates for cost of care measurement; for the services involved in the diagnosis, management and treatment of specific clinical conditions. TCMH's ultimate goal is to reduce health care costs for the patients in our community.

088189803.2.1	2.5.2	I-11	2.5 REDESIGN FOR COST CONTAINMENT- IMAGING SYSTEM	
Throckmorton County Memorial Hospital				088189803
OD-5	IT-5.1 Improved cost savings	**088189803.3.1**	Cost of 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 I-11. Milestone: Improvements in cost containment using innovative project option. Metric 1 I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: TBD Data Source: Documentation Metric 2 I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Milestone 1 Estimated Incentive Payment: $192,981	**Milestone 2** I-11. Milestone: Improvements in cost containment using innovative project option. Metric 1 I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: TBD Data Source: Documentation Metric 2 I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Milestone 2 Estimated Incentive Payment: $222,268	**Milestone 3** I-11. Milestone: Improvements in cost containment using innovative project option. Metric 1 I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: baseline of100 patients Data Source: Documentation Metric 2 I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Milestone 3 Estimated Incentive Payment: $224,773	**Milestone 4** I-11. Milestone: Improvements in cost containment using innovative project option. Metric 1 I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: baseline of100 patients Data Source: Documentation Metric 2 I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Milestone 4 Estimated Incentive Payment: $192,407
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $192,981	Year 3 Estimated Milestone Bundle Amount: $222,268	Year 4 Estimated Milestone Bundle Amount: $224,773	Year 5 Estimated Milestone Bundle Amount: $192,407
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5)**:** $832,429			

Summary Information: United Regional Health Care System

Pass 1 Project 135237906.2.1: Redesign for Cost Containment

- Provider: United Regional Health Care System is a 325-bed hospital in Wichita Falls, Wichita County, Texas serving Wichita and Archer County Texas covering an area of approximately 1,530 square miles and a population of approximately 140,580.

- Intervention(s): The goal will be to reduce the cost per adjusted discharge while delivering high quality care in the most appropriate health care setting. The cost constraints of healthcare reform will affect all providers in our region. We will determine baseline costs for interventions and episodes of care for acute and chronic conditions and then identify the impacts of those interventions as a quality improvement component.

- Need for the project: With the advent of health care reform, we anticipate more individuals opting into government sponsored health insurance plans which will reimburse hospitals at Medicare rates. With fewer commercially-insured individuals to subsidize governmental payments, hospitals must deliver care which is less costly without compromising quality in order to meet the health care needs of the communities they serve today and into the future.

- Medicaid and Uninsured Target population: Although Medicaid reimbursement continues to be reduced and the under and uninsured populations in Texas are expected to increase, we seek to expand our efforts to provide quality primary care for the uninsured, underinsured, Medicaid and Medicare populations. Approximately 31.6% of our patients are either Medicaid eligible or indigent.

- Category 1 or 2 expected patient benefits: The project seeks to implement cost-accounting systems to measure intervention impacts. By the end of the waiver, we expect that we will have identified more cost effective methods of treating patients and improved opportunities for health care delivery. We will establish a common goal between the hospital staff and the cardiologist (formalized with the Co-management dashboard/metrics) to review historic practice patterns and develop an accepted pathway for all providers to follow in the care of Chest Pain patients. The goal for DY4 is a 6% reduction in Cost per adjusted discharge for Chest Pain observation stay over DY1, or reduction from DY1 of $4,000 per observation to $3,750. Approximately 600 patients will benefit from this project in DY4. The goal for DY5 is a 12.5% reduction in Cost per adjusted discharge for Chest Pain observation stay over DY1, or reduction from DY1 of $4,000 per observation to $3,550. Approximately 600 patients will benefit from this project in DY5.

- Category 3 outcomes: OD-5, Cost of Care. Our goal to address Cost of Care is to be determined.

Category 2: Program Innovation and Redesign

Project Title: Redesign for Cost Containment

Project Option: 2.5.3 Project Option: Cost Savings

RHP Project Number: 135237906.2.1

RHP Performing Provider: United Regional Health Care System-135237906

Project Description:

Medicaid reimbursement continues to be reduced and the under and uninsured populations in Texas are expected to increase. High costs are potential barriers to care as referenced in CN.5 of the RHP 19 Community Needs Assessment. Determining services which could be delivered in less costly settings without compromising patient outcomes will be essential to survival under a system of declining reimbursement. Implementing innovative cost accounting and clinical care information technology will positively impact the type, frequency and outcomes of hospital services in relation to the cost of providing them. We will determine baseline costs for interventions and episodes of care for acute and chronic conditions, and then identify the impacts of those interventions as a quality improvement component. We will then re-measure the redesigned processes and compare to baselines. The goal will be to reduce the cost per adjusted discharge while delivering high quality care in the most appropriate health care setting. The cost constraints of healthcare reform will affect all providers in our region; therefore, providers throughout our region have cost containment as a goal. By the end of the waiver, we expect that we will have identified more cost effective methods of treating patients and improved opportunities for health care delivery.

Starting Point/Baseline:

Time and/or Cost to provide care to Chest Pain patients classified as Observation patients. Baseline: 9/1/2012 – 1/31/2013.

Rationale:

Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions; Data Source: Texas Department of State Health Services, Center for Health Statistics.
With the reduction in Medicare and Medicaid payments and fewer commercially-insured individuals to subsidize governmental payments, hospitals must deliver care which is less costly without compromising quality in order to meet the health care needs of the communities they serve today and into the future. As the under and uninsured populations increase, it will become even more important to find more cost effective ways to provide quality care to all patients. The only way to accomplish this is to redesign how we deliver care, and implement

processes which eliminate waste, re-work, redundancy and inconsistencies. In recent years, hospitals have become more aware of measuring and containing costs. However, with the higher expectations and standards that accompany health care reform, we will significantly expand the scope and effort applied to measuring and containing costs associated with the delivery of healthcare to the population in our region. Hospitals must look at patient population needs, access to care, the propensity of patients to seek services, intensity of care and cost of delivering services. Interventions which do not improve patient outcomes add unnecessary cost to patients, hospitals, insurance companies and government payers and will drain resources to provide testing and treatments which positively impact patient care and outcomes. Our plan is to implement an innovative and evidence based intervention that will lead to cost savings. Patient centered health care is proven to reduce costs. Peer review and public postings of quality indicators for providers drives lower cost and better health outcomes for patients.

Required QI: 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. Participate in regular interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation to include:

- sharing challenges and any solutions;
- sharing results and quantitative progress on new improvements that the provider is testing; and
- identifying a new improvement and publicly commit to testing it in the week to come.

Related Category 3 Outcome Measure(s):

135237906.3.2 OD-5. Cost of Care.

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery.

We will analyze savings, as determined by provider, from the following list:
Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis. We will establish a common goal between the hospital staff and the cardiologist (formalized with the Co-management dashboard/metrics) to review historic practice patterns and develop an accepted pathway for all providers to follow in the care of Chest Pain patients. Outcome measurement would be to reduce the cost of the Chest Pain observation stay by 10% in DY4, and 15% in DY5. Once established, this methodology could be applied to other cardiology patients.

Relationship to other Projects:

135237906.2.2 Palliative and PCP---a patient centered approach to the use of Palliative Care Programs, and 135237906.1.1 Expansion of Primary Care Capacity relates directly to the concept of cost containment. As the patient is placed at the center of the effort to provide Primary and Palliative Care, many patient concerns will become obvious. One such concern is sure to be costs associated with various healthcare services. By installing systems, collecting

data and then analyzing data, we will be able to better understand the driving factors behind healthcare costs. This deeper understanding will expose ideas for cost savings which have been heretofore undetected. As these ideas are explored, plans developed and executed, costs will begin to slow in their rate of growth and in some cases decrease. As healthcare costs decrease, consumers pay less for healthcare services. Also related to Category 4 reporting domain: Patient-centered healthcare.

Project Valuation:

$511,423. We will have 7 cardiologists engaged in this quality initiative. With this kind of commitment from physicians, we expect to be able to have a significant impact on per episode cost of care. The goal for DY4 is a 6% reduction in Cost per adjusted discharge for Chest Pain observation stay over DY1, or reduction from DY1 of $4,000 per observation to $3,750. Approximately 600 patients will benefit from this project in DY4. The goal for DY5 is a 12.5% reduction in Cost per adjusted discharge for Chest Pain observation stay over DY1, or reduction from DY1 of $4,000 per observation to $3,550. Approximately 600 patients will benefit from this project in DY5.

135237906.2.1	***PROJECT OPTION 2.5.3***	***2.5.3***	***COST SAVINGS***	
United Regional Health Care System				*135237906*
Related Category 3 Outcome Measure(s):	**IT-5.1**	135237906.3.2	**Improved cost savings**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Implement Cost-accounting systems to measure intervention impacts. Metric [P-X1.1]: Conduct needs assessment, literature review for evidence-based practices and tailor intervention to local context. Baseline/Goal: Implement a Cost Accounting System Data Source: Administrative documentation Milestone 1 Estimated Incentive Payment: $0	**Milestone 2** [P-X2]: Establish a baseline for cost Metric [P-X2.1]: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan Baseline/Goal: Submission of baseline data from implemented Cost Accounting System. Data Source: Cost-accounting system or another administrative, financial or clinical data set Milestone 2 Estimated Incentive Payment: $90,313		**Milestone 4** [I-7]**:** Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost. Metric [I-7.1]: Performing Provider calculation for cost of observation Baseline/Goal: 6% reduction in Cost per adjusted discharge over DY3, or reduction from DY1 of $4,000 per observation to $3,750. Approximately 600 patients will benefit from this project in DY4. Data Source: Cost accounting software	**Milestone 5** [I-7]**:** Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost. Metric [I-7.1]: Performing Provider calculation for cost of observation Baseline/Goal: 12.5% reduction in Cost per adjusted discharge over DY3, or reduction from DY1 of $4,000 per observation to $3,500. Approximately 600 patients will benefit from this project in DY5. Data Source: Cost accounting software

135237906.2.1	***PROJECT OPTION 2.5.3***	***2.5.3***	***COST SAVINGS***	
United Regional Health Care System				*135237906*
Related Category 3 Outcome Measure(s):	**IT-5.1**	135237906.3.2	**Improved cost savings**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 4 Estimated Incentive Payment: $181,151	Milestone 5 Estimated Incentive Payment: $149,646

135237906.2.1	***PROJECT OPTION 2.5.3***	***2.5.3***	***COST SAVINGS***	
United Regional Health Care System				*135237906*
Related Category 3 Outcome Measure(s):	**IT-5.1**	135237906.3.2	**Improved cost savings**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 [P-X3] : Develop / identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions Metric [P-X1.1]: Evaluate intervention, modify intervention as appropriate, develop policies/procedures, and share lessons learned. Baseline/Goal: Documentation of the methodology and. Data Source: Cost-accounting system or another administrative, financial or clinical data set Milestone 3 Estimated Incentive Payment: $90,313			

135237906.2.1	***PROJECT OPTION 2.5.3***	***2.5.3***	***COST SAVINGS***	
United Regional Health Care System				*135237906*
Related Category 3 Outcome Measure(s):	**IT-5.1**	135237906.3.2	**Improved cost savings**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $0	Year 3 Estimated Milestone Bundle Amount: $180,626		Year 4 Estimated Milestone Bundle Amount: $181,151	Year 5 Estimated Milestone Bundle Amount: $149,646
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5): $511,423*				

Summary Information: United Regional Health Care System

Pass 1 Project 135237906.2.2: Use of Palliative Care Programs

- Provider: United Regional Health Care System is a 325-bed hospital in Wichita Falls, Wichita County, Texas serving Wichita and Archer County Texas covering an area of approximately 1,530 square miles and a population of approximately 140,580.

- Intervention(s): We expect to significantly enhance our outreach efforts to qualified patients through better care coordination between physicians, hospitals, nursing homes, and hospice suppliers. The new health reform law allows dying children on Medicaid or the state Children's Health Insurance Program (CHIP) to get hospice or palliative care without halting other treatment. Comprehensive education of physicians, patients with chronic conditions and the community will foster better understanding of the program benefits, and result in more patients receiving the most appropriate care at the right intervals of the progression of their condition.

- Need for the project: Barriers to more widespread use of Supportive Care/Palliative Care stems from patients and families not fully understanding the program components and benefits to improving quality of life no matter where the patient is in the chronic disease process. Also there is reluctance from physicians to discuss/promote Supportive Care/Palliative Care with their patients and families, who could benefit from it, because it is a difficult conversation to have.

- Medicaid and Uninsured Target population: The project includes 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. This project will serve many people that desperately need palliative care that can't get it anywhere else in the community. Of the over 2,600 Palliative Care patients served in 2012, 47% were Medicaid, Medicare, or uninsured/underinsured.

  <u>Category 1 or 2 expected patient benefits</u>: We plan to expand this program to improve patient outcomes and quality of life. Patients will be able to move through units much quicker in turn reducing their LOS while also reducing their cost. This will not only provide better care for the patient but it will also open up beds at other places in the hospital for others in the community to use if needed. We plan to implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care, to improve scores over time. We also plan to document the conditions for which palliative care is consulted. This will cover a large population and has served 2,624 patients in 2012. We expect this project to impact an additional 433 patients (210 patients impacted by Metric P-6.1, 23 patients impacted by Metric I-10.1 and 200 patients impacted by Metric I-9.1) by DY5, with approximately 47% - 50% Medicaid, Medicare, or uninsured/underinsured.

- Category 3 outcomes:
    - IT-13.1 Pain assessment: Our goal addressing Pain assessment is to be determined.
    - IT-13.2 Treatment Preferences: Our goal addressing Treatment Preferences is to be determined.
    - 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 : Our goal is to be determined.

Category 2: Program Innovation and Redesign

Project Title: Use of Palliative Care Programs, 2.10

Project Option: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

RHP Project Number: 135237906.2.2

RHP Performing Provider: United Regional Health Care System-135237906

Project Description:

Currently, United Regional provides a Supportive Care Program which addresses the needs of patients with chronic conditions from the diagnosis of their condition through end of life care. The Supportive Care Program helps patients and their caregivers with quality of life, symptom management and psychosocial issues. Patients are candidates for Supportive Care while there are still participating in curative treatment and are transitioned to hospice care when the patient chooses to discontinue treatment/treatment is no longer effective. We plan to expand this program to improve patient outcomes and quality of life. Barriers to more widespread use of Supportive Care/Palliative Care stems from patients and families not fully understanding the program components and benefits to improving quality of life no matter where the patient is in the chronic disease process. There is reluctance from physicians to discuss/promote Supportive Care/Palliative Care with their patients and families- who could benefit from it, because it is a difficult conversation to have. The new health reform law allows dying children on Medicaid or the state Children's Health Insurance Program (CHIP) to get hospice or palliative care without halting other treatment. Incentive funds would assist in further and more comprehensive education of physicians, patients with chronic conditions and the community to foster better understanding of the program benefits, which would result in more patients receiving the most appropriate care at the right intervals of the progression of their condition. Over the next five years, we plan to enhance our Palliative Care Program to better serve our patients as they transition from acute hospital to a more appropriate post-discharge setting by increasing the number and percentage of palliative care consults, documenting and analyzing the conditions for which palliative care was consulted, and implementing a patient experience survey of patients and/or their families regarding the quality of care. In doing so, we will have a greater understanding of how to best manage pain for specific conditions, what treatment preferences our patients have, and what spiritual and/or religious concerns our patients and their families might have.

Starting Point/Baseline:

Baseline: 01/01/2012-9/30/2012

Rationale:

Through palliative care, patients receive care that improves the quality of their lives during the entire disease process and provides them with dignified and culturally appropriate end-of-life care. In recent years hospitals have become more aware of the Supportive Care/Palliative Care needs of their patients. Costs are high in skilled nursing facilities, long term care facilities, hospice and home health sectors, and slightly higher in physician services. Our goal is to create a sustainable supportive care program to improve the quality of life of patients living with chronic or terminal conditions and to further engage our Medicare, Medicaid and uninsured in the clinical benefits of supportive care. With the aging population in the Wichita Falls area, the need for Supportive Care/Palliative Care will continue to expand. As the tertiary care and safety net facility for pediatric care, we will continue to serve the majority of Medicaid patients in RHP 19, and are sure to encounter Medicaid children with terminal illnesses. Of the 2624 Palliative Care patient consults in 2012, 47% were Medicaid, Medicare, or uninsured/underinsured. Many elderly patients are either under or uninsured, and through expansion of this program, patients with terminal illnesses will receive care that prioritizes pain control, social and spiritual care, and patient/family preferences. Community Needs index CN.1, identifies high rates of chronic disease, including cancer, heart disease, respiratory diseases, and obesity as issues that need to be addressed in RHP 19. (Data Source: County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation; Texas Department of Health and Human Services.) The required core components will be addressed as follows:

Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program: Fulfilled

Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility – We will document the total number of palliative care consults; increase the percentage of palliative care consulted patients that are transitioned into hospice, home care or a SNF; work to increase the percentage of those that die in the hospital that had a palliative care consult; and document the conditions for which palliative care is consulted, using that data to increase the total number of consults.

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: A survey will be developed and distributed to patients receiving a palliative care consult. The results will be reviewed in order to improve survey results.

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. A quality improvement program will be developed that will identify "lessons learned" regarding pain assessment and management, treatment preferences and patients' spiritual and/or religious concerns regarding palliative care.

Better care coordination is required between physicians, hospitals, nursing homes, and hospice suppliers. This would improve patient access and provide improved quality of life earlier in a disease process, during treatment, as well as at end of life. Although we have started to

address Supportive Care/Palliative Care needs in our facility, there is still much to accomplish. We expect to significantly enhance our outreach efforts to qualified patients as we continue to implement components associated with this project.

Required QI: 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. Participate in regular interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation to include:

- sharing challenges and any solutions;
- sharing results and quantitative progress on new improvements that the provider is testing; and
- identifying a new improvement and publicly commit to testing it in the week to come.

Related Category 3 Outcome Measure(s):

IT-13.1 Pain assessment (NQF-1637)
IT-13.2 Treatment Preferences (NQF 1641)
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)
Palliative care improves the quality of life for patients and families struggling with serious diseases they might live with for many years. Health systems are still fragmented in many ways and a coordinated approach can help patients and families wrestling with complex and difficult decisions. Robust palliative care programs help patients to more quickly transition to appropriate levels of care giving the patient what then need when they need it. Reference: The Case for Hospital Palliative Care found at http://www.capc.org.

Relationship to other Projects:

This project relates to the Project 1.1, Expand Primary Care Capacity, because this project will specifically give those providers a resource for facilitating the delivery of palliative care for the patients who need this service. As we increase access to care in our community, it will give patients more opportunities to learn about this kind of resource. The more they **know** about the benefits of palliative care services the more they will use these resources to help address the challenges associated with severe illness. Also related to Category 4 reporting domain: Patient-centered healthcare and 30-Day Readmissions.

Relationship to Other Performing Providers' Projects in the RHP:

There is no other Performing Provider in RHP 19 who is planning on completing the Use of Palliative Care Programs project; although this project relates to the Project 1.9, Expand Specialty Care Capacity, because this project will give those providers a resource for

facilitating the delivery of palliative care for the patients who need this service. This clearly underscores the need for this project. Patients from throughout RHP 19 find themselves needing the services offered by United Regional. Many times the health condition of the patient is compromised for a short period of time and they quickly return to life as usual. Frequently, though, patients have more difficult and lengthy health issues with which to cope. Palliative care can offer relief not available through other means for patients who need it most.

Plan for Learning Collaborative:

We may be able to facilitate a learning collaborative around Palliative Care Services.

Project Valuation:

$1,204,052. This project will achieve waiver goals because it will provide palliative care services to improve patient outcomes and quality of life. The community will benefit from this project in several different ways. Patients will be able to move through units much quicker, in turn reducing their Length Of Stay (LOS) while also reducing their cost. This will not only provide better care for the patient but it will also open up beds at other places in the hospital for others in the community to use if needed. This will cover a large population and has served 2,624 patients in 2012. We expect this project to impact an additional 433 patients (210 patients impacted by Metric P-6.1, 23 patients impacted by Metric I-10.1 and 200 patients impacted by Metric I-9.1) by DY5, with approximately 47% - 50% Medicaid, Medicare, or uninsured/underinsured. This project will be a fairly large investment and will serve many people that desperately need palliative care that can't get it anywhere else in the community. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addressing priority community need.

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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-6]**:** Increase the number of palliative care consults. Metric [P-6.1]: Palliative care consults meet targets established by the program: Increase consults. Goal: 2% increase in consults from 2,624 consults to 2,676 consults. Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report. Milestone 1 Estimated Incentive Payment (maximum amount): $145,639	**Milestone 4** [P-6]: Increase the number of palliative care consults. Metric [P-6.1]: Palliative care consults meet targets established by the program: Increase consults. Baseline/Goal: 4% increase in consults from 2,624 consults to 2,729 consults. Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 4 Estimated Incentive Payment (maximum amount): $67,735 **Milestone 5** [P-8]: Document the conditions for which	**Milestone 8** [P-6] Increase the number of palliative care consults. Metric [P-6.1]: Palliative care consults meet targets established by the program: Increase consults. Baseline/Goal: 6% increase in consults from 2,624 consults to 2,781 consults. Data Source EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report. Milestone 8 Estimated Incentive Payment (maximum amount): $67,932	**Milestone 12** [P-6] Increase the number of palliative care consults. Metric [P-6.1]: Palliative care consults meet targets established by the program: Increase consults. Baseline/Goal: 8% increase in consults from 2,624 consults to 2,834 consults. Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 12 Estimated Incentive Payment (maximum amount): $74,824

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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)**
	palliative care is consulted. Metric [P-8.1]: Investigate breadth of conditions for which palliative care is utilized. Baseline/Goal: Develop documentation of the conditions for which palliative care is consulted. Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 5 Estimated Incentive Payment: $67,735		

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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 2 [I-10]: Among qualifying patients who died in the hospital, increase the proportion of those who received a palliative care consult. Metric [I-10.1]: Increase percent of palliative care consults given to total qualifying patients with in-hospital deaths Baseline/Goal: 3% increase in palliative care consults for qualifying patients who died in the hospital, from 192 consults to 197 consults.	**Milestone 6** [I-10]: Among qualifying patients who died in the hospital, increase the proportion of those who received a palliative care consult. Metric [I-10.1]: Increase percent of palliative care consults given to total qualifying patients with in-hospital deaths Baseline/Goal: 6% increase in palliative care consults for qualifying patients who died in the hospital, from 192 consults to 203 consults	**Milestone 9** [I-10]: Among qualifying patients who died in the hospital, increase the proportion of those who received a palliative care consult. Metric [I-10.1]: Increase percent of palliative care consults given to total qualifying patients with in-hospital deaths Baseline/Goal: 9% increase in palliative care consults for qualifying patients who died in the hospital, from 192 consults to 209 consults	**Milestone 13** [I-10]: Among qualifying patients who died in the hospital, increase the proportion of those who received a palliative care consult. Metric [I-10.1]: Increase percent of palliative care consults given to total qualifying patients with in-hospital deaths Baseline/Goal: 12% increase in palliative care consults for qualifying patients who died in the hospital, from 192 consults to 215 consults

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 2 Estimated Incentive Payment (maximum amount): $145,639	Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 6 Estimated Incentive Payment (maximum amount): $67,734	Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 9 Estimated Incentive Payment (maximum amount): $67,932	Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 13 Estimated Incentive Payment (maximum amount): $74,823

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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 [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 [I-9.1]: Increase in palliative care consults for patient transitions accomplished Baseline/Goal: 3% increase in palliative care consults for patient transitions from acute	**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 [I-9.1]: Increase in palliative care consults for patient transitions accomplished Baseline/Goal: 6% increase in palliative care consults for	**Milestone 10** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric [I-9.1]: Increase in palliative care consults for patient transitions accomplished Baseline/Goal: 9% increase in palliative care consults for patient transitions from acute	**Milestone 14** [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 I-9.1: Increase in palliative care consults for patient transitions accomplished Baseline/Goal: 12% increase in palliative care consults for patient transitions from acute

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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)**
hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services, from 1,668 consults to 1,718 consults. Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 3 Estimated Incentive Payment: $145,638	patient transitions from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services, from 1,668 consults to 1,768 Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 7 Estimated Incentive Payment:$67,735	hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services, from 1,668 consults to 1,818 Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 10 Estimated Incentive Payment: $67,932 **Milestone 11** [I-12]: Implement a patient/family experience survey regarding the quality of care, pain and symptom	hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services, from 1,668 consults to 1,868 Data Source: EHR, palliative care database; Centers to Advance Palliative Care (CAPC) report Milestone 14 Estimated Incentive Payment: $74,823

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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)**
		management, and degree of patient/family centeredness in care and improve scores over time <u>Metric I-12.1</u>: Develop and implement survey, with scores increased over time Goal: 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. Data Source: Patient/family experience survey.	

135237906.2.2	**PROJECT OPTION 2.10.1**	**PROJECT COMPONENTS 2.10.1.A, 2.10.1.B, 2.10.1.C AND 2.10.1.D**	**USE OF PALLIATIVE CARE PROGRAMS**
United Regional Health Care System			135237906
Related Category 3 Outcome Measure(s):	IT-13.1, IT-13.2, and IT-13.5	135237906.3.3 135237906.3.4 135237906.3.5	Pain assessment; Treatment Preferences; Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions 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 11 Estimated Incentive Payment: $67,931	
Year 2 Estimated Milestone Bundle Amount:: $436,916	Year 3 Estimated Milestone Bundle Amount: $270,939	Year 4 Estimated Milestone Bundle Amount: $271,727	Year 5 Estimated Milestone Bundle Amount: $224,470
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $1,204,052			

Summary Information: United Regional Health Care System

Pass 2 Project 135237906.2.3: Conduct Medication Management
Summary Information: United Regional Health Care System

New Pass 3b Project 135237906.2.4: Conduct Medication Management

(Old Pass 2 Project 135237906.2.3)

- Provider: United Regional Health Care System is a 325-bed hospital in Wichita Falls, Wichita County, Texas serving Wichita and Archer County Texas covering an area of approximately 1,530 square miles and a population of approximately 140,580.

- Intervention(s): Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors. Our project will provide the platform to conduct Medication Management so that patients receive the right medications at the right time across United Regional's continuum of care in order to reduce medication errors and adverse effects from medication use. Over the next five years, we expect to address the 2.11.2.a core component listed as: Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations; by utilizing an evidence-based intervention designed to place the teams, technology and processes to avoid medication errors.

- Need for the project: United Regional has historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. It will require additional pharmacist staff to make contact with patients prior to discharge and then follow up regularly to monitor compliance and complications and make recommendations for primary physician contact if necessary to avoid situations from developing to the point of requiring hospitalization.

- Medicaid and Uninsured Target population: Since many Medicare patients are also Medicaid eligible, assuring that taking multiple medications is not causing additional health issues is important to maintaining a healthy lifestyle and reducing costs. We attempt to provide medication management at little to no cost to Medicaid and uninsured/underinsured patients who have one or more chronic diseases. Currently of the patients receiving medication intervention, approximately 67.7% are Medicare, Medicaid or uninsured/underinsured. Our target population will be identified in DY 3 and we will assure that those patients are given discharge instructions and continue to appropriately manage their medications in DY 4 and DY 5.

- Category 1 or 2 expected patient benefits: Costs of care for the individual patients and larger population will be reduced by insuring patients are receiving the appropriate combination of medications and insuring they fully understand medications upon

discharge. Such a comprehensive focus on medication management has the potential to reduce hospital readmissions and reduce overall healthcare expenses on an equitable basis for all patients. Our goal is to:

DY4 :

- Increase in clinical pharmacist consults from DY1 of 6,015 patients receiving consultation to 6,496 patients receiving consultation.
- 10% increase in clinical pharmacist consults (meeting criteria for chronic condition-Congestive Heart Failure, CHF) from DY1 of 204 patients receiving consultation to 224 patients receiving consultation.

DY5:

- Increase in clinical pharmacist consults from DY1 of 6,015 patients receiving consultation to 6,857 patients receiving consultation
- 20% increase in clinical pharmacist consults (meeting criteria for chronic condition-Congestive Heart Failure, CHF) from DY1 of 204 patients receiving consultation to 245 patients receiving consultation.

- Category 3 outcomes: OD-6 Patient Satisfaction. The hospital has been participating in HCAHPS to measure patient experience in the hospital setting. We anticipate that we will be able to raise patient satisfaction in "how well their doctors communicate" (standalone measure/domain) with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.. Our goal addressing Patient Satisfaction through doctors' communication is to reduce physician visits, emergency department visits, hospital days, and overall health care costs.

Category 2: Program Innovation and Redesign

Project Option: Conduct Medication Management Project 2.11

RHP Project Number: 135237906.2.4 (Old RHP Project Number 135237906.2.3)

RHP Performing Provider: United Regional Health Care System-135237906

- **Identifying Project and Provider Information**: 2.11. Conduct Medication Management, Project 2.11.2. Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors. 135237906.2.4 (Old RHP Project Number 135237906.2.3); United Regional Health Care System/135237906
- **Project Description**: The goal of conducting Medication Management is to provide information that facilitates the appropriate use of medications in order to control illness and promote health. Medication management is the monitoring of medications a patient takes to confirm that the patient is complying with a medication regimen, while also ensuring the patient is avoiding potentially dangerous drug interactions and other complications. This is especially important for patients taking large numbers of medications to address chronic illnesses and multiple diseases. Taking numerous medications is known as polypharmacy and it is particularly common among older adults, as they are more likely to need medications to manage an array of chronic conditions. Keeping track of all of the medications currently in use by a patient is an important part of medication management. Monitoring medication administration is also key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications. Since many Medicare patients are also Medicaid eligible, assuring that taking multiple medications is not causing additional health issues is important to maintaining a healthy lifestyle and reducing costs. Our target population will be identified in DY 3 and we will assure that those patients are given discharge instructions and continue to appropriately manage their medications in DY 4 and DY 5.
- **Starting Point/Baseline**: Establish a baseline for number of patients receiving medication management and counseling in DY1. Baseline: 10/1/2011-9/30/2012
- **Rationale**: Our project will provide the platform to conduct Medication Management so that patients receive the right medications at the right time across United Regional's continuum of care in order to reduce medication errors and adverse effects from medication use. Over the next five years, we expect to address the 2.11.2.a core component listed as: Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations; by utilizing an evidence-based intervention designed to place the teams, technology and processes to avoid medication errors.
  We attempt to provide medication management at little to no cost to Medicaid and uninsured/underinsured patients who have one or more chronic diseases. Currently of the patients receiving medication intervention, the vast majority are Medicare,

Medicaid or uninsured/underinsured. The patient will have no obligation, or a discounted obligation, to pay for any services received which are deemed to be Charity Care, as defined by Texas Indigent Health Care and Treatment Act, or are between 150% and 200% of the current Federal Poverty Income Guidelines (FPG). In addition, Medically Indigent patients, whose financial means are insufficient to render a payment, their income exceeds 200% of the FPG, and the patient's financial responsibility meets or exceeds 20% of their income may receive partial Charity coverage. Through this benefit and clinical pharmacist oversight and management, we expect adherence and compliance to medications will increase. The additional advantage to embedding this team within URHCS is patients will receive comprehensive care management to address their needs in one care venue. Managing medications has ancillary effects on outcomes of multiple regional goals. If patients have access to and adhere to their prescriptions, chronic diseases and behavioral health issues would be under better control and there would be fewer exacerbations and visits to the ED.
Community Needs identification CN.1, High rates of chronic disease, including cancer, heart disease, respiratory diseases, and obesity; Data Source: County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation.
Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions; Data Source: Texas Department of State Health Services, Center for Health Statistics.
Costs of care for the individual patients and larger population will be reduced by insuring patients are receiving the appropriate combination of medications and insuring they fully understand medications upon discharge. Such a comprehensive focus on medication management has the potential to reduce hospital readmissions and reduce overall healthcare expenses on an equitable basis for all patients. Improve quality; Decrease readmission rates; Improve patient satisfaction; Improve patient understanding of medications at discharge; Reduce cost to patients by promoting generics or less expensive alternatives when available; Insuring appropriate medication therapy; Coordinating with nursing for medication discharge counseling; Participating in medication reconciliation; Improved pain management; Enhanced communications about medications; and Providing on-going training and education to physicians and hospital staff on medication related topics.
Proper medication adherence and inability to manage pain are among the reasons for the high percentage of readmission rates in the palliative unit; therefore, measures will be put into place to track these changes as patients are referred to outpatient palliative care services.
The intent of the medication management program is to improve medication efficacy and safety in patients the critical transitional phase from acute care to the ambulatory setting. This enhanced medication reconciliation and transitional medication management counseling includes a detailed medication history assessment and reconciliation at admission and discharge. Population-based screening criteria will be used to identify and prioritize patients for pharmacist intervention during hospitalization. Admission assessment will include a best possible medication history (BPMH) that includes compliance, lack of efficacy, and possible side effects. Patients

will receive individualized patient education, discharge medication counseling and post discharge follow-up. Patients will be verbally educated on discharge medications, comprehension of medication instructions and provide written information with patient specific references and learning tools. Examples of educational and teaching tools to be used with patients include: an enhanced patient-friendly medication list and patient education leaflets. After hospital discharge, the targeted patients will receive a follow-up phone call to reassess comprehension of medications, assess compliance, identify possible Adverse Drug Events (ADEs), and address any additional patient concerns.
Project Goals:

- Reduce medication errors and adverse drug events
- Increase adherence to an appropriate medication regimen
- Improve patient satisfaction regarding issues and questions about their medications
- DY4 : Increase of the number of patients (meeting criteria for chronic condition) contacted or receiving medication management by 2% over DY2
- DY5 : Increase of the number of patients (meeting criteria for chronic condition) contacted or receiving medication management by 4% over DY2

- **Required QI**: 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. Participate in regular interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation to include:
  1) sharing challenges and any solutions;
  2) sharing results and quantitative progress on new improvements that the provider is testing; and
  3) identifying a new improvement and publicly commit to testing it in the week to come.

- **Related Category 3 Outcome Measure(s):** OD-6 Patient Satisfaction; IT-6.1 Percent improvement over baseline of patient satisfaction scores. Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider – eventually leading to better outcomes and lower costs. Data from Press Ganey Associates has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. The hospital has been participating in HCAHPS to measure patient experience in the hospital setting. United Regional has historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. We anticipate that we will be able to raise patient satisfaction in how well their doctors communicate (standalone measure/domain) with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety. To improve cost, quality and satisfaction, develop more rigorous discharge processes, especially in the area of

medication reconciliation and patient education. Patients' ability and perception of receiving timely care, appointments, and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Patients will receive medication management, lifestyle management techniques and education about their illness. Approximately 1.5 million preventable ADEs occur annually as a result of medication errors, at a cost of more than 3 billion per year.1 One in five patients discharge from hospitals suffers an adverse event, 72% of which are related to medication.2,3 Seventy-six percent of Medicare readmissions in 2007 were potentially preventable, suggesting that 13 billion of the 15 billion in readmission costs may be unnecessary and preventalb.4 The World Health Organization also estimates that 50% of patients with chronic disease states do not take their medicine as prescribed.5 Pharmacists are uniquely positioned to help increase medication safety and compliance in patients across the continuum of care. Patients who receive medication management as part of the transition from acute to ambulatory care are more likely adhere to an appropriate medication regimen and receive the right medication at the right time. This enhanced adherence to their medication regime will result in fewer complications for the patient, better outcomes, fewer unplanned emergency department visits, fewer hospital admissions, and provide a cost savings to the health care system. Pharmacist-provided medication therapy review and consultation in various settings resulted in reductions in physician visits, emergency department visits, hospital days, and overall health care costs.6 Research suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions.

1. Institute of Medicine. Preventing Medication Errors. Washington, DC: The National Academies Press; 2007.
2. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003; 138:161-7.
3. Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital. CMAJ. 2004; 170:345-9.
4. Medicare Payment Advisory Commission. Report to the Congress: Promoting Greater Efficiency in Medicare. June 2007. Available at: http://www.med pac.gov/documents/jun07_entirereport.pdf. Accessed July 1, 2011.
5. World Health Organization. Adherence to long-term therapies: evidence for action [online]. http://www.who.int/chp/knowledge/publications/adherence_report/en/index.html. Accessed December 27,2011.
6. American Pharmacists Association. Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, Version 2.0. March 2008. Available at: http://www.pharmacist.com/MTM/Core Elements2. Accessed July 1, 2011.

- **Relationship to other Projects:** This Project correlates with 2.10, Use of Palliative Care Programs. Medication Management is a critical element in managing the chronically ill and terminally ill. Also related to Category 4 reporting domain: Patient-centered healthcare.
- **Relationship to Other Performing Providers' Projects in the RHP**: N/A
- **Plan for Learning Collaborative:** N/A
- **Project Valuation**: It will require additional pharmacist staff to make contact with patients prior to discharge and then follow up regularly to monitor compliance and complications and make recommendations for primary physician contact if necessary to avoid situations from developing to the point of requiring hospitalization. Potential savings are significant, especially in the long-term, when one considers the cost of readmissions and ED visits. The major investment in implementing this project consists of using pharmacists and support staff to carry out this new function and monitor the results. The exact number of staff will be determined after data collection is accomplished and the number of patients to be followed is known. Decreasing the readmission rate will produce considerable savings and health outcomes improvement. Developing and testing the data systems to report acute care hospitalizations for ambulatory care sensitive conditions will require IT resources and administrative/clerical/nursing training to collect the necessary data. Readmissions affect CHF patients with multiple hospital stays, but it also has a global effect on facility staffing and global healthcare cost.

  Our goal is to:

  DY4 :
  - Increase in clinical pharmacist consults from DY1 of 6,015 patients receiving consultation to 6,496 patients receiving consultation.
  - 10% increase in clinical pharmacist consults (meeting criteria for chronic condition-Congestive Heart Failure, CHF) from DY1 of 204 patients receiving consultation to 224 patients receiving consultation.

  DY5:
  - Increase in clinical pharmacist consults from DY1 of 6,015 patients receiving consultation to 6,857 patients receiving consultation
  - 20% increase in clinical pharmacist consults (meeting criteria for chronic condition-Congestive Heart Failure, CHF) from DY1 of 204 patients receiving consultation to 245 patients receiving consultation.

  We also anticipate that we will be able to raise patient satisfaction in how well their doctors communicate (standalone measure/domain) with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.

135237906.2.4 (135237906.2.3)	***PROJECT OPTION 2.11.2***	***2.11.2.A***	***CONDUCT MEDICATION MANAGEMENT***	
United Regional Health Care System				***135237906***
Related Category 3 Outcome Measure(s):	*135237906.3.7* (135237906.3.6)	***IT 6.1***	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] **:** Expand a medication management program Metric [P-1.1]: Program elements. Documentation of program, including people, processes and technologies Goal: Develop a delivery system with a written medication management plan that is consistently followed by all providers, to reduce medication errors and increase patient compliance with their medication regimens Data Source: Written medication management plan including workflow for providers	**Milestone 2** [P-2]**:** Develop criteria and identify targeted patient populations. Metric [P-2.1]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs. Goal: Establish guidelines for identifying target population and criteria for program participation in the medication management program to allow for a more systematic adoption and integration into clinical processes. Data Source: Written criterion for target population and		**Milestone 3** [I-15]: Increase number or percent of patients that receive consultation by clinical pharmacists, prior to discharge in the in-patient setting and upon refilling a new prescription in the outpatient setting. Metric [I-15.1]: 36% of patients receiving consultation by clinical pharmacists. Goal: Increase in clinical pharmacist consults from DY1 of 6,015 patients receiving consultation to 6,496 patients receiving consultation. Data Source: Chronic disease	**Milestone 5** [I-15]**:** Increase number or percent of patients that receive consultation by clinical pharmacists, prior to discharge in the in-patient setting and upon refilling a new prescription in the outpatient setting. Metric [I-15.1]: 38% of patients receiving consultation by clinical pharmacists. Goal: Increase in clinical pharmacist consults from DY1 of 6,015 patients receiving consultation to 6,857 patients receiving consultation Data Source: Chronic disease registry and hospital EHR

135237906.2.4 (135237906.2.3)	***PROJECT OPTION 2.11.2***	***2.11.2.A***	***CONDUCT MEDICATION MANAGEMENT***	
United Regional Health Care System				***135237906***
Related Category 3 Outcome Measure(s):	*135237906.3.7* (135237906.3.6)	***IT 6.1***	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment *(maximum amount):* Payment: $438,682	program participation Milestone 2 Estimated Incentive Payment *(maximum amount):* Payment: $450,507		registry and hospital EHR Milestone 3 Estimated Incentive Payment: $226,118	Milestone 5 Estimated Incentive Payment: $ 186,624

135237906.2.4 (135237906.2.3)	***PROJECT OPTION 2.11.2***	***2.11.2.A***	***CONDUCT MEDICATION MANAGEMENT***	
United Regional Health Care System				***135237906***
Related Category 3 Outcome Measure(s):	*135237906.3.7* (135237906.3.6)	***IT 6.1***	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 4 [I-9]: Manage medications for targeted patients Metric [I-9.1]: Increase of the number of patients (meeting criteria for chronic condition-Congestive Heart Failure) contacted or receiving medication management Goal: 10% increase in clinical pharmacist consults from DY1 of 204 patients receiving consultation to 224 patients receiving consultation. Data Source: Medical Assistance/Intervention information from electronic health record Milestone 4 Estimated Incentive Payment: $226,118	**Milestone 6** [I-9]: Manage medications for targeted patients Metric [I-9.1]: Increase of the number of patients (meeting criteria for chronic condition-Congestive Heart Failure) contacted or receiving medication management Goal: 20% increase in clinical pharmacist consults from DY1 of 204 patients receiving consultation to 245 patients receiving consultation. Data Source: Medical Assistance/Intervention information from electronic health record Milestone 6 Estimated Incentive Payment: $186,624

135237906.2.4 (135237906.2.3)	***PROJECT OPTION 2.11.2***	***2.11.2.A***	***CONDUCT MEDICATION MANAGEMENT***	
United Regional Health Care System				***135237906***
Related Category 3 Outcome Measure(s):	*135237906.3.7* (135237906.3.6)	***IT 6.1***	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $438,682	Year 3 Estimated Milestone Bundle Amount: $450,507		Year 4 Estimated Milestone Bundle Amount: $452,236	Year 5 Estimated Milestone Bundle Amount: $373,248
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*: $1,714,673*				

Section V. Category 3

Category 3: Quality Improvements

OD-9 Right Care, Right Setting

RHP Project Number: 127305405.3.1

RHP Performing Provider: Bowie Memorial Hospital - 127305405

Identifying Outcome Measure and Provider Information: 127305405.3.1 OD-9 Right Care, Right Setting. The improvement target is IT 9.2 ED Appropriate Utilization (standalone). The unique RHP outcome identification number is TPI 127305405.1, Bowie Memorial Hospital/ TPI 127305405.

Outcome Measure Description:

The outcome measure chosen for the Category 1 project, Expand Primary Care Capacity, is related to ED appropriate utilization. The improvement target values will be determined during DY 2, and subsequently used during years 3-5. While reducing the ED non-urgent visits is a notable outcome, we also feel that by providing additional primary care in the community, the numbers of appointments and available access will increase appropriate and more desirable levels of care for the patient.

Rationale:

We think that the best measure of success in expanding access to primary care is a resulting decrease in inappropriate ED visits. It is our hope that by expanding provider access and necessary support personnel, as well as hours of availability, that the need for the non-urgent ED visits will decrease. Currently, in this community primary care is not available during the evenings or weekends.

Outcome Measure Valuation:

Reducing the number of ED visits in Montague County will benefit the Medicaid and the uninsured by providing for access to a more cost efficient method of dealing with health issues, as well as insuring that the continuum of care is in the most appropriate setting for the individual.

127305405.3.1	IT 9.2	**Right Care, Right Setting**	
Bowie Memorial Hospital			127305405
Related Category 1 or 2 Projects::	**127305405.1.1**		
Starting Point/Baseline:	ED Level I and II visits in DY 3. (1025)		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 Process Milestone 1 Estimated Incentive Payment (maximum amount): $ 25,428	**Process Milestone 2** P-2: Establish Baseline ED visit working target population by utilizing appropriate software and trained staff members. Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $ 29,474	**Outcome Improvement Target 1** 3. I.T. 9.2 ED appropriate utilization. Improvement Target: Change venue of care by 320 Level I and II ED patient encounters by the end of DY 4. Data Source: ED Registration and triage documentation. Outcome Improvement Target 1 Estimated Incentive Payment: $ 47,296	**Outcome Improvement Target 2** 3 I.T. 9.2 ED appropriate utilization. Improvement Target: Change venue of care for 70 Level I and II ED patient encounters by the end of DY 5. Data Source: ED Registration and triage documentation Outcome Improvement Target 2 Estimated Incentive Payment: $ 113,101
Year 2 Estimated Outcome Amount: $ 25,428	Year 3 Estimated Outcome Amount: $ 29,474	Year 4 Estimated Outcome Amount: $ 47,296	Year 5 Estimated Outcome Amount: $ 113,101
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 215,299			

Category 3: Quality Improvements

Potentially Preventable Re-Admissions
I.T. - 3.1, TBD 30 day readmission rate for target conditions

RHP Project Number: 127305405.3.2

RHP Performing Provider: Bowie Memorial Hospital- TPI 127305405

Pass 3B Category 3: Quality Improvements New ID 127305405.3.3
Old ID 127305405.3.2

- **Identifying Outcome Measure and Provider Information:** The unique Category 3 Outcome *Identifiers* for the Category 2 project of Expand Chronic Care Management is OD 1 Primary Care and Chronic Disease Management. The Improvement target for OD-1, IT-1.10 Diabetes care: HbA1c poor control (greater than 9%). Will promote better health, and fewer complications over time. The unique RHP outcome identification numbers is 127305405.3.3 (127305405.3.2), Bowie Memorial Hospital/ TPI 127305405.
- **Outcome Measure Description:** The outcome measure chosen for the Category 2 is the Diabetes care: HbA1c poor control (greater than 9%).
- **Rationale:** The project to establish chronic disease management initiatives, such as patient education, self-management support, improved patient-provider communication techniques, and coordination of transition resources, will help to provide evidence based interactions and interventions between providers and patients. The early identification of chronic disease related problems, will help to reduce complications, hospitalizations, and will promote healthcare resource conservation. Challenges in a rural setting, patient access to a post hospitalization continuum of care forum, and educational resources, as well as a lack of understanding of the need for self-monitoring create the need for a program such as this project will provide. Primary care resources are essentially limited to acute care visits. Rural population groups are more unaware of the complications resulting from chronic diseases not being managed on a continuing basis increased use of self-monitoring, and early awareness of potential complications will hopefully encourage healthier habits, better adherence to medication

regimes, and improved behaviors to help manage the chronic disease and keep the patients out of the emergency room and hospital beds.

- **Outcome Measure Valuation**: Improving diabetic control of HbA1c in Montague County will benefit the Medicaid and uninsured by providing resources and management in a more cost efficient method of dealing with health issues, as well as ensuring that the continuum of care is more accessible and prompt in securing patient compliance. At present 35 patients are in a limited diabetic program, with approximately 8 of those patients under the 9% HbA1c target. The intent of the program will be to increase the number of patients with HbA1c less than 9%, improving health and decreasing complications and admission. In DY4 the goal is to maintain an additional 8 patients with less than 9% HbA1c and in DY5, 4 additional patients. Decreasing ED visits and hospital admissions for complications will provide significant savings for all covering entities and promote better health practices in the community.

127305405.3.3 (127305405.3.2)	*OD-1; I.T.- 1.10*	*Diabetes care: HbA1c poor control (greater than 9%)*	
Bowie Memorial Hospital			*TPI 127305405*
Related Category 1 or 2 Projects::	127305405.2.2 (127305405.2.1) *Expand Chronic Care Management Model*		
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 1P-1 Project planning - engage stakeholders, identify current process and needed resources, determine timelines and document implementation plans. Metric 1 1.P-1.1 Develop a plan for expanding chronic care management. Goal: Plan for expanding chronic care management. Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment *(maximum*	**Process Milestone 2:** 1.P-2 Establish baseline rates. Metric 1 1.P-2.1 Identify patients for chronic disease management program. Data Source: Documentation of the patient participant roster. Process Milestone 2 Estimated Incentive Payment: $44,733	**Milestone 3**: OD 1- Primary Care and Chronic Disease Management.IT-3.1 All cause 30 day readmission rate- NQF 1789250 (Standalone measure) Improvement Target: -1.10 Diabetes care: HbA1c poor control (greater than 9%)- NQF 0059 (Standalone measure) Baseline: Established in DY2 Goal: Increase number of participants with improved HbA1c by 25% from a base of 35 patients. Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Milestone 4:** OD 1- Primary Care and Chronic Disease Management. Improvement Target: - 1.10 Diabetes care: HbA1c poor control (greater than 9%)- NQF 0059 (Standalone measure) Baseline: Established in DY 2. Goal: to increase the number of participants with improved HbA1c over last year's measurement by 15% from a base of 42 patients. Outcome Improvement Target 2 Estimated Incentive Payment*:* $111,836

127305405.3.3 (127305405.3.2)	*OD-1; I.T.- 1.10*	*Diabetes care: HbA1c poor control (greater than 9%)*	
Bowie Memorial Hospital			*TPI 127305405*
Related Category 1 or 2 Projects::	127305405.2.2 (127305405.2.1) *Expand Chronic Care Management Model*		
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)**
amount): $29,129		$59,873	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $29,129	Year 3 Estimated Outcome Amount: $44,733	Year 4 Estimated Outcome Amount: $59,873	Year 5 Estimated Outcome Amount: $111,836
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $245,571			

Category 3: Quality Improvements

RHP Project Number: 094138703.3.1

RHP Performing Provider: Clay County Memorial Hospital- 094138703

Category 3: Quality Improvements

RHP Project Number: 094138703.3.3
(Old 094138703.3.1)

RHP Performing Provider: Clay County Memorial Hospital- 094138703

Outcome Measure Description:

Patient Satisfaction, Percent Improvement over baseline of patient satisfaction scores. For milestone I-11 we will improve patient access to primary care as measured by reducing third next available appointment times in primary care clinics to fewer than 5 calendar days or improving upon baseline rate by 5% by end of waiver. Regarding milestone I-12, we will decrease baseline days to third next available appointment by 5% by end of waiver. For milestone I-14, we will improve the patient experience by reducing the time a patient waits while in the office, without reducing the time the patient spends with the provider by 5% by end of waiver.

Rationale:

Right now in Clay County, a resident cannot make a new appointment with a local family practice physician. The four doctors aren't taking any new patients**.** We must strive to enhance our citizen's health care as much as we can. The 1115 Waiver will enable us to provide the needed additional physicians.

Outcome Measure Valuation:

Valuing the percent improvement over baseline of patient satisfaction scores will be accomplished with third party surveys. These surveys will be compiled by the third party company to give us a better idea of how patient satisfaction is increasing overall.

094138703.3.3 (094138703.3.1)	3.IT-6.1	Patient Satisfaction	
Clay County Memorial Hospital			094138703
Related Category 1 or 2 Projects:	094138703.1.2 (094138703.1.1)		
Starting Point/Baseline: ZERO			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Registry Process Milestone 1 Estimated Incentive Payment: $**19,445**	Process Milestone 2 P-2: Establish baseline rates Data Source: Registry Process Milestone 2 Estimated Incentive Payment: $**22,540**	**Outcome Improvement Target 1** IT-6.1: Improvement Target: TBD Data Source: Surveys Outcome Improvement Target 1 Estimated Incentive Payment: **$36,168**	**Outcome Improvement Target 2** IT-6.1: Improvement Target: TBD Data Source: Surveys Outcome Improvement Target 2 Estimated Incentive Payment: **$86,490**
Year 2 Estimated Outcome Amount: **$19,445**	Year 3 Estimated Outcome Amount: **22,540**	Year 4 Estimated Outcome Amount: **$36,168**	Year 5 Estimated Outcome Amount: **$86,490**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $164,643			

Category 3: Quality Improvements

ED Appropriate Utilization

RHP Project Number: 094138703.3.2

RHP Performing Provider: Clay County Memorial Hospital/094138703

Category 3: Quality Improvements

ED Appropriate Utilization

RHP Project Number: 094138703.3.4
(Old 094138703.3.2)

RHP Performing Provider: Clay County Memorial Hospital/094138703

Outcome Measure Description:

Emergency Department Appropriate Utilization. Our goal is to reduce all Emergency Department visits by providing other access to primary care. Too many residents go to the Emergency Room as their first source of health care. They visit for sore throats, earaches and stomachaches. These complaints could be handled in a physician's office. The physicians in Henrietta are not taking new patients. Much of the time, an established patient must wait days to get in to see their doctor.

Rationale:

Right now in Clay County, a resident cannot make a new appointment with a local family practice physician. The four doctors aren't taking any new patients**.** We must strive to enhance our citizen's health care as much as we can. The 1115 Waiver will enable us to provide the needed additional physicians. We will be able to provide more clinic space on weekends and after hours.

Outcome Measure Valuation:

Valuing the percent of improvement in Emergency Department visits over the next four years will be accomplished with registration data.

094138703.3.4 (094138703.3.2)	3.IT-9.2	Right Care, Right Setting	
Clay County Memorial Hospital			094138703
Related Category 1 or 2 Projects:1	094138703.2.2 (094138703.2.1)		
Starting Point/Baseline: ZERO			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Planning for recruitment of two family practice physicians to increase available patient visits in a clinic setting. Data Source: Hospital Board of managers, Medical Staff Process Milestone 1 Estimated Incentive Payment: : $12,153	**Process Milestone 2** P-2: Recruitment of two family practice physicians to increase available patient visits in a clinic setting. Data Source: Hospital Board of managers, Medical Staff Process Milestone 2 Estimated Incentive Payment: $14,087	**Outcome Improvement Target 2** IT-9.2: Improvement Target: Reduce ED visits Data Source: Registration Outcome Improvement Target 2 Estimated Incentive Payment: $22,605	**Outcome Improvement Target 2** IT-9.2: Improvement Target: Reduce ED visits Data Source: Registration Outcome Improvement Target 3 Estimated Incentive Payment: : $54,056
Year 2 Estimated Outcome Amount: $: $12,153	Year 3 Estimated Outcome Amount: : $14,087	Year 4 Estimated Outcome Amount: $22,605	Year 5 Estimated Outcome Amount: $54,056
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $102,901			

Right Care, Right Setting
ED appropriate utilization

RHP Project Number: 135034009.3.1

RHP Performing Provider: Electra Memorial Hospital-135034009

Category 3: Quality Improvements

Right Care, Right Setting
ED appropriate utilization
RHP Project Number: New Pass 3B: 135034009.3.5
(Old Pass 1: 135034009.3.1)

RHP Performing Provider: Electra Memorial Hospital-135034009
Outcome Measure Description:
Right Care, Right Setting for ED appropriate utilization has been selected in order to achieve the improvement target of reducing total ED visits including Ambulatory Care Sensitive Conditions or ACSCs. By the end of the waiver, we expect a reduction in the number of total ED visits and a percentage reduction in visits that are for these conditions by expanding our clinic space and hours, and utilizing the two nurse practitioners that were hired in September, 2012 to provide primary care services 12 hours per day, six days per week. The nurse practitioners will be trained in the Texas Health Steps Program in order to provide primary care and immunizations to Medicaid as well as low-income patients. Milestones will include planning for the expansion of the clinic space in DY 2, and then measuring the effectiveness of the delivery system reform in DY 3, 4 and 5 by developing improvement targets.
Rationale:
As evidenced by the health statistics in our community needs assessment in CN.4 and CN.5, there is low utilization of preventive services in the region, as well as a need to overcome barriers to patient access. We plan to address these needs by making it more convenient for patients to access the primary care services they need in the appropriate setting. A reduction in the total number of emergency department visits will lower costs to patients, payers and providers. By developing baseline data in DY 2, we can

determine what percentage of emergency visit diagnoses are ACSCs and work to lower that percentage by serving those patients in the clinic setting.

Outcome Measure Valuation:

The value of serving patients in the most appropriate setting was valued by considering several factors. This initiative is projected to reduced non-emergent ED utilizations, increase vaccination rates and disease screenings which would prevent hospitalizations. We project savings to the public payer systems of $160,000 each year based on pilots by DSHS and other initiatives across the nation. Our estimate of the savings to payers and to our local hospital district taxpayers could be double that amount due to the availability of primary care in a more cost effective setting to low income and uninsured patients. The value of this project is $518,881.

135034009.3.5 (135034009.3.1)	3.IT-9.2	OD-9. Right Care, Right Setting/ED appropriate utilization	
Electra Memorial Hospital			135034009
Related Category 1 or 2 Projects::	135034009.1.4 (135034009.1.1)		
Starting Point/Baseline:	We will establish the baseline in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment: $61,283	**Process Milestone 2 P-2.** Establish baseline rates Data Source: EHR records indicating ACSC diagnoses. Process Milestone 2 Estimated Incentive Payment: $71,035	**Outcome Improvement Target 1** IT-9.2: ED appropriate utilization. Improvement Target: TBD Data Source: EHR reports indicating number of emergency department visits and their related diagnoses. Outcome Improvement Target 2 Estimated Incentive Payment: $113,986	**Outcome Improvement Target 2** IT-9.2: ED appropriate utilization. Improvement Target: TBD Data Source: EHR reports indicating number of emergency department visits and their related diagnoses. Outcome Improvement Target 3 Estimated Incentive Payment: $272,577
Year 2 Estimated Outcome Amount: $61,283	Year 3 Estimated Outcome Amount: $71,035	Year 4 Estimated Outcome Amount: $113,986	Year 5 Estimated Outcome Amount: $272,577
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $518,881			

Category 3: Quality Improvements

Potentially Preventable Re-Admissions
30 Day Readmission Rates (PPRs)/Congestive Heart Failure 30 day readmission rate OD-3. IT-3.2

RHP Project Number: 135034009.3.2

RHP Performing Provider: Electra Memorial Hospital-135034009

Category 3: Quality Improvements

Potentially Preventable Re-Admissions
30 Day Readmission Rates (PPRs)/Congestive Heart Failure 30 day readmission rate OD-3. IT-3.2

RHP Project Number: New Pass 3B: 135034009.3.6
(**Old Pass 1:** 135034009.3.2)

RHP Performing Provider: Electra Memorial Hospital-135034009

Outcome Measure Description:

PPRs have been selected in order to achieve the improvement target of reducing the rate of congestive heart failure (CHF) readmissions in RHP 19. We plan to accomplish this by working with United Regional Health Care System, the safety net and tertiary referral center for this region, to expand specialty care services to the entire region, thereby removing distance barriers for low income and Medicaid patients. By accessing specialty care at the local level and priority scheduling at URHCS specialty clinics in Wichita Falls on a more frequent basis, patients can avoid delay in treatment, resulting in a focus on preventative rather than acute treatment of CHF and other diseases. Readmissions can be avoided as well as emergency department treatment. Milestones will include planning for the expansion of specialty care services and space, as well as determining which specialty care providers are in the highest demand in the region as determined by the gap analysis performed in DY 2, establishing additional clinics and hours throughout the region in DY 3, and then measuring the effectiveness of the delivery system reform in DY 4 and 5 by calculating readmission rates for CHF.

Rationale:

In order to meet the Triple Aim goals of RHP 19, the region needs to increase the number of specialty care providers. As evidenced by our community needs assessment in CN.3, there is a shortage of health care professionals in RHP 19. Additionally, CN.4 and CN.5, demonstrate that there is low utilization of preventive services in the region, as well as a need to overcome barriers to patient access. In order to transform the delivery system in RHP 19, we plan to address these needs by making it more convenient for patients to access the specialty care

services they need in order to reduce readmission rates and improve quality of care. A reduction in readmission rates will lower costs to patients, payers and providers. By developing baseline data in DY 2, we can determine current readmission rates and work to improve those in DY 3, 4 and 5.

Outcome Measure Valuation:

Outcome measure valuations were determined by considering cost savings throughout the entire region by preventing readmissions for CHF. From 2005 – 2010, there were 4,128 potentially preventable admissions for CHF in RHP 19 with an average charge of $24,226, the second highest after long term diabetes complications. (Source: Center for Health Statistics, Texas Department of State Health Services www.dshs.state.tx.us/ph.June2012) For valuation purposes, we estimated that 2% of those were potentially preventable readmissions. Savings to payers and taxpayers throughout the region could be double that amount due to the availability of specialty care in a more cost effective setting to low income and uninsured patients. The value of this project is $3,113,295.

135034009.3.6 (135034009.3.2)	3.IT-3.2	Congestive Heart Failure 30 day readmission rate	
Electra Memorial Hospital			135034009
Related Category 1 or 2 Projects::	135034009.1.5 (135034009.1.2)		
Starting Point/Baseline:	TBD in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment: $367,699	**Process Milestone 2 P-2.** Establish baseline rates Data Source: EHR reports on readmission rates Process Milestone 2 Estimated Incentive Payment: $213,105.50 **Process Milestone 3 P-5.** Disseminate findings, including lessons learned and best practices, to stakeholders. Data Source: Administrative records including minutes of learning collaboratives, distribution records or other Performing Provider source. Process Milestone 3 Estimated Incentive Payment: $213,105.50	**Outcome Improvement Target 1** IT-3.2: Congestive Heart Failure 30 day readmission rate Improvement Target: TBD Data Source: EHR reports on readmission rates Outcome Improvement Target 1 Estimated Incentive Payment: $683,921	**Outcome Improvement Target 2** IT-3.2: Congestive Heart Failure 30 day readmission rate Improvement Target: TBD Data Source: EHR reports on readmission rates Outcome Improvement Target 2 Estimated Incentive Payment: $1,635,464

Year 2 Estimated Outcome Amount: $367,699	Year 3 Estimated Outcome Amount: $426,211	Year 4 Estimated Outcome Amount: $683,921	Year 5 Estimated Outcome Amount: $1,635,464
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $3,113,295			

Category 3: Quality Improvements

Potentially Preventable Re-Admissions
30 Day Readmission Rates (PPRs)/ IT-3.1.**OD-3.** All Cause 30 day readmission rate

RHP Project Number: 135034009.3.3.

RHP Performing Provider: Electra Memorial Hospital/135034009

Category 3: Quality Improvements

Potentially Preventable Re-Admissions
30 Day Readmission Rates (PPRs)/ IT-3.1.**OD-3.** All Cause 30 day readmission rate

RHP Project Number: New Pass 3B: 135034009.3.7
(**Old Pass 1:** 135034009.3.3)

RHP Performing Provider: Electra Memorial Hospital/135034009

Outcome Measure Description:

PPRs have been selected in order to achieve the improvement target of reducing the rate of all cause 30 day readmissions. By the end of the waiver, we expect a reduction in the rate of all PPRs and hope to identify those diseases that have the greatest impact on those rates. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay and the transition therefrom. Milestones will include engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans in DY 2. We will establish baselines in DY 3 for discharges and patients identified as needing some type of care transition, and then measuring the effectiveness of the delivery system reform in DY 4 and 5 by calculating readmission rates. Lessons learned will be distributed to all stakeholders as well as best practices identified through the project.

Rationale:

This outcome measure was chosen based on data in the appendix of the CNA, specifically Table Y illustrating potentially preventable admissions. We believe that providing the Triple Aim of right care, right time, right setting, admissions and readmissions can be reduced for all types of patients, not just those with specific diagnoses. No baseline data has been established, but we believe by establishing protocols for discharge and post-discharge follow up throughout

the entire region, we can reduce readmissions and transition patients into the appropriate care setting. By establishing baselines and collecting current data to identify admission and readmission diagnoses and then analyzing that data on a collective basis to determine the cause, potentially preventable readmissions can be avoided. This will assist us in estimating the hospital-level, risk standardized rate of unplanned, all-cause readmission after admission for any eligible condition (http://www.qualityforum.org/QPS/) within 30 days of hospital discharge (RSRR) for patients ages 18 and older.
A reduction in readmission rates will lower costs to patients, payers and providers. By developing baseline data in DY 2, we can determine current readmission rates and work to improve those in DY 3, 4 and 5.

Outcome Measure Valuation:

Outcome measure valuations were determined by considering cost savings throughout the entire region by preventing readmissions. By expanding the scope to include all readmissions, data can be compiled that will determine the diseases with the highest readmission rates. From 2005 – 2010, there were 17,596 potentially preventable admissions in RHP 19 with an average charge of $21,417. (Source: Center for Health Statistics, Texas Department of State Health Services www.dshs.state.tx.us/ph.June2012) For valuation purposes, we calculate that 2% of those were potentially preventable readmissions at URHCS. The intrinsic value to patients of returning to a post-acute setting that best meets their needs is paramount, and keeping all patients, including low income and uninsured, healthy and out of the inpatient setting alleviates the burden to taxpayers in the entire region, but also improves the patient experience and promotes wellness.

135034009.3.7 (135034009.3.3)	OD-3.IT-3.1	All cause 30 day readmission rate	
Electra Memorial Hospital			135034009
Related Category 1 or 2 Projects::	135034009.2.2 (135034009.2.1)		
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: Administrative records Process Milestone 1 Estimated Incentive Payment: $245,135	**Process Milestone 2 P-2.** Establish baselines Data Source: EHR records Process Milestone 1 Estimated Incentive Payment: $284,148	**Outcome Improvement Target 1** IT-3.1: All cause 30 day readmission rate Improvement Target: TBD Data Source: EHR & Claims Outcome Improvement Target 1 Estimated Incentive Payment: $455,954	**Outcome Improvement Target 2** IT-3.1: All cause 30 day readmission rate Improvement Target: TBD Data Source: EHR & Claims Outcome Improvement 2 Estimated Incentive Payment: $1,090,312
Year 2 Estimated Outcome Amount: $245,135	Year 3 Estimated Outcome Amount: $284,148	Year 4 Estimated Outcome Amount: $455,954	Year 5 Estimated Outcome Amount: $1,090,312
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $2,075,549			

Pass 3

Category 3: Quality Improvements

OD-1 IT-1.7. Primary Care and Chronic Disease Management/Controlling high blood pressure

RHP Project Number: 135034009.3.4.

RHP Performing Provider: Electra Memorial Hospital-135034009.

Outcome Measure Description:

Chronic disease management of high blood pressure (BP) has been selected in order to achieve the improvement target of controlling high blood pressure. By the end of the waiver, we expect to increase the percentage of patients at our Iowa Park Clinic with a diagnosis of hypertension whose most recent blood pressure is adequately controlled. Milestones will include planning for and securing new clinic space in DY 2, gathering data from patients in order to establish a baseline in DY 3, and then working towards improving on those rates in DY 4 and DY 5. Providing primary care services and preventative services will encourage healthy lifestyles and promote positive changes that should result in achieving this outcome. It should also have long term effects on the Medicaid and uninsured populations that will benefit from improved access to primary care services at an early age.

Rationale:

As evidenced by the health statistics in our community needs assessment in CN.1 and Table T of the Appendix, there is an extremely high rate of chronic disease in the region, with the highest number of deaths resulting from heart disease. Approximately 33.5 percent of people in the United States have high blood pressure. It is well documented that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure. With only one primary care physician in Iowa Park, residents of that community have very limited access to primary care, particularly the low income populations that have difficulty traveling outside the community for their health care, and Medicaid patients that can only receive their preventative services if they have chosen Superior Health Care as their Medicaid managed care provider. We plan to address these needs by opening a clinic in Iowa Park that will provide patients with greater access to the primary care services that they need in order to maintain healthy lifestyles and result in having a controlled blood pressure. By developing baseline data in DY 3, we can determine what percentage of patients with a diagnosis of hypertension have a controlled blood pressure, and work to increase that percentage by serving those patients in a primary care setting.

Outcome Measure Valuation:

The value of controlling high blood pressure was calculated by considering the cost of establishing a new clinic in Iowa Park, including space, professional and support staff, computer software, equipment, and supplies. This initiative is projected to increase the number of patients in the community with controlled high blood pressure, thereby reducing hospitalizations for CHF and hypertension. Table Y of our CNA Appendix shows that these two diseases account for over 26% of all potentially preventable admissions in the region. The population of Iowa Park is approximately 8,000 people. We have used the above estimate of 33.5% as having high blood pressure, treatment of which could result in 53-75% of those achieving a controlled BP of less than 140/90. Table Y of the Appendix shows a weighted average of charges for these heart disease related illnesses to be approximately $23,500. We conservatively estimated that only one of those admissions would be prevented each year, resulting in savings to the public payer systems of $23,500 annually. In addition, we estimate that at least one emergency room visit each month could be avoided, and also included the value to payers and taxpayers of maintaining a healthy community and having increased access to primary care in a more cost effective setting for low income and uninsured patients. The total value of this Category 3 project is $761,677.

135034009.3.4	3.IT-1.7	OD-1. Primary Care and Chronic Disease Management/Controlling high blood pressure	
Electra Memorial Hospital			135034009
Related Category 1 or 2 Projects::	135034009.1.3		
Starting Point/Baseline:	We will establish the baseline in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment: $60,233	**Process Milestone 2 P-2.** Establish baseline number of patients 18-85 years of age with hypertension diagnosis and the percentage of those patients whose blood pressure (BP) is adequately controlled. Data Source: EHR records indicating number of targeted patients with hypertension diagnosis and those with a BP of less than 140/90. Process Milestone 2 Estimated Incentive Payment: $69,377	**Outcome Improvement Target 1** IT-1.7: Controlling high blood pressure. Improvement Target: Increase the percentage of patients with a controlled hypertension by 2% over DY 3. Data Source: EHR records indicating number of targeted patients with hypertension diagnosis and those with a BP of less than 140/90. Outcome Improvement Target 2 Estimated Incentive Payment: $111,426	**Outcome Improvement Target 2** IT-1.7: Controlling high blood pressure.. Improvement Target: Increase the percentage of patients with a controlled hypertension by 4% over DY 3. Data Source: EHR records indicating number of targeted patients with hypertension diagnosis and those with a BP of less than 140/90. Outcome Improvement Target 3 Estimated Incentive Payment: $266,211

135034009.3.4	3.IT-1.7	OD-1. Primary Care and Chronic Disease Management/Controlling high blood pressure	
Electra Memorial Hospital			135034009
Related Category 1 or 2 Projects::	135034009.1.3		
Starting Point/Baseline:	We will establish the baseline in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $60,233	Year 3 Estimated Outcome Amount: $69,377	Year 4 Estimated Outcome Amount: $111,426	Year 5 Estimated Outcome Amount: $266,211
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $507,247			

Category 3: Quality Improvements

OD-12
Primary Care and Prevention- Breast cancer screening

RHP Project Number: 119874904.3.1

RHP Performing Provider: Faith Community Hospital - 119874904

Outcome Measure Description

Wellness by Faith Category OD-12
Faith Community Hospital Old I.D. 119874904.3.1
New I.D. 119874904.3.5

Outcome Measure Description

The breast cancer screening measure was selected as one of a set of three from the primary care and prevention domain related to screenings. Initial milestones to be met are a planning process to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Records will be reviewed and a baseline established of the number of female clinic patients aged 40 to 69. Patients who have had a bilateral mastectomy will be excluded. There is currently minimal follow up for patients that do receive screening recommendations. Providers and staff in the Faith Community Hospital Rural Health Clinic will develop a plan to promote and provide increased cancer screenings and age appropriate immunizations. Health Promotion Committee fundraising efforts will be put in place to cover or offset the cost of screenings or immunizations for qualified persons in order to eliminate cost as a factor for receiving the intervention(s).

Teaching and patient reminders will be provided to all patients based upon the American Cancer Society guidelines for early detection of cancer and CDC immunization guidelines. The clinic will use the medical home model of preventive service clinician reminders.

Rationale

CN.4 Low utilization of preventative care services, including sigmoidoscopy, colonoscopy, and immunizations (Texas Behavioral Risk Factors Surveillance System)

According to the County Health Rankings conducted by the University of Wisconsin in 2011, Jack County residents ranked 76th percentile in clinical care and 53rd percentile (1 being the best) in health behaviors. It is the aim of Faith Community Hospital to take a broad approach to promoting improved focus on and access to wellness interventions across the lifespan. To achieve this goal, the hospital is establishing a Health Promotion Program through which a number of programs and initiatives will be made available to the general public as well as specific, target populations.

Faith Community Hospital currently does not provide on-site mammography. Arrangements will be made for a mobile mammography unit to be made available for area patients four times per year. Future hospital construction plans include areas dedicated to surgical and mammography services.

In the past 3 months, 3 local women were diagnosed with early stage breast cancer during routine annual screening. The women are fully insured and able to receive annual screening and seek prompt medical care. It is currently unknown how many women in our area meet screening criteria but are unable to afford screening or arrange transportation to receive it. Efforts to promote and find resources for life saving early screening are vital not only to reduce the financial cost to treat advanced disease but also to prevent the emotional cost to families. When resources are limited, family budgets are often directed at meeting basic needs and medical care is postponed or neglected. Faith Community Hospital intends to identify members of the community that cannot afford screenings and help them find ways to make early screening a priority. The clinic recently became a provider of the Texas Women's Health Program and qualifying patients will receive application information to assist with paying for screening services.

Faith Community Rural Health Clinic is located within the hospital. The clinic is staffed by 3 physicians and 1 nurse practitioner. The providers will develop a plan to increase breast screenings and referrals. A system will be put in place to monitor and track these interventions. Quality improvement monitors will be used to track progress toward goals.

Fundraising activities will be conducted by the Health Promotion Program to cover or offset the cost of screenings and/or immunizations for qualified persons in order to eliminate cost as a factor for receiving the intervention(s).

In addition to teaching during clinic visits, monthly awareness presentations will be available to educate the community. Topics will include a variety of health promotion topics including current screening and prevention recommendations.

Starting Point/Baseline

The clinic is currently using a new electronic finance system and reorganizing patient flow processes. Program planning for screenings will be part of this reorganization. During DY2 a primary care physician will leave the clinic practice after 20+ years of service and many patients may transfer to his private practice. Baseline data for Category 3 will not be determined until DY3 due to this restructuring.

Challenges/Issues

Internal factors that present challenges to the implementation of this program are:

- the time element of providing the training necessary to educate staff to provide/reinforce services
- physical space and equipment to perform mammograms
- developing a system identifying and tracking patient
- generating system of reminders to clinic patients eligible for screenings

Meetings will be conducted to determine an action plan to increase screenings. Training will be provided to current clinic staff. Staffing needs will be assessed and new staff hired as needed.

External factors intrinsic to health prevention measures are the challenges of patient compliance and right to refuse treatment. Follow-up, marketing and promotion efforts will need to be continuous to both maintain participation and generate new interest in programs.

Outcome Measure Valuation

Valuation assumes agreement with a study by Scott, et al, (2002) which specifically addressed a tendency among populations with low health literacy levels toward not receiving mammography, cervical screening or flu shots[1]. Applying waiver protocol outcome measures and based upon pro-rated Healthy People 2020 goals, we aim to achieve the following through health promotion efforts: Increased breast cancer screening: DY2 – Program planning; DY3 – Establish baseline; DY4 - Increase breast cancer screening by 20 patients over baseline; DY 5 Increase breast cancer screening by 40 patients over baseline.

[1]Scott TL, Gazmararian JA, Williams MV, Baker DW. 2002. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Medical Care.* 40(5): 395-404.

Old I.D.119874904.3.1 *New I.D. 119874904.3.5*	*3.IT-12.1*	*Primary Care and Prevention- Breast cancer screening*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects: 2.6.3 Evidence Based Health Promotion Program	*Old I.D. 119874904.2.1* *New I.D. 119874904.2.3*		
Starting Point/Baseline:	*To be established*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(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**: Document plan **Goal:** 1 Health Promotion Planning Worksheet completed	**Milestone 2 [P-2]:** Establish baseline rates Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. (Women who have had a bilateral mastectomy are excluded) **Metric:** Documentation of baseline	**Outcome Improvement Target 1 [IT-12]:** Increased 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 to 69 in the patient or target population. (Women who have had a bilateral mastectomy are excluded) **Metric:** Documentation of screenings	**Outcome Improvement Target 2** **[IT-12]:** Increased 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 to 69 in the patient or target population. (Women who have had a bilateral mastectomy are excluded) **Metric:** Documentation of screenings

Old I.D.119874904.3.1 *New I.D. 119874904.3.5*	*3.IT-12.1*	*Primary Care and Prevention- Breast cancer screening*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects: 2.6.3 Evidence Based Health Promotion Program	*Old I.D. 119874904.2.1* *New I.D. 119874904.2.3*		
Starting Point/Baseline:	*To be established*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
by clinic staff **Data Source**: Health Promotion Planning Worksheet	**Goal:** Baseline established **Data Source**: EHR, Claims	**Goal:** 20 patient over baseline increase in screenings **Data Source**: EHR, Claims	**Goal:** 40 patient over baseline increase in screenings **Data Source**: EHR, Claims
Year 2 Estimated Outcome Amount: ***$ 21,069.00***	Year 3 Estimated Outcome Amount: ***$ 24,419.00***	Year 4 Estimated Outcome Amount: ***$ 39,180.00***	Year 5 Estimated Outcome Amount: ***$ 93,689.00***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: ***$ 178,357.00***			

Category 3: Quality Improvements

OD-12
Primary Care and Prevention- Cervical cancer screening

RHP Project Number: 119874904.3.2

RHP Performing Provider: Faith Community Hospital-119874904

Wellness by Faith Category OD-12
Faith Community Hospital Old I.D. 119874904.3.2
New I.D. 119874904.3.6

Outcome Measure Description
The cervical cancer screening measure was selected as one of a set of three from the primary care and prevention domain related to screenings. Initial milestones to be met are a planning process to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Records will be reviewed and a baseline established of the number of female clinic patients aged 21 to 64. Women who have had a complete hysterectomy with no residual cervix will be excluded.

Rationale
CN.4 Low utilization of preventative care services, including sigmoidoscopy, colonoscopy, and immunizations (Texas Behavioral Risk Factors Surveillance System)

According to the County Health Rankings conducted by the University of Wisconsin in 2011, Jack County residents ranked 76th percentile in clinical care and 53rd percentile (1 being the best) in health behaviors. It is the aim of Faith Community Hospital to take a broad approach to promoting improved focus on and access to wellness interventions across the lifespan. To achieve this goal, the hospital is establishing a Health Promotion Program through which a number of programs and initiatives will be made available to the general public as well as specific, target populations.

A local woman was recently diagnosed with Stage 4 cervical cancer. She suspected a possible problem for years but could not afford the cost of the office visit and testing to evaluate this. She is the mother of two school-aged children. Efforts to promote and find resources for life saving early screening are vital not only to reduce the financial cost to treat advanced disease but also to prevent the emotional cost to families. When resources are limited, family budgets are often directed at meeting basic needs and medical care is postponed or neglected. Faith Community Hospital intends to identify members of the community that cannot afford screenings and help them find ways to make early screening a priority. The clinic recently became a provider of the Texas Women's Health Program and qualifying patients will receive application information to assist with paying for screening services.

Faith Community Rural Health Clinic is located within the hospital. The clinic is staffed by 3 physicians and 1 nurse practitioner. The providers will develop a plan to increase cervical cancer screenings. A system will be put in place to monitor and track these interventions. Quality improvement monitors will be used to track progress toward goals.

Fundraising activities will be conducted by the Health Promotion Program to cover or offset the cost of screenings for qualified persons in order to eliminate cost as a factor for receiving the intervention(s).

In addition to teaching during clinic visits, monthly awareness presentations will be available to educate the community. Topics will include a variety of health promotion topics including current screening and prevention recommendations.

Starting Point/Baseline

The clinic is currently using a new electronic finance system and reorganizing patient flow processes. Program planning for screenings will be part of this reorganization. During DY2 a primary care physician will leave the clinic practice after 20+ years of service and many patients may transfer to his private practice. Baseline data for Category 3 will not be determined until DY3 due to this restructuring.

Challenges/Issues

Internal factors that present challenges to the implementation of this program are:

- the time element of providing the training necessary to educate staff to provide/reinforce services
- developing a system identifying and tracking patient
- generating system of reminders to clinic patients eligible for screenings

Meetings will be conducted to determine an action plan to increase screenings. Training will be provided to current clinic staff. Staffing needs will be assessed and new staff hired as needed.

External factors intrinsic to health prevention measures are the challenges of patient compliance and right to refuse treatment. Follow-up, marketing and promotion efforts will need to be continuous to both maintain participation and generate new interest in programs.

Outcome Measure Valuation

Valuation assumes agreement with a study by Scott, et al, (2002) which specifically addressed a tendency among populations with low health literacy levels toward not receiving mammography, cervical screening or flu shots[1]. Applying waiver protocol outcome measures and based upon pro-rated Healthy People 2020 goals, we aim to achieve the following through health promotion efforts: Increased cervical cancer screening: DY2 – Program planning; DY3 – Establish baseline; DY4 - Increase cervical cancer screening by 20 patients over baseline; DY 5 Increase cervical cancer screening by 40 patients over baseline.

[1]Scott TL, Gazmararian JA, Williams MV, Baker DW. 2002. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Medical Care.* 40(5): 395-404.

Old I.D. 119874904.3.2 *New I.D. 119874904.3.6*	*3.IT-12.2*	*Primary Care and Prevention- Cervical cancer screening*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects: 2.6.3 Evidence Based Health Promotion Program	*Old I.D. 119874904.2.1* *New I.D. 119874904.2.3*		
Starting Point/Baseline:	*To be established*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(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**: Document plan **Goal: :** 1 Health Promotion Planning Worksheet completed by clinic staff **Data Source**: Health Promotion Planning Worksheet	**Milestone 2 [P-2]:** Establish baseline rates 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. **Metric:** Documentation of baseline **Goal:** Baseline data set established **Data Source**: EHR, Claims	**Outcome Improvement Target 1 [IT-12]:** Increased 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. **Metric:** Documentation of screenings **Goal:** 20 patient over baseline increase in screenings	**Outcome Improvement Target 2 [IT-12]:** Increased 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. **Metric:** Documentation of screenings **Goal:** 40 patient over baseline increase in screenings

Old I.D. 119874904.3.2 *New I.D. 119874904.3.6*	*3.IT-12.2*	*Primary Care and Prevention- Cervical cancer screening*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects: 2.6.3 Evidence Based Health Promotion Program	*Old I.D. 119874904.2.1* *New I.D. 119874904.2.3*		
Starting Point/Baseline:	*To be established*		
Year 2 **(10/1/2012 – 9/30/2013)**	**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, Claims	**Data Source**: EHR, Claims
Year 2 Estimated Outcome Amount: ***$ 21,069.00***	Year 3 Estimated Outcome Amount: ***$ 24,419.00***	Year 4 Estimated Outcome Amount: ***$ 39,180.00***	Year 5 Estimated Outcome Amount: ***$ 93,689.00***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: ***$ 178,357.00***			

Category 3: Quality Improvements

OD-12
Primary Care and Prevention- Pneumonia vaccination for older adults

RHP Project Number: 119874904.3.3

RHP Performing Provider: Faith Community Hospital - 119874904
Wellness by Faith Category OD-12
Faith Community Hospital Old I.D. 119874904.3.3
New I.D. 119874904.3.7

Outcome Measure Description

The pneumonia vaccination measure was selected as one of a set of three from the primary care and prevention domain related to screenings. Initial milestones to be met are a planning process to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Records will be reviewed and a baseline established of the number of clinic patients aged 64 and older. Patients will an allergy to the vaccine will be excluded.

Rationale

CN.4 Low utilization of preventative care services, including sigmoidoscopy, colonoscopy, and immunizations (Texas Behavioral Risk Factors Surveillance System)

According to the County Health Rankings conducted by the University of Wisconsin in 2011, Jack County residents ranked 76th percentile in clinical care and 53rd percentile (1 being the best) in health behaviors. It is the aim of Faith Community Hospital to take a broad approach to promoting improved focus on and access to wellness interventions across the lifespan. To achieve this goal, the hospital is establishing a Health Promotion Program through which a number of programs and initiatives will be made available to the general public as well as specific, target populations.

The Centers for Disease Control recommends pneumonia vaccination for all persons age 65 and older and special populations such as: the elderly, adults with diabetes, functional or anatomic asplenia (sickle cell disease or post splenectomy), and HIV-infected persons. A new recommendation by the Advisory Committee on Immunization Practices recommends immunization for all cigarette smokers due to the increased chance for developing pneumonia. The cost of treating pneumonia is $8-$10 billion dollars per year in the U.S. These costs increase when treatment is hindered by comorbid conditions.

Community teaching and access to resources are vital to increasing vaccination rates to prevent pneumonia. Emphasis should be placed on the importance of the vaccine based not only on meeting age criteria, but also in the presence of additional risk factors that could complicate care in the event of developing pneumonia.

Faith Community Rural Health Clinic is located within the hospital. The clinic is staffed by 3 physicians and 1 nurse practitioner. The providers will develop a plan to increase pneumonia

vaccinations for older adults. A system will be put in place to monitor and track these interventions. Quality improvement monitors will be used to track progress toward goals.

Fundraising activities will be conducted by the Health Promotion Program to cover or offset the cost of immunizations for qualified persons in order to eliminate cost as a factor for receiving the intervention.

In addition to teaching during clinic visits, monthly awareness presentations will be available to educate the community, and shot clinics may be made available at the senior citizens center. Topics will include a variety of health promotion topics including immunization and prevention recommendations.

Starting Point/Baseline

The clinic is currently using a new electronic finance system and reorganizing patient flow processes. Program planning for screenings will be part of this reorganization. During DY2 a primary care physician will leave the clinic practice after 20+ years of service and many patients may transfer to his private practice. Baseline data for Category 3 will not be determined until DY3 due to this restructuring.

Challenges/Issues

Internal factors that present challenges to the implementation of this program are:

- the time element of providing the training necessary to educate staff to provide/reinforce services
- developing a system identifying and tracking patient
- generating system of reminders to clinic patients eligible for immunization

Meetings will be conducted to determine an action plan to increase screenings. Training will be provided to current clinic staff. Staffing needs will be assessed and new staff hired as needed.

External factors intrinsic to health prevention measures are the challenges of patient compliance and right to refuse treatment. Follow-up, marketing and promotion efforts will need to be continuous to both maintain participation and generate new interest in programs.

Outcome Measure Valuation

Valuation assumes agreement with a study by Scott, et al, (2002) which specifically addressed a tendency among populations with low health literacy levels toward not receiving mammography, cervical screening or flu shots[1]. Applying waiver protocol outcome measures and based upon pro-rated Healthy People 2020 goals, we aim to achieve the following through health promotion efforts: Increased pneumonia vaccinations in older adults: DY2 – Program planning; DY3 – Establish baseline; DY4 - Increase pneumonia vaccination in older adults by 30 patients over baseline; DY 5 Increase pneumonia vaccinations by 50 patients over baseline.

[1]Scott TL, Gazmararian JA, Williams MV, Baker DW. 2002. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Medical Care.* 40(5): 395-404.

Old I.D. 119874904.3.3 *New I.D. 119874904.3.7*	*3.IT-12.4*	*Primary Care and Prevention- Pneumonia vaccination for older adults*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects: 2.6.3 Evidence Based Health Promotion Program	*Old I.D. 119874904.2.1* *New I.D. 119874904.2.3*		
Starting Point/Baseline:	*To be established*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(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:** Document plan **Goal:** 1 Health Promotion Planning Worksheet completed by clinic staff **Data Source**: Health Promotion Planning Worksheet	**Milestone 2 [P-2]:** Establish baseline rates Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine Denominator: Number of adults aged 64 and older in the patient or target population. **Metric:** Documentation of baseline **Goal:** Established baseline **Data Source**: EHR, Claims	**Outcome Improvement Target 1 [IT-12]:** Increased pneumonia vaccination status of older adults Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine Denominator: Number of adults aged 64 and older in the patient or target population. **Metric:** Documentation of screenings **Goal:** 30 patient over baseline increased in screenings **Data Source**: EHR, Claims	**Outcome Improvement Target 2 [IT-12]:** Increased pneumonia vaccination status of older adults Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine Denominator: Number of adults aged 64 and older in the patient or target population. **Metric:** Documentation of screening **Goal:** 50 patient over baseline increased in screenings **Data Source**: EHR, Claims

Old I.D. 119874904.3.3 *New I.D. 119874904.3.7*	*3.IT-12.4*	*Primary Care and Prevention- Pneumonia vaccination for older adults*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects: 2.6.3 Evidence Based Health Promotion Program	*Old I.D. 119874904.2.1* *New I.D. 119874904.2.3*		
Starting Point/Baseline:	*To be established*		
Year 2 **(10/1/2012 – 9/30/2013)**	**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: ***$ 21,069.00***	Year 3 Estimated Outcome Amount: ***$ 24,419.00***	Year 4 Estimated Outcome Amount: ***$ 39,180.00***	Year 5 Estimated Outcome Amount: ***$ 93,689.00***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: ***$ 178,357.00***			

Pass 3

Category 3: Quality Improvements

Appropriate ED Utilization
Reduce all ED visits3.IT-9.2

RHP Project Number: 119874904.3.4

RHP Performing Provider: Faith Community Hospital -119874904

Appropriate ED Utilization Category OD-9
IT-9.2
Faith Community Hospital 119874904.3.4

Outcome Measure Description

The Emergency Department Care Transition program seeks to reduce future, avoidable emergency department visits by Medicaid and uninsured patients without a primary care provider. Using the Care Transition Program developed bv Dr. Eric Coleman, a Transition Coach provides education on appropriate emergency department use and the importance of having a primary care provider. A transition team staff member makes a series of follow up phone calls to encourage the patient to keep appointments, assess the patient's understanding of discharge instructions and condition specific red flags, and identify any access to care barriers in place.

The program seeks to identify and provide teaching to patients with ambulatory care sensitive conditions. Patients in this population often return to the emergency department or become admitted to the hospital due to their lack of post discharge follow up with a primary care provider. These admissions may be prevented through care transition teaching and follow up contact.

To date, approximately 83% of patients presenting to Faith Community Hospital Emergency Department were classified as non-emergencies. Many of these individuals face significant barriers to accessing regular care, including having behavioral health or substance abuse issues; and not having adequate insurance, a primary care provider, the ability to afford prescribed medications or reliable transportation to appointments.

Frequent use of the Emergency Department for chronic, non-emergent conditions creates problems for patients and the hospital. Visits from a few "frequent flyers" can lead to significantly higher costs for the system as a whole.

Rationale

CN.5 Need to overcome patient access to care barriers (Texas Behavioral Risk Factors Surveillance System, US Census Bureau)

Many uninsured and underinsured patients use the emergency department for non-emergent conditions that could be better handled in a lower-cost setting. Many of these individuals have ambulatory care sensitive conditions. Frequently they face significant barriers to receiving care outside the Emergency Department, and there is no effective way of linking them to a more appropriate source of care. According to recent census data, 1in 4 Texans are uninsured. The Healthy People 2020 baseline of persons without a primary care provider is 76.3%. Our program is intended to bridge the gap between non-emergent ED use and appropriate use of primary care through patient follow up and education.

Required Quality Improvement

The ED utilization program will be monitored using the principles of continuous quality improvement. Plan Do Study Act worksheets will be completed at quarterly intervals and as needed to analyze effectiveness of all programs . Modifications explored, implemented, and analyzed as needed.

Challenges/Issues

Internal factors that present challenges to the implementation of this program are:

- the time element of providing the training necessary to educate select staff to provide new services
- the time element of providing ongoing training to staff as part of continuous quality improvement
- EHR system requirements necessary to identify and track emergency room patients

The project will provide staffing, database management and patient teaching materials. Staff and patient teaching will be ongoing throughout the project as new staff are hired and as the program evolves through quality improvement evaluation.
External factors intrinsic to patient access to care are the challenges of patient compliance with instructions, overcoming financial barriers that may prevent the patient from receiving the medication and follow up recommended, and language barriers. The transition staff will include a member that speaks fluent Spanish to assist in translating materials and making follow up phone calls.

Relationship to Other Performing Providers' Projects in the RHP:

Other Performing Providers in RHP 19 that are doing similar projects in their local areas, are:

Bowie Memorial Hospital 127305405.1.1

Clay County Memorial Hospital 094138703.1.1
Electra Memorial Hospital- 135034009.1.1
Graham Regional Medical Center 130613604.1.1
Hamilton Hospital 110856504.1.1
Hardeman County Memorial Hospital 121692107.1.1
North Texas Medical Center 121777003.1.1
United Regional Health Care System 135237906.1.1
Wilbarger General Hospital 112707803.1.1

None of these address ED utilization in the Jacksboro community.

Outcome Measure Valuation

Valuation assumes the development of a care transition program in DY2, refining the program using Plan, Do, Study, Act system during DY3, and program improvement as evidenced by 100 fewer non-emergent patients seen in DY4 and 200 fewer non-emergent patients in DY5. A potential limitation to this program is that there is not a local urgent care clinic level of care to divert patients to from the ED. Faith Community Hospital does not have the space or resources to establish such a clinic.

Appropriate ED Utilization 119874904.3.4	*Reduce all ED visits IT-9.2*	*Appropriate ED Utilization*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects:	*Implement Care Transitions Program 119874904.2.12*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric**: Documentation of program planning **Goal**: 1 Care Transition Planning packet **Milestone 2 [P- 2]**: Establish baseline rate **Metric**: Documentation of ED visit baseline (including ACSC) **Goal:** 1 set of baseline ED visits (including ACSC) data **Milestone 1** Estimated Incentive Payment (maximum amount): **$ 24,606.50** **Milestone 2** Estimated	**Milestone 3 [P- 4]**: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric**: Documentation of project data reports **Goal**: 3 quarterly Plan, Do, Study, Act worksheets **Milestone 3** Estimated Incentive Payment (maximum amount): ***$75,556***	**Outcome Improvement Target 1** [IT-9.2]: Appropriate ED utilization **Metric**: Reduce all ED visits (including ACSC) **Goal:** 100 patient over baseline reduction in ED visits (including ACS) **Outcome Improvement Target 1** Estimated Incentive Payment*:* **$ 101,155**	**Outcome Improvement Target 2** [IT-9.2]: Appropriate ED utilization **Metric**: Reduce all ED visits (including ACSC) **Goal:** 200 patient over baseline reduction in ED visits (including ACSC) **Outcome Improvement Target 2** Estimated Incentive Payment*:* **$ 188,946**

Appropriate ED Utilization 119874904.3.4	*Reduce all ED visits IT-9.2*	*Appropriate ED Utilization*	
Faith Community Hospital			*119874904*
Related Category 1 or 2 Projects:	*Implement Care Transitions Program 119874904.2.12*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment (maximum amount): **$ 24,606.50**			
Year 2 Estimated Outcome Amount: **$ 49,213**	Year 3 Estimated Outcome Amount: **$ 75,576**	Year 4 Estimated Outcome Amount: **$ 101,155**	Year 5 Estimated Outcome Amount: **$ 188,946**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$ 414,890**			

Category 3: Quality Improvements

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

RHP Project Number: 130613604.3.1

RHP Performing Provider: Graham Regional Medical Center - 130613604

Category 3: Quality Improvements

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

RHP Project Number: 130613604.3.2 (130613604.3.1)

RHP Performing Provider: Graham Regional Medical Center - 130613604

Outcome Measure Description:

Graham Regional Medical Center recognizes the need to divert non-emergent cases from our ED in order to more appropriately serve those patients truly in an emergency and to make the healthcare system more efficient. Through our 1.1 Expand Primary Care Capacity project, we expect to be able to more efficient see patients with urgent care needs and through the nurse advice line reduce non-emergent ED utilization. We will work with our nurses and staff in DY 2 and 3 to begin proper training on how to best educate clinic and ED patients. We expect to also find out more details as to why people come to the ED and address those issues. Historical claims indicate we have high volume of non-emergent utilization in our ED. We will establish an official baseline for the clients served in Category 1 and then measure their utilization. We expect to report reductions, which are TBD, in DY 4 and DY 5.

Rationale:

GRMC has identified an issue with the non-emergent utilization of the ED. We will establish a baseline and then targets for DY 4 and DY 5 to reduce non-emergent ED utilization by those who we are able to see in the clinic or advise on the nurse advice line.

Outcome Measure Valuation:

GRMC has identified an issue with the non-emergent utilization of the ED. A high volume of visits are non-emergent medical needs. We know the ED is the most expensive setting for care and has the highest level of medical professionals on call in order to treat true emergencies. Utilizing the ED for routine primary and/or preventive care is not a cost effective nor efficient

model. We will identify barriers for patients who are utilizing the ED for all their care needs and educate them on other care settings which are more efficient and cost effective. We expect to reduce our non-emergent ED claims within the patients seen and treated through our expanded primary care clinic and nurse advice line.

130613604.3.2 (130613604.3.1)	OD-9 IT-9.2	ED Appropriate Utilization	
Graham Regional Medical Center			130613604
Related Category 1 or 2 Projects::	130613604.1.2 (130613604.1.1)		
Starting Point/Baseline:	We estimate in 80 percent of ED visits in FY 2011 were non-emergent.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of Planning and Stakeholder Engagement Process Milestone 1 Estimated Incentive Payment (maximum amount): $113,757	**Process Milestone 3** P- 2 Establish baseline rates Data **Source: EMR/Registry** Process Milestone 3 Estimated Incentive Payment: $131,859	**Outcome Improvement Target 1** IT-9.2 ED appropriate utilization Reduce all ED visits (including ACSC)271 Improvement Target: TBD Data Source: EMR/Registry Outcome Improvement Target 1 Estimated Incentive Payment: $211,588	**Outcome Improvement Target 2** IT-9.2 ED appropriate utilization Reduce all ED visits (including ACSC)271 Improvement Target: TBD Data Source: EMR/Registry Outcome Improvement Target 2 Estimated Incentive Payment: $505,972
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $113,757	Year 3 Estimated Outcome Amount: $131,859	Year 4 Estimated Outcome Amount: $211,588	Year 5 Estimated Outcome Amount: $505,972

130613604.3.2 (130613604.3.1)	OD-9 IT-9.2	ED Appropriate Utilization	
Graham Regional Medical Center			130613604
Related Category 1 or 2 Projects::	130613604.1.2 (130613604.1.1)		
Starting Point/Baseline:	We estimate in 80 percent of ED visits in FY 2011 were non-emergent.		
Year 2 (10/1/2012 – 9/30/2013)	**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)**:** $963,176			

Category 3: Quality Improvements

OD-9 Right Care, Right Setting

RHP Project Number: 110856504.1.1

RHP Performing Provider: Hamilton Hospital-110856504

Outcome Measure Description:

The outcome measure chosen for the Category 1 project, Expand Primary Care Capacity, is related to ED appropriate utilization. The improvement target values will be determined during DY 2, and subsequently used during years 3-5. This will be accomplished by offering the residents of Archer City and surrounding areas access to primary care; consequently lowering the utilization of the ED.

Rationale:

We think that the best measure of success in expanding access to primary care is a resulting decrease in inappropriate ED visits. It is our belief that by expanding provider access into Archer City along with necessary staff, as well as hours of availability, that the need for the non-urgent ED visits from Archer City and surrounding communities will decrease. As of July 31, 2012 primary care was not available in Archer City, Texas.

Outcome Measure Valuation:

By adding a Provider and a clinic to Archer City we will help with the prevention of readmissions and admissions due to chronic illness and diseases. But, more importantly we will ease the load on our Hospital ED. Patients will save time and money related to transportation to and from Olney and will have the opportunity to access primary and preventive care in their local community for services like immunizations and everyday illnesses which will keep them out of the ED.

110856504.3.1	IT 9.2	ED APPROPRIATE UTILIZATION	
HAMILTON HOSPITAL			110856504
Related Category 1 or 2 Projects::	110856504.1.1		
Starting Point/Baseline:	Baseline will be established after year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Establish additional/expand existing/relocate primary care clinics. <u>Metric 1</u> P-1.1: Number of additional clinics or expanded hours or space. Baseline/Goal: July 31, 2012 no clinic in Archer City so no baseline. Goal is to open the clinic and see 5 patients per day by the end of DY 2 Data Source: Operating system printed admissions report. Milestone 1 Estimated Incentive Payment: $56,268	**Milestone 2** P-1: Establish additional/expand existing/relocate primary care clinics. <u>Metric 1</u> P-1.1: Number of additional clinics or expanded hours or space. Baseline/Goal: Baseline will be opening the clinic and seeing 5 patients per day by the end of DY 2. Goal is to see 7 patients per day by the end of DY 3 Data Source: Operating system printed admissions report. Milestone 2 Estimated Incentive Payment: $86,961	**Outcome Improvement Target 1** 3. I.T. 9.2 ED appropriate utilization. Metric 3. I.T. 9.2.1 Number of ED visits reduced from baseline by 5%. Goal: Reduce ED visits for non-emergent care. Data Source: ED Registration and triage documentation. Outcome Improvement Target 1 Estimated Incentive Payment: $116,286	**Outcome Improvement Target 1** 3. I.T. 9.2 ED appropriate utilization. Metric 3. I.T. 9.2.1 Number of ED visits reduced from baseline by 10%. Goal: Reduce ED visits for non-emergent care. Data Source: ED Registration and triage documentation. Outcome Improvement Target 1 Estimated Incentive Payment: $217,404

110856504.3.1	IT 9.2	ED APPROPRIATE UTILIZATION	
HAMILTON HOSPITAL			110856504
Related Category 1 or 2 Projects::	110856504.1.1		
Starting Point/Baseline:	Baseline will be established after year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $56,268	Year 3 Estimated Outcome Amount: $86,961	Year 4 Estimated Outcome Amount: $116,286	Year 5 Estimated Outcome Amount: $217,404
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $476,919			

*See RHP 19 Addendum to see original and revised Category 3 and 4 amounts for the Pass 1 workbook. Category 4 was included in Pass 1, but provider is exempt. Therefore Category 3 funding is adjusted to account for those funds.

Category 3: Quality Improvements

Addressing Health Disparities in Minority Populations
IT 11.1 Improvement in Clinical Indicator in identified disparity group

RHP Project Number: 110856504.3.2

RHP Performing Provider: Hamilton Hospital -110856504

Category 3: Quality Improvements

Narrative for each Category 3 Outcome Measure shall include:

- **Identifying Outcome Measure and Provider Information:** The unique Category 3 Outcome Domain for the Category 2 project of Establish Self-Management Programs and Wellness Using Evidence-Based Designs is OD-11 Addressing Health Disparities in Minority Populations. The improvement target is IT 11.1 Improvement in Clinical Indicator in identified disparity group. The unique RHP outcome identification number is 110856504.3.3, (110856504.3.2) Hamilton Hospital/110856504.

- **Outcome Measure Description:** The outcome measure chosen for the Category 2 project, Establish Self-Management Programs and Wellness Using Evidence-Based, is related to Addressing Health Disparities in Minority Populations. The improvement target values will be determined during DY 2, and subsequently used during years 3-5. This will be accomplished by offering the residents of Olney and surrounding areas access to wellness and fitness and education classes that will promote healthy living therefore decreasing admissions related to obesity in the minority population and others as well.

- **Rationale:** This project will address Category 3 OD-11 Addressing Health Disparities in Minority Populations; specifically IT-11.1 Improvement in Clinical Indicator in identified disparity group. The need to prevent hospital admissions alone for rural Americans with weight problems is reason enough to want to provide these self-management programs. The next reason is to prevent clinical health issues in our rural teen and adult citizens, specifically our minority population. Also, by offering a place locally for people to exercise and enroll in fitness and or nutrition classes we believe that the low-income people will benefit by not having to have the expense of travel to accomplish this and consequently by being healthier will not be burdened by preventable health costs.

- **Outcome Measure Valuation:** We recently did a strategic plan where we listened to our community leaders express the desire for a wellness center to promote healthy employees. We are answering this by establishing a self-management program with a

wellness center and education opportunities. Like mentioned above, the value will be by saving at least $10,000 per year for each obese person that changes their life style through our wellness center. Our baseline for participation is 0 but we will plan on increasing participation each year until DY5 where we plan to have 9 minority or obese patients enrolled. This increase will be monitored by wellness center enrollment. We also value the project by monitoring each client enrolled that has previous hospital admissions to see if hospital usage is decreased. Our baseline for obesity related admissions will be calculated at year end for the year and our goal will be to decrease this 10% per subsequent year.

110856504.3.3 (110856504.3.2)	*IT 11.1*	*Addressing Health Disparities in Minority Populations*	
HAMILTON HOSPITAL			*110856504*
Related Category 1 or 2 Projects::	*110856504.2.2 (110856504.2.1)*		
Starting Point/Baseline:	*Baseline will be established after year 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 3.P-1: Project planning - engage stakeholders, identify current process and needed resources, determine timelines and document implementation plans. Metric 1 3.P-1.1 Develop a plan for expanding chronic care management. Goal: Plan for expanding chronic care management. Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment *:* $22,839	**Process Milestone 2:** 3. P-2 Establish Baselines-Establish patient roster for chronic care disease management registry. Metric 1 3.P-9.1 Identify patients for chronic disease management program. Data Source: Documentation of the patient roster. Process Milestone 2 Estimated Incentive Payment: $35,074	**Outcome Improvement Target 1** I.T. 11.1 Addressing Health Disparities in Minority Populations Metric 3. I.T. 11.1 Improvement in Clinical Indicator (Obesity) in identified disparity group (minority, low-income) Data Source: Enrollment log for the program. Outcome Improvement Target 1 Estimated Incentive Payment: $46,945	**Outcome Improvement Target 1** I.T. 11.1 Addressing Health Disparities in Minority Populations Metric 3. I.T. 11.1 Improvement in Clinical Indicator (Obesity) in identified disparity group (minority, low-income) Data Source: Enrollment log for the program. Outcome Improvement Target 1 Estimated Incentive Payment: $87,687
Year 2 Estimated Milestone Bundle Amount: $22,839	Year 3 Estimated Outcome Amount: $35,074	Year 4 Estimated Outcome Amount: $46,945	Year 5 Estimated Outcome Amount: $87,687
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $192,545			

Category 3: Quality Improvements

IT-10.1 Quality of Life

RHP Project Number: 127373205.3.1

RHP Performing Provider: Helen Farabee Center /127373205

Outcome Measure Description:

The outcome measure is designed to track improvement in quality of life scores as measured by the Substance Abuse Adult/Child Treatment Assessment. This is the assessment mandated by the Department of State Health Services and maintained in the Clinical Management for Behavioral Health Services (CMBHS) database. The assessment is a multi-purpose tool developed for adult and child substance abuse services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

Rationale:

The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in the region. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services.

Outcome Measure Valuation:

Substance abuse imposes a heavy burden on emergency room and primary care settings. When individuals are screened for substance abuse and receive appropriate treatment, the related utilization and abuse of health care settings will go down 50% with a savings of $3.81 to $4.30 for every dollar spent on treatment services. We used the average of $4.05 saved for every dollar spent on treatment services. The savings of $4.05 was determined by

the Texas Drug Demand Reduction Advisory Committee Report to state leadership[47]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[47] Texas Drug Demand Reduction Advisory Committee: Report to State Leadership, January 2009 (http://www.dshs.state.tx.us/sa/ddrac/)

127373205.3.1	3.IT-10.1	Quality of Life	
[The Helen Farabee Center]			[127373205]
Related Category 1 or 2 Projects::	127373205.1.1		
Starting Point/Baseline:	No SA service encounters in counties outside Wichita County		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 1:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment (maximum	**Process Milestone 2:** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 2:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment (maximum	**Outcome Improvement Target 1:** **IT-10.1 Quality of Life-275,276,277 (Standalone measure)** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of the target population. Data Source: Substance Abuse Adult/Child Treatment Assessment. Outcome Improvement Target 1 Estimated Incentive Payment: $75,109	**Outcome Improvement Target 2:** **IT-10.1 Quality of Life-275,276,277 (Standalone measure)** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 10% of the target population. Data Source: Substance Abuse Adult/Child Treatment Assessment. Outcome Improvement Target 2 Estimated Incentive Payment: $173,923

127373205.3.1	3.IT-10.1	Quality of Life	
[The Helen Farabee Center]			[127373205]
Related Category 1 or 2 Projects::	127373205.1.1		
Starting Point/Baseline:	No SA service encounters in counties outside Wichita County		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
amount): $30,446 Add more process milestones/improvement targets, as applicable	amount): $65,028		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $30,446	Year 3 Estimated Outcome Amount: $65,028	Year 4 Estimated Outcome Amount: $75,109	Year 5 Estimated Outcome Amount: $173,923
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $344,056			

Category 3: Quality Improvements

IT-10.1. Quality of Life

RHP Project Number: 127373205.3.2

RHP Performing Provider: Helen Farabee Centers -127373205

Outcome Measure Description:

The outcome measure is designed to track improvement in quality of life scores as measured by the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths assessment (CANS). The ANSA and CANS are multi-purpose tools developed for adult and child behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. These tools are mandated for use by the Department of State Health Services within the Texas Recovery and Resiliency model of care. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the ANSA, for 5% of patients in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

Rationale:

The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in the region. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services.

Outcome Measure Valuation:

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years. Based on the literature, an estimated Quality of Life Year gained by this intervention is 0.0245 years. Based on past performance in fiscal year 2012, we estimate demand for psychiatric evaluations to be 914 per year. The result is a valuation of $1,119,344 per year (914 x 0.0245 x $50,000). The valuation is aligned with the Medicaid Waiver goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research). Cost-utility

analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The number of life-years added is based on a review of the scientific literature. A search of the scientific literature identified the following two studies. The first study looked at telemedicine and mental health and was conducted by Pyne (2010) [48] which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010) [49] examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

[48] Pyne, J. M., Fortney, J. C., Tripathi, S. P., Maciejewski, M. L., Edlund, M. J., & Williams, D. K. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Arch Gen Psychiatry, 67*(8), 812-821.

[49] Hollinghurst, S., Peters, T. J., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomized controlled trial. *Br J Psychiatry, 197*(4), 297-304.

127373205.3.2	3.IT-10.1	Quality of Life	
[The Helen Farabee Center]			127373205
Related Category 1 or 2 Projects::	127373205.1. 2		
Starting Point/Baseline:	0 on-demand routine psychiatric evaluations to date		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 1:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment (maximum	**Process Milestone 2:** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 2:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment (maximum	**Outcome Improvement Target 1:** **IT-10.1 Quality of Life-275,276,277 (Standalone measure)** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 5% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 1 Estimated Incentive Payment: $64,106	**Outcome Improvement Target 2:** **IT-10.1 Quality of Life-275,276,277 (Standalone measure)** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 10% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 2 Estimated Incentive Payment: $134,286

127373205.3.2	3.IT-10.1	Quality of Life	
[The Helen Farabee Center]			127373205
Related Category 1 or 2 Projects::	127373205.1. 2		
Starting Point/Baseline:	0 on-demand routine psychiatric evaluations to date		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
amount): $28,095 Add more process milestones/improvement targets, as applicable	amount): $62,387		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,095	Year 3 Estimated Outcome Amount: $62,387	Year 4 Estimated Outcome Amount: $64,106	Year 5 Estimated Outcome Amount: $134,286
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $288,874			

Category 3: Quality Improvements

IT-10.1 Quality of Life

RHP Project Number: 127373205.3.3

RHP Performing Provider: Helen Farabee Centers- 127373205

Outcome Measure Description:

The outcome measure is designed to track improvement in quality of life scores as measured by the Daily Living Assessment (DLA)[50]. The DLA is a multi-domain tool applicable to adult IDD individuals to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation. The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the DLA, for 5% of patients in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

Rationale:

The process milestones were selected in order to provide stakeholders with status reports regarding the new intervention in the region. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new IDD respite services.

Outcome Measure Valuation:

Valuation methodology consisted of applying a gain in Quality of Life Years (QALY) of 0.03 per standard value of one life year ($50,000) times 30 (estimated crisis-prevention cases in one year).

The rational for this valuation begins with the goal of reducing unnecessary emergency department usage and psychiatric hospitalizations for people with Intellectual/Developmental Disabilities (IDD). Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The number of life-years added is being used as a common health goal or outcome. A standard value of $50,000 is assigned to one life year. One study by Clark et

[50] Scott, R, Presmanes, W. (2001). Reliability and Validity of the Daily Living Activities Scale: A Functional Assessment Measure for Severe Mental Disorders. *Research on Social Work Practice, 11*(3), 373-389.

al. (1998)[51] considered the use of Assertive Community Treatment (ACT) for people with severe mental illness and substance abuse disorders versus standard care. This is not perfectly comparable to an IDD population. The Quality of Life Years (QALYs) gained through ACT versus standard care was 0.03 years. This QALY gain was considered in addition to Latimer's (2005)[52] review which found that a high-fidelity ACT team can reduce the number of hospital days by about 78%.

[51] Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Serv Res, 33(5),* 1285-1308.

[52] Latimer, E. (2005). Economic considerations associated with assertive community treatment and supported employment for people with severe mental illness. *Journal of Psychiatry & Neuroscience 30(5),* 355-359.

127373205.3.3	3.10.1	Quality of Life	
[Helen Farabee Center]			[127373205]
Related Category 1 or 2 Projects::	127373205.1.3		
Starting Point/Baseline:	0 IDD respite bed days used		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: Disseminate findings, including lessons learned and best practices, to stakeholders **<u>Metric 1:</u>** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment (maximum	**Process Milestone 2:** Disseminate findings, including lessons learned and best practices, to stakeholders **<u>Metric 2:</u>** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment (maximum	**Outcome Improvement Target 1:** **IT-10.1 Quality of Life-275,276,277 (Standalone measure)** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the DLA assessment, for 5% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 1 Estimated Incentive Payment: $88,405	**Outcome Improvement Target 2:** **IT-10.1 Quality of Life-275,276,277 (Standalone measure)** Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the DLA assessment, for 10% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 2 Estimated Incentive Payment: $186,618

127373205.3.3	3.10.1	Quality of Life	
[Helen Farabee Center]			[127373205]
Related Category 1 or 2 Projects::	127373205.1.3		
Starting Point/Baseline:	0 IDD respite bed days used		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
amount): $33,243 Add more process milestones/improvement targets, as applicable	amount): $85,360		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $33,242	Year 3 Estimated Outcome Amount: $85,360	Year 4 Estimated Outcome Amount: $88,405	Year 5 Estimated Outcome Amount: $186,618
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $393,626			

Pass 3

Category 3: Quality Improvements

IT-10.1 Quality of Life (Peer Support)

RHP Project Number: 127373205.3.4

RHP Performing Provider: Helen Farabee Center- 127373205

Outcome Description:

Please describe the outcome measure, specifically process milestones and selected improvement target(s) for each year (e.g., improve by 5% by end of waiver).
The outcome measure is designed to track improvement in quality of life scores as measured by the Adult Needs and Strengths Assessment (ANSA). The ANSA is a multi-purpose tool developed for adult behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It is the tool mandated for use by the Department of State Health Services within the Texas Recovery and Resiliency model of care. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 2 project implementation. The measurement timeframe is one assessment 3 months post intake compared to a subsequent assessment 6 months later. This measurement timeframe is chosen to avoid measuring any effects produced by the Pass 1 Open Access project (127373205.1.2). The expected improvement milestone for developmental year 4 is to see improvement in quality of life, comparing assessments at 3 months with assessments at 6 months, as measured by the ANSA for 5% of adults receiving peer support services in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The milestone increases to 10% for year 5.

Rationale:

Please describe the reasons for selecting the process milestones and outcome improvement targets. If improvement targets are not determined, please indicate that outcome improvement targets will be determined in DY2 for DY3 implementation.
The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services.

Outcome Measure Valuation:

Approach/Methodology:

Please describe your approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets).
Applied a benefit-cost ratio of $3.71 per dollar invested.

Rationale/Justification:

Please describe your rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.
The closest studies relating to valuation of peer support programs came from Sari et al. (2008)[53] who found the benefit-cost ratio for a peer support program related to preventing adolescent suicide was $3.71 for each dollar invested. Kuyken et al. (2008)[54], in another peer-support program for prevention of adolescent suicide, found a benefit cost ratio of $43 for each dollar invested for Native American Youth. The average benefit cost ratio between these two studies is $23.36, however since our target population contains little or no Native American representation, we chose the conservative amount of $3.71.

Related Category 1 and/or 2 projects. Please list the projects linked to this outcome below.
127373205.2.1

[53] Sari, N., de Castro, S., Newman, F.L., & Mills, G. (2008). Should we invest in suicide prevention programs? *The Journal of Socio-Economics 37 (2008),* 262–275.
[54] Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., . . . Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *J Consult Clin Psychol, 76(6)*, 966-978.

127373205.3.4	3.IT-10.1	Quality of Life (Peer Support)	
[The Helen Farabee Center/ Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties]			127373205
Related Category 1 or 2 Projects::	127373205.2.1		
Starting Point/Baseline:	0 Peer Services specific to Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties to date.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1 [P-5.1]: Submit findings, lessons and best practices to stakeholders Numerator: Number of findings, lessons learned and best practices submitted to stakeholders Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment: $23,284	**Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 2 [P-5.1]: Submit findings, lessons and best practices to stakeholders Numerator: Number of findings, lessons learned and best practices submitted to stakeholders Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment: $53,635	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life-275,276,277 (Standalone measure) Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 5% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 1 Estimated Incentive Payment: $57,430	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life-275,276,277 (Standalone measure) Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 10% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 2 Estimated Incentive Payment: $124,735

127373205.3.4	3.IT-10.1	Quality of Life (Peer Support)	
[The Helen Farabee Center/ Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties]			127373205
Related Category 1 or 2 Projects::	127373205.2.1		
Starting Point/Baseline:	0 Peer Services specific to Wichita, Montague, Young, Hardeman, Wilbarger, Foard, Baylor, Archer, Clay, Jack, and Throckmorton counties to date.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $23,284	Year 3 Estimated Outcome Amount: $53,635	Year 4 Estimated Outcome Amount: $57,430	Year 5 Estimated Outcome Amount: $124,735
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $259,084			

Category 3: Quality Improvements

Potentially Preventable Complications and Healthcare Acquired Conditions
IT-4.5 Patient Fall Rate- NQF 0141255 (Standalone measure)

RHP Project Number: 120745806.3.1

RHP Performing Provider: Muenster Memorial Hospital - 120745806

K. Category 3: Quality Improvements

The goal of Category 3 is to assess an outcome of a project implemented under Category 1 or 2. As described in the Program Funding and Mechanics Protocol, each Category 1 and 2 project is required to have an associated Category 3 outcome measure.

Category 3 Outcome Measure :

- **Identifying Project and Provider Information:**
  - **120745806.3.2 (120745806.3.1)**
  - **Muenster Memorial Hospital/120745806**
- **Category 3 Outcome Measure(s):**
  - **OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions**
  - **IT-4.5 Patient Fall Rate- NQF 0141255 *(Standalone measure)***
- Project Description:
- Muenster Memorial Hospital wants to improve patient safety by reducing patient fall rate within the facility. Remote pharmacists will perform a drug regimen review of all patients that will include contradictions between medications that may precipitate a fall of a patient. The remote pharmacist will make clinical interventions prospectively to address the possibility of a drug potentiating the effect of the patient home medications and the ordered hospital medication that could cause a patient to fall.

  Outcome Measure Description Starting Point/Baseline: The expected outcome is an increase in the number of prescriber orders that are reviewed in a timely manner providing pharmacist oversight. Resulting clinical interventions and recommendations will decrease the number of falls related to medications ordered and given.

- **Outcome Measure Valuation:** To decrease the patient falls related to medications by 15 % over the course of the project

120745806.3.2 (120745806.3.1)	*IT-4.5 Patient Fall Rate*	*OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions*	
Muenster Memorial Hospital/120745806			**120745806**
Related Category 1 or 2 Projects::	**120745806.1.2 (120745806.1.1)**		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 2 Establish baseline rates: Patient Fall Rate Data **Source: EMR/Registry** Process Milestone 3 Estimated Incentive Payment: $21,067	**Outcome Improvement Target 1** IT-4.5 Patient Fall Rate Improvement Target: TBD Baseline/Goal: To reduce patient falls related to medications by 5% compared to baseline FY 2012 Data Source: EMR/Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $24,418	**Outcome Improvement Target 2** IT-4.5 Patient Fall Rate Improvement Target: TBD Goal: Increase number of pharmacist interventions and counseling by 10% compared to base line FY 2012 Data Source: EMR/Registry Outcome Improvement Target 2 Estimated Incentive Payment*:* $39,183	**Outcome Improvement Target 3** IT-4.5 Patient Fall Rate Improvement Target: TBD Goal: Increase number of pharmacist interventions and counseling by 15% compared to base line FY 2012 Data Source: EMR/Registry Outcome Improvement Target 3 Estimated Incentive Payment*:* 93,698

120745806.3.2 (120745806.3.1)	*IT-4.5 Patient Fall Rate*	*OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions*	
Muenster Memorial Hospital/120745806			**120745806**
Related Category 1 or 2 Projects::	**120745806.1.2 (120745806.1.1)**		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $21,067	Year 3 Estimated Outcome Amount: $24,418	Year 4 Estimated Outcome Amount: $39,183	Year 5 Estimated Outcome Amount: $93,698
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $178,366			

Category 3: Quality Improvements

Patient Satisfaction
Percent improvement over baseline of patient satisfaction scores

RHP Project Number: 127310404.3.1

RHP Performing Provider: Nocona General Hospital- 127310404

NOCONA GENERAL HOSPITAL CATEGORY 3 NARRATIVE

Outcome Measure Description:

Percent improvement over baseline of patient satisfaction scores has been chosen to document year over year the success of the category 2 project. By the end of the waiver period, the hospital expects its patient satisfaction scores to improve a minimum of 5% year over year, thus improving quality of care especially in the low income population, and reducing the number of costly readmissions.

Rationale:

The hospital and its staff fully understand the need to appropriately care for and listen to its patients. The cost of healthcare has been driven upward partially by the increase of costly readmissions and the failure of the system to adequately provide follow up instructions and post discharge instructions. These issues, the hospital believes, can be overcome by detailed patient questionnaires detailing the patients' satisfaction or dissatisfaction of the hospital's services.

Outcome Measure Valuation:

As a small rural county, the need to appropriately care in the initial setting is vitally important. The need for readmissions and repeat procedures drive the cost of healthcare up thus disproportionately affecting the taxpayers of the district.

127310404.3.1	3.IT-6.1	OD-6 Patient Satisfaction	
Nocona General Hospital			127310404
Related Category 1 or 2 Projects::	127310404.2.1		
Starting Point/Baseline:	Baseline will be established in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone 1 Estimated Incentive Payment (maximum amount): $10,491	**Process Milestone 2** P-2 Establish baseline rates Process Milestone 2 Estimated Incentive Payment: $12,160	**Outcome Improvement Target 1** IT-6.1: Percent improvement over baseline of patient satisfaction scores. Improvement Target: x% increase in satisfaction scores over baseline Data Source: HCAHPS survey results **Outcome Improvement** Target Estimated Incentive Payment: $19,513	**Outcome Improvement Target 2** IT-6.1: Percent improvement over baseline of patient satisfaction scores. Improvement Target: x% increase in satisfaction scores over Year 4 Data Source: HCAHPS survey results Outcome Improvement Target 2 Estimated Incentive Payment: $46,663
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $10,491	Year 3 Estimated Outcome Amount: $12,160	Year 4 Estimated Outcome Amount: $19,513	Year 5 Estimated Outcome Amount: $46,663
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $88,827			

Category 3: Quality Improvements

Reduce all ED visits (including ACSC
IT – 9.2 ED Appropriate Utilization

RHP Project Number: 121777003.3.1

RHP Performing Provider: North Texas Medical Center- 121777003

Category 3: Quality Improvements

IT – 9.2 ED Appropriate Utilization

New Pass 3B Project 121777003.3.3
Old Pass 1 121777003.3.1
North Texas Medical Center 121777003

<u>Outcome Measure Description:</u>
IT – 9.2 ED appropriate Utilization

- Reduce all ED visits (including ACSC)

Process Milestones:
Over the next four years of the DSRIP program NTMC will decrease all ED visits by expanding primary care capacity. NTMC will use the following process milestones to prepare for our improvement target which will be determined during DY2 and DY3.

DY2

- Process Milestone P-1 Project Planning
    - Conduct educational activities for the public to make them aware of clinic days/hours and the appropriate use of the ED and the clinics
    - Conduct educational activities with ED staff so that they are aware of the clinic hours and capabilities.
- Process Milestone P-2 Establish baseline ED visit rates

DY3

- Process Milestone P-4 Conduct quality improvement for project. Activities may include, but are not limited to, identifying "lessons learned", opportunity 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.
- Process Milestone P-5 Disseminate findings including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

DY4

- IT-9.2 ED Appropriate Utilization
    - Decrease all ED visits TBD% below baseline

DY5

- IT-9.2 ED Appropriate Utilization
    - Decrease all ED visits TBD% below baseline

Rationale:

We feel that the best measure of the success in expanding access to primary care is decreasing all ED visits. Although we expect to see reductions in admissions and readmissions of chronic disease such as diabetes, CHF, COPD, and Asthma, these outcomes may not be achieved as quickly.

The process milestones were chosen to facilitate the decrease in ED visits that may be achieved when patients have readily available primary care, including evening and weekend hours.[1] Since primary care has not been available during evenings and weekends until recently we will need to spend time and efforts to educate the public about the changes so that they are aware of an alternative to ED and what constitutes need for the ED as opposed to services that can be furnished in the primary care/urgent care setting. We will also need to educate the ED staff on days/times that the clinics are open and clinic capabilities. Quality improvement projects will maximize the gains of our project.

Outcome Measure Valuation:

Reducing all ED visits will benefit the entire population of Cooke County but in particular Medicaid and the uninsured. With easy access to appropriate levels of care Cooke county residents will not have to resort to the expensive and temporary care afforded in the emergency room**.** With a population of approximately 40,000 and a sixty bed hospital ED this will be a significant cost reduction. Additionally patients will be getting the preventative and chronic care they need which is not afforded in an emergency department setting.

1. Flores-Mateo G, Violan-Fors C, et.al. (2012) Effectiveness of Organizational Interventions to Reduce Emergency Department Utilization: A Systematic Review. PLoS ONE 7(5): e3509. Doi10.1371/journal.pone.003590

OLD 121777003.3.1 *NEW 121777003.3.3*	*3.IT-9.2*	*ED Appropriate Utilization*	
North Texas Medical Center			*121777003*
Related Category 1 or 2 Projects::	*OLD 121777003.1.1* *NEW 121777003.1.2*		
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 – Education of Public/Staff P-1.1 Metric: Document education of public Data Source: Documentation of education activities ,flyers, newspaper articles & ads P-1.2 Metric: Documentation of education of ED personnel Data Source: documentation of staff training materials & HR records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $126,397 **Process Milestone 2** P-2: Establish Baseline ED visit P-2.1 Metric: ED Baseline visit Data Source: EHR	**Process Milestone 3** P-4 Conduct Plan Do Study Act (PDSA) to improve data collection & intervention activities. P-4.1 Metric: Number of PDSA cycles Data Source: Documentation of PDSA cycles. Process Milestone 3 Estimated Incentive Payment: $195,347 **Process Milestone 4** P-5: Disseminate findings including lessons learned & best practices to ED personnel P-5.1 Metric: Number of monthly ED meetings Data Source: meeting notes	**Outcome Improvement Target 1** IT-9.2:ED appropriate utilization - Improvement Target: reduce all ED visits X% Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $522,440	**Outcome Improvement Target 2** IT-9.2:ED appropriate utilization - Improvement Target: Reduce all ED visits X% Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $976,736

OLD 121777003.3.1 *NEW 121777003.3.3*	*3.IT-9.2*	*ED Appropriate Utilization*	
North Texas Medical Center			*121777003*
Related Category 1 or 2 Projects::	*OLD 121777003.1.1* *NEW 121777003.1.2*		
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 2 Estimated Incentive Payment: $126,397	Process Milestone 4 Estimated Incentive Payment: $195,347		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $252,794	Year 3 Estimated Outcome Amount: $390,694	Year 4 Estimated Outcome Amount: $522,440	Year 5 Estimated Outcome Amount: $976,736
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,142,664			

Pass 3

Category 3: Quality Improvements

IT-3.2 Congestive Heart Failure 30 day readmission rate: The percentage of readmissions for any cause, within 30 days of discharge from the index heart failure admission.

RHP Project Number: 121777003.3.2

RHP Performing Provider: North Texas Medical Center- 121777003

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-2 - Establish baseline rates for Congestive Heart Failure 30 day readmission rate and other 2 top readmission conditions.
  - P-3 – Develop and test data systems
- DY3:
  - P-4 - Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 – Disseminate Findings, including lessons learned & best practices to stakeholders

Outcome Improvement Targets for each year

- DY3:
  - IT-3.2: Decrease Congestive Heart Failure 30 day readmission rate: Decrease CHF 30 day readmission rate by TBD below baseline.
- DY4
  - IT-3.2: Decrease Congestive Heart Failure 30 day readmission rate: Decrease CHF 30 day readmission rate by TBD below baseline.
- DY5
  - IT-3.2: Decrease Congestive Heart Failure 30 day readmission rate: Decrease CHF 30 day readmission rate by TBD below baseline.

Rationale:

Process milestones P-1 through P-5 were chosen because at present we are not certain what our three top readmission conditions are. We need to gather the data and make this decision so that that our care transitions team can give priority to patients with these diagnoses. We feel anecdotally and through reports on readmissions given to us by Texas Medical Foundation that CHF is probably number one. The TMF data is only covers Medicare patients. We must make sure our data systems are correct and establish our baselines. Once we see our baselines and do further research we will be able to set actual improvement targets. In DY3 we can perform PDSA cycles to check accuracy of data collection and improve interventions. We feel that we can achieve some decrease in CHF 30 day admissions during DY3 also and continue to improve in DY4 and DY5.

Outcome Measure Valuation:

Hospital readmissions are expensive with a median cost of $13,463 per readmitted patient.[55] Reducing the CHF readmissions would reduce the costs associated with these hospitalizations and improve the health outcomes of the targeted patients, CHF and the other top conditions resulting in most frequent 30 day readmissions. By providing a smooth transition out of the inpatient setting we would improve patient satisfaction, by reducing patient's frustration in dealing with an increasing complex healthcare system. NTMC plans an ambitious program for a 60 bed hospital with expectations that care transitions team members can operate outside the traditional confines of a care transitions program. We plan for the dietitian and pharmacist to link with local physician practices and community organizations providing their expertise to low income chronic disease patients who do not normally have coverage for their services.

[55] Peterson, Eric D "Health Care Costs & Financing – Bundled payments for heart failure disease management programs can save money while reducing readmissions" Agency for Healthcare Research and Quality (HS 16964) Jan 2012.

121777003.3.2	IT-3.2	Congestive Heart Failure 30 Day Readmission Rate	
North Texas Medical Center			121777003
Related Category 1 or 2 Projects::	121777003.2.12		
Starting Point/Baseline:	TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity, & needed resources, determine timelines & document implementation plans. Data Source: implementation plan Process Milestone 1 Estimated Incentive Payment: $ 25,929 **Process Milestone 2** [P-2]: Establish baseline CHF 30 day readmission rate Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $ 25,930 **Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR	**Process Milestone 4**[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection & intervention activities. Data Source: QI Reports Process Milestone 5 Estimated Incentive Payment: $ 39,819 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned & best practices to stakeholders Process Milestone 5 Estimated Incentive Payment: $ 39,820 **Outcome Improvement Target 1** [IT-3.2]: Congestive Heart Failure 30 day readmission rate Numerator: the number of readmissions (for patients 18 years and older), for any	**Outcome Improvement Target 2** [IT-3.2]: Congestive Heart Failure 30 day readmission rate Numerator: the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principle discharge of HF and with a complete claims history for the 12 months prior to admission. Improvement Target:TBD Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $159,890	**Outcome Improvement Target 3** [IT-3.2]: Congestive Heart Failure 30 day readmission rate Numerator: the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principle discharge of HF and with a complete claims history for the 12 months prior to admission. Improvement Target:TBD Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment: $298,656

Process Milestone 3 Estimated Incentive Payment: $ 25,930	cause, within 30 days of discharge from the index HF admission Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principle discharge of HF and with a complete claims history for the 12 months prior to admission. Improvement Target:TBD Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $39,820		
Year 2 Estimated Outcome Amount: $ 77,789	Year 3 Estimated Outcome Amount: $ 119,459	Year 4 Estimated Outcome Amount: $ 158,890	Year 5 Estimated Outcome Amount: $ 298,656
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $ 655,794			

Category 3: Quality Improvements

Perinatal Outcomes (Percentage of Low Birth-Weight Births,
IT-8.2, Percentage of Low Birth-Weight Births

RHP Project Number: 138353107.3.1

RHP Performing Provider: Seymour Hospital-138353107

A. Category 3: Quality Improvements

Perinatal Outcomes

Percentage of Low Birth-Weight Births

RHP Project Number: New Pass 3B: *138353107.3.4*
(Old Pass 1: *138353107.3.1)*

RHP Performing Provider: *Seymour Hospital - 138353107*

- **Outcome Measure Description:** *The outcome measure for our project to Expand Specialty Care Capacity involves monitoring OD-8, Perinatal Outcomes, specifically improvement target IT-8.2, Percentage of Low Birth-Weight Births. We plan to document baseline data for the percentage of low birth weight births collected during DY-3 and improve upon them in subsequent years DY-4 and DY-5. Birth data will be collected from the hospital EMR records of all obstetric patients who receive prenatal care at our facility in order to document the birth weight of the each baby. We anticipate a direct correlation between adequate prenatal care that begins in the first trimester with healthy birth weights. The target populations for our project are the obstetric patients who give birth at our facility as well as the babies that they give birth to, of which approximately 92% are either covered by Medicaid or are uninsured.*
- **Rationale:** *The primary reasons for selecting the process milestones and improvement targets for this project are to create a more comprehensive care plan for our obstetrical patients. By increasing the quality and adequacy of care and prenatal education that our patients receive, we will be able to reduce the incidence of low birth-weight births at our facility.*
- **Outcome Measure Valuation:** *The approach for valuing this outcome measure is based upon the positive impact that adequate prenatal care and education have on increasing birth weights. The rationale/justification for this measure addresses priority community needs, specifically CN-5 (Need to Overcome Patient Care Barriers) and CN-6 (Need for Improvement in Fertility and Natality Care), as identified in the community needs*

assessment for Region 19, which was conducted in July 2012. By increasing prenatal care and education and in turn birth weight, we will be able to fulfill the needs of our community in these areas. The value of this project is $205,120.

138353107.3.4 (138353107.3.1)	*3.IT-8.2*	*Percentage of Low Birth-Weight Births*	
Seymour Hospital			*138353107*
Related Category 1 or 2 Projects::	138353107.1.3 (138353107.1.1)		
Starting Point/Baseline:	*To 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 and Administrative Records* Process Milestone 1 Estimated Incentive Payment*: $24,226*	**Process Milestone 2:** *P-2* Establish Baseline of Percentage of Low Birth-Weight Births (<2500 Grams). Data Source: *EHR Records for Labor & Delivery Patients Documenting Newborns with a Birth-Weight of < 2500 Grams.* Process Milestone 3 Estimated Incentive Payment: *$28,081*	**Outcome Improvement Target 1**: *IT-8.2* *Percentage of Low Birth-Weight Births* Improvement Target: Decrease Percentage of Low Birth-Weight *Births by 1% Over DY 3.* Data Source: *EHR Records for Labor & Delivery Patients Documenting Newborns with a Birth-Weight of < 2500 Grams.* Outcome Improvement Target 1 Estimated Incentive Payment*: $45,060*	**Outcome Improvement Target 2:** *IT-8.2* *Percentage of Low Birth-Weight Births* Improvement Target: Decrease Percentage of Low Birth-Weight *Births by 2% Over DY 3.* Data Source: *EHR Records for Labor & Delivery Patients Documenting Newborns with a Birth-Weight of < 2500 Grams.* Outcome Improvement Target 3 Estimated Incentive Payment*: $107,753*
Year 2 Estimated Outcome Amount: *$24,226*	Year 3 Estimated Outcome Amount: *$28,081*	Year 4 Estimated Outcome Amount: *$45,060*	Year 5 Estimated Outcome Amount: *$107,753*

138353107.3.4 (138353107.3.1)	*3.IT-8.2*	*Percentage of Low Birth-Weight Births*	
Seymour Hospital			*138353107*
Related Category 1 or 2 Projects::	138353107.1.3 (138353107.1.1)		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5): $205,120*			

Category 3: Quality Improvements

Primary Care and Chronic Disease Management

Controlling High Blood Pressure

RHP Project Number: New Pass 3B: 138353107.3.5
(**Old Pass 1**: 138353107.3.2)

RHP Performing Provider: Seymour Hospital - 138353107

Outcome Measure Description:

The outcome measure for our project to Implement Evidence-Based Health Promotion Programs involves monitoring OD-1, Primary Care and Chronic Disease Management, specifically improvement target IT-1.7, Controlling High Blood Pressure. Milestones for our project include planning and implementing a Wellness Center during DY-2. During DY-3, we will monitor clinic patients who have been diagnosed with hypertension and document those whose blood pressures are well controlled at or below 140/90. We will then document patients who improve their blood pressure in subsequent years DY-4 and DY-5. We anticipate a direct correlation between the patients who participate in the Wellness Program and those who are able to successfully reduce their blood pressures into the acceptable range. Data will then be complied to demonstrate the correlation between an increase in the amount of physical exercise and nutritional improvements made and a decrease in a patient's blood pressure. The target populations for our project are adult hypertensive patients who are seen by physicians at our clinic and are subsequently referred to either our on-site Wellness Program or to an at-home exercise and healthy eating plan. We also anticipate positive health outcomes for both Medicaid and uninsured patients through participation in the Wellness Program.

Rationale:

The primary reasons for selecting the process milestones and improvement targets for this project are to reduce the mortality rate from heart disease, stroke and renal failure through the aggressive treatment of high blood pressure. By reducing the diastolic blood pressure by 5 mm to 6 mm, there is an associated 14-20% reduction in mortality from coronary heart disease and a 42% reduction in stroke mortality. A healthy diet and a monitored exercise plan are the primary drug-free methods for reducing blood pressure. It is for this reason that we plan to implement a Community Wellness Center, which will not only help our patients to reduce their blood pressure, but also to manage weight, control diabetes and improve their general health and wellbeing.

Outcome Measure Valuation:

The approach for valuing this outcome measure is based upon the positive impact that decreasing blood pressure will have on reducing the risk for coronary heart disease and stroke for our community. The rationale/justification for this measure addresses priority community needs, specifically CN-1 (High Rates of Chronic Disease, Including Cancer, Heart Disease, Respiratory Diseases and Obesity), as identified in the community needs assessment for region 19, which was conducted in July 2012. The value of this project is $205,120.

138353107.3.5 (138353107.3.2)	3.IT-1.7	Controlling High Blood Pressure	
Seymour Hospital			138353107
Related Category 1 or 2 Projects::	138353107.2.2 (138353107.2.1)		
Starting Point/Baseline:	To 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 and Administrative Records Process Milestone 1 Estimated Incentive Payment: $24,226	**Process Milestone 2:** P-2 Establish Baseline Percentage of Adult Patients Diagnosed with Hypertension, Who Have Subsequently Well Controlled Blood Pressures Less Than or Equal to 140/90. Data Source: Clinic EHR, Claims Process Milestone 2 Estimated Incentive Payment: $28,081	**Outcome Improvement Target 1:** IT-1.7 Controlling High Blood Pressure Improvement Target: Increase the Percentage of Adult Patients Who Have Well Controlled Hypertension (≤140/90) by 3% Over DY-3. Data Source: Clinic EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $45,060	**Outcome Improvement Target 2:** IT-1.7 Controlling High Blood Pressure Improvement Target: Increase the Percentage of Adult Patients Who Have Well Controlled Hypertension (≤140/90) by 5% Over DY-3. Data Source: Clinic EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $107,753

138353107.3.5 (138353107.3.2)	3.IT-1.7	Controlling High Blood Pressure	
Seymour Hospital			138353107
Related Category 1 or 2 Projects::	138353107.2.2 (138353107.2.1)		
Starting Point/Baseline:	To be established in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $24,226	Year 3 Estimated Outcome Amount: $28,081	Year 4 Estimated Outcome Amount: $45,060	Year 5 Estimated Outcome Amount: $107,753
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $205,120			

Pass 3

Category 3: Quality Improvements

Right Care, Right Setting

ED Appropriate Utilization

RHP Project Number: 138353107.3.3

RHP Performing Provider: Seymour Hospital -138353107

Outcome Measure Description:

The outcome measure for our project to Expand Primary Care Capacity involves monitoring OD-9, Right Care, Right Setting, specifically improvement target IT-9.2, ED Appropriate Utilization. Our goal is to establish an Urgent Care Clinic during DY-2. We will then document baseline data for the number of non-urgent encounters in the Emergency Department during DY-3 and improve upon them in subsequent years DY-4 and DY-5. Data will be collected from the EMR and Emergency Department Records. We will monitor the number of patients who visit the Emergency Department for non-emergent, non-life threatening conditions which would be more efficiently and cost effectively treated in a primary care setting such as the Urgent Care Clinic. The target populations for our project are the underserved members of our community which include the elderly, indigent and charity populations, Medicaid/Medicare recipients, the uninsured/underinsured and those who face financial or geographical barriers to care.

Rationale:

The primary reasons for selecting the process milestones and improvement targets for this project are to improve patient access to timely and cost effective, non-emergent health care. By increasing the accessibility of our patients to primary care through the implementation of an Urgent Care Clinic, we will be able to improve patient satisfaction and care as well as decrease the number of non-urgent encounters that present to our Emergency Department.

Outcome Measure Valuation:

The approach for valuing this outcome measure is based upon our ability to improve patient care and the patient experience through utilization of the Right Care in the Right Setting. By implementing an Urgent Care Clinic, we will be offering our patients and our community a timelier and more cost effective alternative to the Emergency Department for minor and non-

life threatening illnesses and injuries. Additionally, we will be improving the satisfaction that our patients have in regard to their care at the Urgent Care Clinic through decreased wait times and a more appropriate level of patient care. The rationale/justification for this measure addresses priority community needs, specifically CN-5 (Need to Overcome Patient Care Barriers), as identified in the community needs assessment for Region 19, which was conducted in July 2012. We anticipate the patient impact for this project will by approximately 1000 patient encounters per year being served through the Urgent Care Clinic.

138353107.3.3	IT-9.2	Right Care, Right Setting (ED Appropriate Utilization)	
Seymour Hospital			138353107
Related Category 1 or 2 Projects::	138353107.1.2		
Starting Point/Baseline:	Established During DY-3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project Planning- Engage Stakeholders, Identify Current Capacity and Needed Resources, Determine Timelines and Document Implementation Plans Data Source: Documentation and Administrative Records Process Milestone 1 Estimated Incentive Payment: $46,038	**Process Milestone 2:** P-2 Establish Baseline Rates a. Determine the Number of Non-Emergent Encounters in the Emergency Dept b. Data Source: EMR; Emergency Department Records Process Milestone 3 Estimated Incentive Payment: $70,700	**Outcome Improvement Target 1**: IT-9.2 ED Appropriate Utilization a. Improvement Target: Reduce Non-Urgent ER Visits by 50 Under Baseline Established in DY-3 b. Data Source: EMR; Emergency Department Records Outcome Improvement Target 1 Estimated Incentive Payment: $94,628	**Outcome Improvement Target 1**: IT-9.2 ED Appropriate Utilization a. Improvement Target: Reduce Non-Urgent ER Visits by 100 Under Baseline Established in DY-3 b. Data Source: EMR; Emergency Department Records Outcome Improvement Target 1 Estimated Incentive Payment: $176,755
Year 2 Estimated Outcome Amount: $46,038	Year 3 Estimated Outcome Amount: $70,700	Year 4 Estimated Outcome Amount: $94,628	Year 5 Estimated Outcome Amount: $176,755

138353107.3.3	IT-9.2	Right Care, Right Setting (ED Appropriate Utilization)	
Seymour Hospital			138353107
Related Category 1 or 2 Projects::	138353107.1.2		
Starting Point/Baseline:	Established During DY-3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $388,121			

Category 3: Quality Improvements

ED Appropriate Utilization (Standalone measure)

Category 3: Quality Improvement

Unique RHP Outcome Identification Number: 084434201.3.1
Outcome Measure Title: OD-10 Quality of Life/Functional Status
Provider: Texoma Community Center/084434201

Related Category 3 Outcome Measure(s): OD-10 Quality of Life/Functional Status
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: Assessment of Quality of Life Tool Data Results
c. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

Outcome Measure Description: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 and Category 2 process milestones selected for Project 084434201.1.1 are as follows: DY2 (1) procurement of necessary equipment and systems; DY 3 (2) establishing additional service sites, (3) implement training for staff; DY 4 (4) rewrite operational protocols and clinical guidelines to include additional types of patients, (5) [establish] individuals being served who have used telemedicine, telehealth, telementoring, and/or telemonitoring services for mental illness / substance use disorders, (6) participate in regional learning collaborative and implement "raise the floor" initiatives.

Outcome Improvement Targets for Project 084434201.1.1 are as follows: TCC currently uses telemedicine services in the Child and Adolescent Program for psychiatric appointments only, averaging 52 telemedicine encounters center-wide per month with about 1/3 (17) of these encounters for the approximate 40 children and adolescents in Cooke County. The DY 2 goal is to procure additional telemedicine equipment. DY 3 goal is to select 1 additional telemedicine site, install the equipment and have staff fully trained. Telemedicine services will be expanded in this region to different types of services, for a goal of 100 additional patients being served in DY 4 and 140 in DY 5 through expanded telehealth services. Overall, 240 patients will benefit from this $294,813.00 project by DY 5. (1e) Another, goal is for 20% to be new patients receiving substance abuse treatment in DY 4 and 25% receiving substance abuse treatment in DY 5

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity."(42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse,

as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services, expanding provider network for substance abuse treatment, providing counseling options for those with no health insurance and expanding capacity through telementalhealth options as well as ensuring quality improvements across all projects will have an overall achievement level that has a positive impact on patient functioning and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for Texoma Community Center to use to assess the impact of both individual projects and to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

Outcome Measure Valuation: "The term ***quality of life*** (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." **(44)** Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects. This measure spans four of the five projects; using measured quality of life improvements to give definition to the size, scope, community benefit, and even efficiency and cost reduction/avoidance as each produces beneficial outcomes. TCC currently uses telemedicine services in the Child and Adolescent Program for psychiatric appointments only, averaging 52 telemedicine encounters center-wide per month with about 1/3 (17) of these encounters for the approximate 40 children and adolescents in Cooke County. The DY 2 goal is to procure additional telemedicine equipment. DY 3 goal is to select 1 additional telemedicine site, install the equipment and have staff fully trained. Telemedicine services will be expanded in this region to different types of services, for a goal of 100 additional patients being served in DY 4 and 140 in DY 5 through expanded telehealth services. Category 1 improvement target is 240 patients for a patient impact of $294,813.00 DY 5. (1e) Based on the valuation methodology selected, the Category 3 valuation is set at $39,393.00.

TCC's Telehealth Project will provide the electronic/internet-based means for transmitting, storing and accessing important information that will enhance treatment intended to improve the quality of lives. For some, the technological advancements to be made by TCC may even be their lives due to rapid communications and insights gained through immediate access to information. The value of this project will be significant, both for individuals and community stakeholders, because the relatively high initial cost will be quickly offset by costs that will be reduced to routine systems maintenance and occasional upgrades. As the

telecommunication system expands, it will produce an even greater value to our communities and stakeholders as it is used for increase networking and educational collaborations.

TCC's Quality Improvement Project increases value by creating an evolving system of continuous quality improvement, which will use rapid and low cost retrieval of electronically stored information, to assess life quality improvements for individuals and continue to "raise the floor" in their improved levels of functioning.

Milestone and Metrics Table

084434201.3.1	3.IT-10.1	Quality of Life (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Project::1.11,1.1	084434201.1.1		
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: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: Not established Goal: Plan documentation verified Data Source: Plan documentation, meeting minutes and surveys Baseline: No documentation Goal: Plan documentation in place Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,760.50 Process Milestone 2 [P-2]: Establish baseline number of individuals in underserved area using telemedicine/telehealth/ telemonitoring/ telementoring services Metric: Baseline established Baseline: No baseline number established	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No results Goal: Results collected and assessed Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: $ 4,081.00 Outcome Improvement Target 1 [IT-10.1]: Quality of Life	Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Baseline: No improvement Goal: Improvement noted Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 8,732.00	Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Baseline: No improvement Goal: Improvement noted Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 18,978.00

084434201.3.1	3.IT-10.1	Quality of Life (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Project::1.11,1.1	084434201.1.1		
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)
Goal: Baseline number established Data Source: Plan and resource documentation, AQoL Initial Results Process Milestone 2 Estimated Incentive Payment: $ 1,760.50	Improvement Target: TBD IT-1 Metric: Target established Baseline: No targeted improvement Goal: Target established and improvement noted Data Source: AQoL survey assessment results Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 4,081.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 3,521.00	Year 3 Estimated Outcome Amount: $ 8,162.00	Year 4 Estimated Outcome Amount: $ 8,732.00	Year 5 Estimated Outcome Amount: $ 18,978.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 39,393.00			

Category 3: Quality Improvement

Unique RHP Outcome Identification Number: 084434201.3.2

Outcome Measure Title: OD-10 Quality of Life/Functional Status

Provider: Texoma Community Center/084434201

Related Category 3 Outcome Measure(s): OD-10 Quality of Life/Functional Status

IT-10.1 Quality of life- (standalone measure)

d. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
e. Data source: Assessment of Quality of Life Tool Data Results
f. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was

Improvement Project selected by TCC which will assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

Outcome Measure Description: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 process milestones selected for Project 084434201.1.2 are as follows: DY2 (1) procurement of necessary equipment & licenses; and (2) develop protocols and clinical guidelines needed; DY 3 (3) hire and train certified and experienced licensed professionals for the program; (4) establish appropriate service sites, (5) participate in regional learning collaborative; DY 4 (7) participate in regional learning collaborative; DY 5 (9) Participate in regional learning collaborative.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.2 are as follows: TCC expects to provide intensive substance-abuse out-patient treatment to 15 patients by DY 4 and 44 (29 additional) patients by DY 5 and provide LCDC supervision to at least 3 interns by DY 5. Intensive services typically result in four to six encounters per patient per month or 2,112 to 3,168 face-to-face patient encounters annually. .

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment <u>do not receive care</u>…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as

well in our communities as individuals with no trauma history. Providing additional substance abuse services as well as ensuring quality improvements across all projects will have an overall achievement level that has a positive impact on their functioning in the community and result in a reduction of health costs across the regional area. The Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier to assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.5)

Outcome Measure Valuation: "The term ***quality of life*** (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." **(44)** Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects.
Substance abuse services and the Internship program will focus TCC energies on increased individual and community value by expanding services to the "un-served" individual. In concert with enhanced technological capabilities and a Quality Improvement Department, the expanded services will evidence an increased value that will ultimately equate to improved quality of life for more people than have been traditionally served by TCC. As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. Based on project expectations, TCC can expect to intervene with estimated 44 individuals. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** With the Category 1 Project, TCC will establish one new substance abuse treatment site accommodating this under-served county and expects to provide intensive substance-abuse out-patient treatment to 15 patients by DY 4 and 44 (29 additional) patients by DY 5 and provide LCDC supervision to at least 3 interns by DY 5. Intensive services typically result in four to six encounters per patient per month or 2,112 to 3,168 face-to-face patient encounters annually. The 44 individuals served through this project will exemplify a savings to the health treatment community of $246,449.00 through Category 1. Using the same methodology, the corresponding Category 3 project valuation is $32,926.00.

Milestones/Metric Table:

084434201.3.2	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.1.2		
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: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve AQoL scores for patients. Baseline: No documentation of planning. Goal: Planning documentation in place. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1471.50 Process Milestone 2 [P-2]: Establish baseline TBD	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No collection or assessment results Goal: Collection and assessment results in place. Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: $ 3,411.00 Outcome Improvement Target 1 [IT-10.1]: Quality of Life	Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Baseline: No targeted improvement Goal: improvement noted Data Source: AQoL survey assessment results Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,298.00	Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Baseline: No targeted improvement Goal: improvement noted Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 15,863.00

084434201.3.2	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.1.2		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
P-2 Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results Rationale: It is necessary to measure current performance to plan improvement. Process Milestone 2 Estimated Incentive Payment: $ 1471.50	Improvement Target: TBD IT-1 Metric: Improved Outcomes Baseline: No targeted improvement Goal: improvement noted Data Source: AQoL survey assessment results Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 3,411.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 2,943.00	Year 3 Estimated Outcome Amount: $ 6,822.00	Year 4 Estimated Outcome Amount: $ 7,298.00	Year 5 Estimated Outcome Amount: $ 15,863.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 32,926.00			

Category 3: Quality Improvement

Unique RHP Outcome Identification Number: 084434201.3.3
Outcome Measure Title: OD-10 Quality of Life/Functional Status
Provider: Texoma Community Center/084434201

Related Category 3 Outcome Measure(s): OD-10 Quality of Life/Functional Status
IT-10.1 Quality of life- (standalone measure)

g. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
h. Data source: Assessment of Quality of Life Tool Data Results
i. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was

selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

Outcome Measure Description: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 process milestones selected for Project 084434201.1.3 are as follows: DY2 (1) procurement of necessary equipment & licenses to operate services; and (2) develop administrative protocols and clinical guidelines needed; DY 3 (3) hire and train 2 experienced licensed professionals for the program; (4) establish counseling services in 1 new community-based service site who are serving 1.5% over TCC baseline; (5) participate in regional learning collaborative; DY 4 (7) participate in regional learning collaborative; DY 5 (9) Participate in regional learning collaborative.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.3 are as follows: By DY 3 TCC will serve 14 new counseling patients, 19 in DY 4 and 25 in DY 5. All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements, goals to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment <u>do not receive care</u>…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services, expanding provider network for substance abuse treatment, providing counseling options for those with no health insurance and expanding capacity

through telementalhealth options as well as ensuring quality improvements across all projects will have an overall achievement level that has a positive impact on their functioning in the community and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for this Local Mental Health Authority to use in assessing in impact of not only the individual projects, but to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

Outcome Measure Valuation: "The term ***quality of life*** (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." **(44)** Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects. This measure spans four of the five projects; using measured quality of life improvements to give definition to the size, scope, community benefit, and even efficiency and cost reduction/avoidance as each produces beneficial outcomes.

TCC's Telehealth Project will provide the electronic/internet-based means for transmitting, storing and accessing important information that will enhance treatment intended to improve the quality of lives. For some, the technological advancements to be made by TCC may even be their lives due to rapid communications and insights gained through immediate access to information. The value of this project will be significant, both for individuals and community stakeholders, because its relatively high initial cost will be quickly offset by costs that will be reduced to routine systems maintenance and occasional upgrades. As the telecommunication system expands, it will produce an even greater value to our communities and stakeholders as it is used for increase networking and educational collaborations.

TCC's Quality Improvement Project increases value by creating an evolving system of continuous quality improvement, which will use rapid and low cost retrieval of electronically stored information, to assess life quality improvements for individuals and continue to "raise the floor" in their improved levels of functioning. The quality improvement project will create value for individuals, funding sources that may be applicable, and the community at large as it continuously reviews treatment planning and service system designs for implementing best practices that reduce costs by applying the types of supports in the right amounts at the right time. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost

of the intervention exceeds this standard. One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained and there is an expected minimum of 23 individuals to be served. **(9g)** There are typically four face-to-face patient encounter hours per month with counseling services which will result in approximately 1,104 additional hours of counseling valued by Katon's (2012) methodology, as he examined collaborative care interventions for multi-symptom patients, at $391,951.00. By DY 3 TCC will serve 14 new counseling patients, 19 in DY 4 and 25 in DY 5. Using Daly's methodology, the valuation for just 23 patients would be $1,246,544.00. These patients would not otherwise have access to counseling due to a lack of funding. The related Category 3 Project valuation, based on same methodology is $52,365.00.

Substance abuse services and the Internship program will focus TCC energies on increased individual and community value by expanding services to the "un-served" individual. As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid.

Milestones/Metric Table

084434201.3.3	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.1.3		
Starting Point/Baseline:	Baseline to be established in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No documentation of planning. Goal: Planning documentation in place. Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 2,340.00 Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Baseline: No baseline established Goal: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No data or assessment results Goal: Data collected and assessment results noted Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: $ 5,425.00 Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD	Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Baseline: No improvement noted Goal: Improvement documented Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 11,607.00	Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Baseline: No improvement noted Goal: Improvement documented Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 25,228.00

084434201.3.3	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.1.3		
Starting Point/Baseline:	Baseline to be established in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 2 Estimated Incentive Payment: $ 2,340.00	IT-1 Metric: Target established Baseline: No improvement noted Goal: Improvement documented Data Source: AQoL survey assessment results Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 5,425.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $4,680.00	Year 3 Estimated Outcome Amount: $ 10,850.00	Year 4 Estimated Outcome Amount: $11,607.00	Year 5 Estimated Outcome Amount: $ 25,228.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 52,365.00			

Category 3: Quality Improvements

Unique RHP Outcome Identification Number: 084434201.3.4

Outcome Measure Title: OD-9 ED Appropriate Utilization (Standalone measure)

Provider: Texoma Community Center/084434201

Outcome Measure Description: Reduce Emergency Department visits for target conditions:

- Behavioral Health/Substance Abuse

The process milestones selected to facilitate reporting outcomes for this Category Three Project will be as follows:

- P-1-- The Project Planning- engage stake holders, identify current capacity and needed resources.
- P-2—Establish baseline rates.
- P-3—Develop and test data systems.
- P-5—Disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome Measure Description: As capacity and resources are determined in Year 2, specific target reduction rates will then be determined and set. Based on past experience by TCC crisis staff, a reduction of emergency room visits will be experienced as additional patients are stabilized, both in the existing programs and in the newly planned substance abuse treatment facility and counseling center. Part of the project will be to track and document individuals with mental health, behavioral health, and substance abuse issues as presenting to emergency rooms for treatment, and reduce these ED visits over time. It is expected that TCC's projects (084434201.1.1, 084434201.1.2, 084434201.1.3 and 084434201.2.1) can, when facilitated, directly impact Category 3 Outcome Domain 9, and over time reduce costly emergency department visits for the targeted individuals. The selected Outcome Improvement Targets have not been determined for each year yet, since the baseline still needs to be established. However, each year does have an Improvement Target goal so that when the target percentages are determined, the outcome data can be tracked. It is expected to have positive outcomes across the region to reduce expensive emergency department use by individuals receiving the targeted interventions.

The Category 1 and Category 2 process milestones selected are designed to ensure effective implementation of each project regardless of the project scope. The process milestones are designed to ensure effective implementation of each project and the "Expand Quality Improvement Capacity" Project is specifically designed to enhance all other project's implementation success.

The Process Milestone for DY 2 is: (1) Hire and train two quality improvement staff who will be trained in well-proven quality and efficiency improvement principles, tools and processes. The expectation is to increase the reports utilized to assess improvement by 10% in DY3, 15% in DY 4, and 20% in DY 5. This means that by DY 5, the QI Department will be using a minimum of 18 different QI reports to track improvement trends. Goals are in place to improve quality of care and collaboration of care with other providers in the region. TCC is poised to continue improvement trends into the next four years and beyond.

Rationale: This Outcome Domain was selected by TCC for our Quality Improvement Project since these are areas TCC treat and intend to expand treatment. The Quality Improvement Project will focus attention on the targeted Category 3 elements and, based on TCC's intervention experience, will lead to positive outcomes that will improve the desired achievement level. At this point, baseline improvement targets were not determined and will be established as the project roles out in DY2 and the baseline is established, along with evaluating capacity and resources. (CN.2, CN.3, CN.4, CN.5)

Project Valuation: "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, according to a 2010 survey by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. Ten percent said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients and overcrowding. The problem has worsened during the economic downturn. Since 2009, 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on Mental Illness, a patient advocacy group. And since 2010, states have closed or are planning to close nearly 4,000 state psychiatric beds, about 8 percent of capacity, according to the National Association of State Mental Health Program Directors Research Institute. " **(39)** Although the emergency room wait times are not as severe for hospitals in the TCC service area, emergency room care is costly and does not produce long-term results. Quality care means that providers are "… treating mental disorders as early as possible, holistically and close to the person's home and community lead to the best health outcomes."**(40)** Quality improvement for TCC will be focused on reducing emergency room visits, and readmissions, for persons with behavioral and or substance abuse problems. Substantial value will be created for individuals, and for the community at large, as TCC implements its projects and focuses its attention on delivering the right care at the right time. Interception of individuals inclined to seek care through hospital emergency rooms will result in reduced cost for an over-burdened medical system by creating more effective treatment options that result in stabilization of individuals with behavioral health and/or substance abuse issues because continuing community supports are "Very cost effective in the community when primary care is linked to a network of services." (41) To this end, the projects will collectively and progressively increase value by using an array of community-based services as the right care is delivered in the proper location.

The value of this project will be significant, both for individuals and community stakeholders, because its relatively high initial cost will be quickly offset by costs that will be reduced to routine systems maintenance and occasional upgrades. As the telecommunication system expands, it will produce an even greater value to our communities as early communications help avoid emergency room visits. "Enhance Performance Improvement and Reporting Capacity" is a project that will create enduring high value for TCC and the people it serves in that its scope, over time, will become quite broad; creating an evolving system of continuous quality improvement that will use rapid and low cost retrieval of electronically stored information to develop treatment planning that will "raise the floor" in individuals' levels of functioning; thus reducing the need for emergency room care.

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A cost-utility analysis by Holtgrave, 2012 was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life. **(9a, 9b)** Currently TCC reviews a minimum of twelve QI reports weekly, bi-weekly or monthly. The expectation is to increase the reports utilized to assess improvement by 10% in DY3, 15% in DY 4, and 20% in DY 5. This means that by DY 5, the QI Department will be using a minimum of 18 different QI reports to track improvement trends. To consider patient impact, the studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), were used to show that an additional 80 individuals would be served within the region based on an enhancement of capacity at an average cost savings of $13,856 per person, which calculated to a total saving of $1,108,480.00 for the region. (9i, 9k, 9l, 9m) The related Category 3 Project value, using the same methodology, is $15,947.00.

As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

Milestones/Metric Table:

084434201.3.4	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.1.4		
Starting Point/Baseline:	There is no baseline established but will be 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: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys Baseline: No documentation Data Source: Plan documentation Estimated Incentive Payment *(maximum amount):* $ 712.50 Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results Process Milestone 2 Estimated Incentive Payment: $ 712.50	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Data Source: Quality Improvement Records Process Milestone 3 Estimated Incentive Payment: $ 1,652.00 Outcome Improvement Target 1 [IT-9.2]: ED utilization reduced for target condition Improvement Target: TBD Data Source: UM and encounter data records Outcome Improvement	Outcome Improvement Target 2 [IT-9.2]: ED utilization reduced for target condition Improvement Target: TBD Data Source: UM and encounter data records Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,535.00	Outcome Improvement Target 3 [IT-9.2]: ED utilization reduced for target condition Improvement Target: TBD Data Source: UM and encounter data records Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 7,683.00

084434201.3.4	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.1.4		
Starting Point/Baseline:	There is no baseline established but will be 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)
	Target 1 Estimated Incentive Payment*:* 1,652.00		
Year 2 Estimated Outcome Amount: $ 1425.00	Year 3 Estimated Outcome Amount: $ 3,304.00	Year 4 Estimated Outcome Amount: $ 3,535.00	Year 5 Estimated Outcome Amount: $7,683.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 15,947.00			

Category 3: Quality Improvement

Unique RHP Outcome Identification Number: 084434201.3.5
Outcome Measure Title: OD-10 Quality of Life/Functional Status
Provider: Texoma Community Center/084434201

Related Category 3 Outcome Measure(s): OD-10 Quality of Life/Functional Status: IT-10.1 Quality of life- (standalone measure)

j. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
k. Data source: Assessment of Quality of Life Tool Data Results
l. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts, sensory experiences and overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

Outcome Measure Description: **Outcome Measure Description**: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 and Category 2 process milestones selected for Project 084434201.2.1 are as follows: DY2 (1) Identify 3 community agencies that have relevant data to identify service patterns of individuals with co-occurring disorders; (2) Identify and train

BH case managers for blended services; DY 3 (3) Develop and put protocols and clinical guidelines in place, (4) Hire physician, nurse and clerical staff.

Outcome Improvement Targets: DY 3 improvement target is for 104 patient encounters to occur (for approximately 93 targeted patients) which will then become the baseline for DY 4 and 5. Improvement targets in DY 4 and DY 5 are 25% (130) and 40% (146) increased encounters respectively for a total patient impact of 380 new integrated health care patient encounters. All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment <u>do not receive care</u>…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing primary care physician treatment along with psychiatric care, as well as ensuring quality improvements across all projects, will have an overall achievement level that has a positive impact on patient functioning in the community and result in a reduction of health costs across the regional area.

The Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for this Local Mental Health Authority to use in assessing in impact of not only the

individual projects, but to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

Outcome Measure Valuation: "The term ***quality of life*** (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." **(44)** Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects. This measure spans four of the five projects; using measured quality of life improvements to give definition to the size, scope, community benefit, and even efficiency and cost reduction/avoidance as each produces beneficial outcomes. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained. **(9g)** There are an average of 850 adult mental health patients served by TCC staff each month, and 527 (62%) <u>need</u> integrated primary and behavioral health services. Of these 527, 38% have Medicaid, leaving about 93 unfunded, uninsured adult patients (18%) who reside in RHP 19, specifically Cooke County. Since integrated care will be new to TCC, we initially intend to provide ½ day of primary/preventive care through this project, to be shared among three counties, allowing for about 48 patient encounters per month at an average of 17 minutes per patient which, according to a Medscape Physician Compensation Report (2011), is the time most physicians spend with patients.(h-b) Since the RHP 19 patients make up 18% of the total, and depending on frequency of return appointments, that allows for about 12 patient encounters per month for RHP 19 (104 per year) for Cooke County. DY 3 improvement target is for 104 patient encounters to occur (for approximately 93 targeted patients) which will then become the baseline for DY 4 and 5. Improvement targets in DY 4 and DY 5 are 25% (130) and 40% (146) increased encounters respectively for a total patient impact of 380 new integrated health care patient encounters for a valuation of $367,694.00. Using the same methodology, the related Category 3 project valuation is $49,125.00.

As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

Milestones/Metric Table:

084434201.3.5	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.2.1		
Starting Point/Baseline:	Baseline Data to be determined in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys Baseline: No documentation Goal: Documentation in place Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 2,195.50 Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Baseline: No baseline established Goal: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No data or assessment results found Goal: Data collected and assessment results noted Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: $ 5,089.00 Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD	Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Baseline: No improvement noted Goal: Improvement evident and noted Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 10,889.00	Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Baseline: No improvement noted Goal: Improvement evident and noted Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 23,667.00

084434201.3.5	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.2.1		
Starting Point/Baseline:	Baseline Data to be determined in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 2 Estimated Incentive Payment: $ 2,195.50	IT-1 Metric: Improved assessment outcomes Baseline: No improvement noted Goal: Improvement evident and noted Data Source: AQoL survey assessment results Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 5,089.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 4,391.00	Year 3 Estimated Outcome Amount: $ 10,178.00	Year 4 Estimated Outcome Amount: $ 10,889.00	Year 5 Estimated Outcome Amount: $ 23,667.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 49,125.00			

Category 3: Quality Improvements

Unique RHP Outcome Identification Number: 084434201.3.6

Outcome Measure Title: OD-9 ED Appropriate Utilization (Standalone measure)

Provider: Texoma Community Center/084434201

Outcome Measure Description: Reduce Emergency Department visits for target conditions:

- Behavioral Health/Substance Abuse

The process milestones selected to facilitate reporting outcomes for this Category Three Project will be as follows:

- P-1-- The Project Planning- engage stake holders, identify current capacity and needed resources.
- P-2—Establish baseline rates.
- P-5—Disseminate findings, including lessons learned and best practices, to stakeholders and other entities.

Outcome Measure Description: As capacity and resources are determined in Year 2, specific target improvement rates will then be determined and set. Based on past experience of TCC crisis staff, a reduction of emergency room visits will occur as additional patients are stabilized through the utilization of existing and planned programs. Part of the project will be to track and document individuals' outcomes of individuals with mental health, behavioral health, and substance abuse issues who present to emergency rooms for treatment. The goal is to reduce these ED visits over time. It is expected that all of TCC's PASS 1 projects (084434201.1.1, 084434201.1.2, 084434201.1.3 and 084434201.2.1) and PASS 2 project (084434201.2.2) can, when implemented, positively impact Category 3 Outcome Domain 9. Again, this will reduce costly emergency department visits and hospitalizations for the targeted individuals, as it did with TCC's ACT patients and other high-risk psychosocial rehabilitation patients. The selected Outcome Improvement Targets have not been determined for each year yet, since the baseline still needs to be established. However, each year will have an Improvement Target goal so that when the target percentages are determined, the outcome data can be tracked. These interventions are expected to have positive outcomes across RHP 19.

The selected Category 2 process milestones in the related project (084434201.2.2) are designed to ensure effective implementation of the project and facilitate improvement. The Process Milestone for DY 2 is: Design the community-based specialized interventions for the target populations, including significantly expanding the existing residential/respite facility. It is recognized that proper planning and designing is the foundation for project success.

DY 3 is "implementation year" and the process milestones are to: (1) Secure and ensure compliance of residential facility and enroll and serve individuals with targeted complex needs; and (2) Evaluate and continuously improve interventions using the "plan, do, study, act quality improvement cycles." These goals are self-evident in that success requires implementation of the resources needed and actualization of the interventions being used. (3) Improvement goals by DY are that TCC expects to serve 75 RHP 19 patients with comprehensive community based services in DY 3, 161 in DY 4 and 200 in DY 5 for a total patient impact of at least 436. In addition, it is expected that 20% of the served individuals will demonstrate significant functional status improvement in DY 4 and 30% in DY 5.

Rationale: This Outcome Domain was selected by TCC for Project 084434201.2.2 since "Right Care, Right Setting" and reducing emergency department usage are TCC goals. TCC will expand treatment and, based on the cited past experience, anticipates a solid positive impact on reducing emergency room, hospital and jail use by the target population. One way to do this is to improve overall patient functioning. This intervention expansion project will focus attention on the targeted Category 3 elements to reduce and, based on TCC's intervention experience, will lead to positive outcomes. Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (11) Lost output and low productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across will give a picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report: "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to efforts to stabilize individuals with co-occurring disorders. She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (12) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history.

The baseline target for this intervention effort will begin in DY 2 and be zero. While qualifying individuals are served by TCC already, the DY 3 enrollment assessments (ANSA) will be used for the expansion quality improvement baseline and improvement will be calculated as a percentage over these initial scores as if they are at zero.(CN.1, CN.2, CN.3, CN.5)

Project Valuation: "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, according to a 2010 survey by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. Ten percent said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients and overcrowding. The problem has worsened during the economic downturn. Since 2009, 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on Mental Illness, a patient advocacy group. And since 2010, states have closed or are planning to close nearly 4,000 state psychiatric beds, about 8 percent of capacity, according to the National Association of State Mental Health Program Directors Research Institute." (13) Emergency room care is costly and does not produce long-term results. Substantial value is inherent for both individuals and for the community at large as TCC implements its projects and focuses its attention on delivering the right care at the right time. Intervention with the target population, who are inclined to seek care through hospital emergency rooms, will reduce health care costs for an over-burdened medical system. Creating more effective treatment options will result in stabilization of individuals with behavioral health and/or substance abuse issues. The World Health Organization (2003) states that community supports are: "Very cost effective in the community

when primary care is linked to a network of services." (14) To this end, the projects will collectively and progressively increase value by using an array of community-based services as the right care is delivered in the proper location.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). **(9g)** In this study, the effect of the intervention was 0.0335 incremental life years gained. Likewise, Dewa et al. (2009) found that collaborative care saved $503 per patient in disability benefits. **(9h)** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. **(9a)** Simon et al. (2012) found that collaborative health care yielded 47.7 additional depression-free days per year at a cost of $52 per depression-free day. **(9m)** Utilizing the QALY methodology, with the research as backup, the related Category 1 Project's value will be $705,786.00 and the Outcome Measure value is $94,211.00.

As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

Milestones/Metric Table:

084434201.3.6	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.2.2		
Starting Point/Baseline:	There is no baseline established but will be 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: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No planning documentation in place Goal: Project planning documentation in place and available Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 8,467.00	Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline set. Baseline: No baseline set. Goal: Appropriate baseline established Data Source: Plan and resource documentation, AQoL scores Process Milestone 2 Estimated Incentive Payment: $19,503.00	Outcome Improvement Milestone 3 – OD 9—Right Care, Right Setting Metric [IT-9.2]: Reduce emergency department visits for targeted behavioral health/ substance abuse patients Improvement Target: TBD Baseline: No reduction in ED visits noted Goal: Reduction in ED visits evident and documented Data Source: Hospital records/ UM, AQoL scores and crisis encounter data records Outcome Improvement Target 3 Estimated Incentive	Outcome Improvement Milestone 4 – OD 9—Right Care, Right Setting Metric [IT-9.2]: Reduce emergency department visits for targeted behavioral health/ substance abuse patients Improvement Target: TBD Baseline: No reduction in ED visits noted Goal: Reduction in ED visits evident and documented Data Source: Hospital records/ UM, AQoL scores and crisis encounter data records Outcome Improvement Target 4 Estimated Incentive

084434201.3.6	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.2.2		
Starting Point/Baseline:	There is no baseline established but will be 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)
		Payment*:* $20,883.00	Payment*:* $45,358.00

084434201.3.6	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects::1.11,1.1	084434201.2.2		
Starting Point/Baseline:	There is no baseline established but will be in DY2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $8,467.00	Year 3 Estimated Outcome Amount: $19,503.00	Year 4 Estimated Outcome Amount: $20,883.00	Year 5 Estimated Outcome Amount: $45,358.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $94,211.00			

Category 3: Quality Improvements

Cost of Care
IT-5-1 Improved cost savings

RHP Project Number: 088189803.3.1

RHP Performing Provider: Throckmorton County Memorial Hospital -088189803

Outcome Measure Description:

Improved cost savings outcome measure; with a CT-Scan and updated Mobile X-Ray we can improve better health to our community which will decrease cost and increases the opportunity to diagnose and treat earlier without having to transport a patient. Therefore, this improves the value in emergency care to diagnose locally and treat immediately. Outcome and overall usage; for Y2 baseline is to service 100 patients and each year after to be determined.

Rationale:

We selected Cost benefits analysis to determine the positive factors in acquiring a CT-Scan and updated Mobile X-Ray. This will decrease the cost to the patient by increasing the opportunity to diagnose and treat patient at an earlier stage without having to transport. As a result this improves the value in emergency care to diagnose locally and treat immediately. If our doctors order a CT-Scan, the patient then has to travel to another facility to receive this service. This then accumulates more cost to the patient. Again, if the patient is seen in the ED and a CT-Scan is needed, the patient will need to be transported to another facility. We have discovered that this has been a problem due to the overall impact cost to the patient and decreased response time for immediate care. This outcome will help improve the overall health for all patients and including the low-income population.

Example: A patient being treated in the ED having complications needing an abdomen CT-Scan and Mobile X-Ray, will have to be transported by ambulance to another facility. Not only has the patient now incurred charges from Throckmorton County Memorial Hospital (TCMH), for an ED charge of or around $650 and an Ambulance cost of around $1,000. The additional charges could cost up to $2000 with other pending charges incurred at that facility.

When TCMH implements a CT-Scan and updated Mobile X-Ray, it will lower the overall cost to the patient.

These milestones were selected for the planning process of the CT-Scan and Mobile X-Ray Project; to help with the planning and implementation of the project.

Process Measures:

To begin Planning
- Development
- Policy & Procedure
- Develop QA
- Prepare CT-Scan Docking Site
- Enhance Service Availability to appropriate Levels of Care.
- Establish baseline rates Improvement Measure.

Outcome Measure Valuation:

TCMH understands that as health care costs rise that we will strive to find better ways to stay increasingly interested in developing accurate ways to measure outcomes. To be achieved towards the improvement of cost containment. This will be done by tracking the total cost per member of the population per month and to track the cost per episode for the hospital and ER utilization rates for cost of care measurement; for the services involved in the diagnosis, management and treatment of specific clinical conditions.

The TCMH project scope is to reduce health care costs for the patients in our community. TCMH will develop cost-of-care measures by achieving high value to benefit the community. This will help those who get, give and pay for care. Value is our overall goal of health care delivery, with value defined as the health outcomes achieved per dollar spent. This goal is what matters for our patients served in our community. This will help serve the community better for those that have no way of transportation, any insurance and poverty.

TCMH is the only Acute Care Facility and Medical Clinic in Throckmorton County, a county with a population of 1780. TCMH is located in the middle of four Acute Care Facilities, all approximately 30 to 35 miles away-to the North, West, East, and South. Throckmorton County has a population living at or below the poverty level of 14.3%, has a population with no insurance of 33%, adult obesity rates of 29%, heart disease is the second leading cause of death, and approximately 80% of TCMH's inpatient visits and 50% of clinic visits are from Medicare patients. In 2011, TCMH recorded $91,500 in Charity Care, not including unpaid Self-Pay accounts of individuals that fell through the screening cracks.

Our goal is to be the preferred provider for our residents in this area. With the ability to provide quicker and better service, to be more efficient in an effective way and lower cost to the patient we can meet any new challenges that may arise.

088189803.3.1	IT-5.1 Improved cost savings	Improved Cost Savings	
Throckmorton County Memorial Hospital			088189803
Related Category 1 or 2 Projects::	2.5 Redesign for Cost Containment and CT-Scan and Mobile X-Ray Imaging System, 088189803.2.1		
Starting Point/Baseline:	100		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 Process Measure: Begin Planning/Development/Policy & Procedure/Develop QA/ Train Radiology Staff/ Enhance Service Availability to appropriate Levels of Care Data Source: Documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $10,721 **Process Milestone 2** P-2 Establish baseline rates Improvement Measure: Increase by 100 Data Source: Documentation Process Milestone 2 Estimated Incentive Payment: $10,721	**Process Milestone 3** P-2 Establish baseline rates Improvement Measure: TBD Data Source: Documentation Process Milestone 3 Estimated Incentive Payment: $25,000 **Outcome Improvement Target 1** OD-5 Cost of Care IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery; Improvement Target: TBD Measure: total cost for episode of care Data Source: Documentation Outcome Improvement Target 1 Estimated Incentive Payment: $24,696	**Outcome Improvement Target 2** OD-5 Cost of Care IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery; Improvement Target: TBD Measure: total cost for episode of care Data Source: Documentation **Outcome Improvement Target 2** Estimated Incentive Payment: $39,665	**Outcome Improvement Target 3** OD-5 Cost of Care IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery; Improvement Target: TBD Measure: total cost for episode of care Data Source: Documentation **Outcome Improvement Target 3** Estimated Incentive Payment: $94,767

088189803.3.1	IT-5.1 Improved cost savings	Improved Cost Savings	
Throckmorton County Memorial Hospital			088189803
Related Category 1 or 2 Projects::	2.5 Redesign for Cost Containment and CT-Scan and Mobile X-Ray Imaging System, 088189803.2.1		
Starting Point/Baseline:	100		
Year 2 (10/1/2012 – 9/30/2013)	**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: $21,442	Year 3 Estimated Outcome Amount: $24,696	Year 4 Estimated Outcome Amount: $39,665	Year 5 Estimated Outcome Amount: $94,767
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $180,570			

Category 3: Quality Improvements

Potentially Preventable Readmissions
IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate

RHP Project Number: 135237906.3.1

RHP Performing Provider: United Regional Health Care System - 135237906

Outcome Measure Description

OD-3 Potentially Preventable Re-Admissions- IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate was selected to measure the effectiveness of expanding primary care capacity so that patients with a principal diagnosis of AMI and with a complete claims history for the 12 months prior to admission can be treated in the appropriate setting post discharge and avoid readmission to the hospital. Increased access will encourage patients to seek care sooner than they might if primary care services were difficult to access.

Rationale:

Identifying Category 1 related project: Expand Primary Care Capacity, Project 135237906.1.1. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. (Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." Health Care Financing Review. 30:1; pp75-91.) By accessing a primary care physician after being discharged from a hospital stay with a primary diagnosis of AMI, patients may be better equipped to handle post discharge complications and seek care before symptoms escalate. This project will achieve waiver goals because it will provide primary care services to improve patient access to care thereby improving outcomes and lowering the overall costs of healthcare delivery. As healthcare services become more affordable, patients will find it easier to take advantage of health care services that will improve their overall health. The community will benefit from this project in several different ways. Easier access to preventive screenings and health care services will mean that more people in our community receive intervention sooner. As patients take advantage of greater capacity with Primary Care Providers, lifestyle behaviors can be addressed before they have resulted in adverse health outcomes.

Outcome Measure Valuation:

$3,739,090.The presence of more Primary Care Providers will help patients in Wichita Falls access much needed health care services with less effort. As has been shown, this project will be a fairly large investment and will serve many people that desperately need Primary Care services that can't get it anywhere else in the community. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addressing priority community need.

135237906.3.1	**IT-3.5**	**IT-3.5,** AMI 30 Day Readmission Rates	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.1.1, Expand Primary Care Capacity		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implantation plans Process Milestone 1 Estimated Incentive Payment (maximum amount): $462,617	**Process Milestone 2** P-2 Establish baseline rates Data Source: Process Milestone 2 Estimated Incentive Payment: $677,348	**Outcome Improvement Target 1** IT-3.5: Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index AMI admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of AMI and with a complete claims history for the 12 months prior to admission. Improvement Target: TBD Data Source: EHR reports	**Outcome Improvement Target 2** IT-3.5: Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index AMI admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of AMI and with a complete claims history for the 12 months prior to admission. Improvement Target: TBD Data Source: EHR reports

135237906.3.1	**IT-3.5**	**IT-3.5,** AMI 30 Day Readmission Rates	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.1.1, Expand Primary Care Capacity		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $905,755	indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $1,693,370
Year 2 Estimated Outcome Amount:: $462,617	Year 3 Estimated Outcome Amount: $677,348	Year 4 Estimated Outcome Amount: $905,755	Year 5 Estimated Outcome Amount: $1,693,370
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $3,739,090			

Category 3: Quality Improvements

Cost of Care
IT-5.2 Per episode cost of care

RHP Project Number: 135237906.3.2

RHP Performing Provider: United Regional Health Care System, 135237906

Outcome Measure Description:

OD-5 Cost of Care, IT.5.2, Per Episode Cost of Care was chosen as the outcome measure for project, because it quantifies the services involved in the diagnosis, management and treatment of diseases, and will measure the effectiveness of redesigning the way we deliver care to chest pain patients admitted to observation status. Episode-of-care measures can be developed to determine if the redesign process is effective in containing costs for those patients.

Rationale:

Identifying Category 2 related project: Redesign for Cost Containment, Project 2.5; 135237906.2.1; Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions; Data Source: Texas Department of State Health Services, Center for Health Statistics. By redesigning the delivery of care to chest pain patients admitted to observation, and utilizing cost accounting software to determine the efficacy of interventions to contain costs, we expect that we will be able to reduce the per episode cost of care. This will benefit Medicaid and other payers as well as the patient and the provider. Reducing the cost of care will also reduce the burden of the under and uninsured that is placed on payers and effectively benefit all populations.

Outcome Measure Valuation:

IT-5.2 Per episode cost of care$218,431. These outcome measures, process milestones and outcome improvement targets are all valued as listed because the size of our facility is the largest in the region and we service the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

135237906.3.2	3.IT-5.2	IT-5.2, Per episode cost of care	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.1		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implantation plans Process Milestone 1 Estimated Incentive Payment (maximum amount): $	**Process Milestone 2** P-2 Establish baseline rates Data Source: Process Milestone 2 Estimated Incentive Payment: $45,156	**Outcome Improvement Target 1** IT-5.2: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures can be developed for the full range of acute and chronic conditions, including diabetes, congestive heart failure, acute myocardial infarction, asthma, low back pain and many others. Improvement Target: TBD Data Source: EHR reports indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $60,384	**Outcome Improvement Target 2** IT-5.2: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures can be developed for the full range of acute and chronic conditions, including diabetes, congestive heart failure, acute myocardial infarction, asthma, low back pain and many others. Improvement Target: TBD Data Source: EHR reports indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $112,891

135237906.3.2	3.IT-5.2	IT-5.2, Per episode cost of care	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.1		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $	Year 3 Estimated Outcome Amount: $45,156	Year 4 Estimated Outcome Amount: $60,384	Year 5 Estimated Outcome Amount: $112,891
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $218,431			

Category 3: Quality Improvements

Palliative Care
IT-13.1, Pain Assessment

RHP Project Number: 135237906.3.3

RHP Performing Provider: United Regional Health Care System -135237906

Outcome Measure Description:

Palliative Care has been selected in order to achieve the improvement target of assessing patients that screen positive for pain, within 24 hours of that screening. By the end of the waiver, we expect to increase the number and/or percentages of patients assessed for pain within 24 hours of their screening, and hope to identify those diseases that have the greatest impact on those rates.

Rationale:

Identifying Category 2 related project: Use of Palliative Care Programs, Project 2.10. Pain is often under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illnesses. By assessing and treating quickly, outcomes of function and the patient's quality of life can be improved. The process milestones were selected because in DY2 the palliative care program enhancement plan will be written. In DY3 the baseline will be established. The improvement milestones measuring Pain Assessment, Treatment Preferences, and Clinical Record of Discussion were selected because these establish a better quality of life and better outcomes for the patients, focusing on relief and prevention of suffering. Patients receive dignified and culturally appropriate care, prioritizing pain control, social, and spiritual care, as well as patient/family preferences.

Outcome Measure Valuation:

$134,917These outcome measures, process milestones and outcome improvement targets are all valued as listed because the size of our facility is the largest in the region and we service the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

135237906.3.3	3.IT-13.1	Pain assessment	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.2		
Starting Point/Baseline:	To be established		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 implantation plans Process Milestone 1 Estimated Incentive Payment (maximum amount): $25,701	**Process Milestone 2** P-2 Establish baseline rates Data Source: EHR records indicating number of hospice or palliative care patients encountered in the ED who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Process Milestone 2 Estimated Incentive Payment: $22,578	**Outcome Improvement Target 1** 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. Improvement Target: TBD Data Source: EHR reports indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $30,192	**Outcome Improvement Target 2** 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. Improvement Target: TBD Data Source: EHR reports indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $56,446

135237906.3.3	3.IT-13.1	Pain assessment	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.2		
Starting Point/Baseline:	To be established		
Year 2 (10/1/2012 – 9/30/2013)	**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): $25,701	Year 3 Estimated Outcome Amount: $22,578	Year 4 Estimated Outcome Amount: $30,192	Year 5 Estimated Outcome Amount: $56,446
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $134,917			

Category 3: Quality Improvements

Palliative Care
IT-13.2, Treatment Preferences

RHP Project Number: 135237906.3.4

RHP Performing Provider: United Regional Health Care System - 135237906

Outcome Measure Description:

Percentage of patients with chart documentation of preferences for life sustaining treatment. By identifying treatment preferences, patients will have a better quality of life and providers will benefit from learning what treatments patients perceive as the most beneficial for given conditions. Over time, this should reduce the number of different treatments utilized, thereby reducing costs and improving quality.

Rationale:

Identifying Category 2 related project: Use of Palliative Care Programs, Project 2.10. The process milestones were selected because in DY2 the palliative care program enhancement plan will be written. In DY3 the baseline will be established. The improvement milestones measuring Pain Assessment, Treatment Preferences, and Clinical Record of Discussion were selected because these establish a better quality of life and better outcomes for the patients, focusing on relief and prevention of suffering. Patients receive dignified and culturally appropriate care, prioritizing pain control, social, and spiritual care, as well as patient/family preferences.

Outcome Measure Valuation:

$134,917. Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we service the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

135237906.3.4	3.IT-13.2	Treatment Preferences	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.2		
Starting Point/Baseline:	To be decided		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 implantation plans Process Milestone 1 Estimated Incentive Payment (maximum amount): $25,701	**Process Milestone 2** P-2 Establish baseline rates Data Source: EHR reports indicating the number of patients encountered in the emergency department with chart documentation of preferences for life sustaining treatments. Process Milestone 2 Estimated Incentive Payment: $22,578	**Outcome Improvement Target 1** IT-13.2: Percentage of patients with chart documentation of preferences for life sustaining treatments. Improvement Target: TBD Data Source: EHR reports indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $30,192	**Outcome Improvement Target 2** IT-13.2: Percentage of patients with chart documentation of preferences for life sustaining treatments. Improvement Target: TBD Data Source: EHR reports indicating number of emergency room visits and their related diagnoses. Estimated Incentive Payment: $56,446
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $25,701	Year 3 Estimated Outcome Amount: $22,578	Year 4 Estimated Outcome Amount: $30,192	Year 5 Estimated Outcome Amount: $56,446
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $134,917			

Category 3: Quality Improvements

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/ religions concerns or documentation that the patient/caregiver did not want to discuss.

RHP Project Number: 135237906.3.5

RHP Performing Provider: United Regional Health Care System - 135237906

Outcome Measure Description:

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 documenting spiritual and/or religious concerns that patients and caregivers don't want to discuss, providers will become more mindful of those issues and find better ways to address those types of needs.

Rationale:

Identifying Category 2 related project: Use of Palliative Programs, Project 2.10. The process milestones were selected because in DY2 the palliative care program enhancement plan will be written. In DY3 the baseline will be established. The improvement milestones measuring Clinical Record of Discussion were selected because these establish a better quality of life and better outcomes for the patients, focusing on relief and prevention of suffering. Patients receive dignified and culturally appropriate care, prioritizing pain control, social, and spiritual care, as well as patient/family preferences. 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.

Outcome Measure Valuation:

$134,916. Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we service the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of

comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

135237906.3.5	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.**	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.2		
Starting Point/Baseline:	To be decided		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 implantation plans Process Milestone 1 Estimated Incentive Payment (maximum amount): $25,701	**Process Milestone 2** P-2 Establish baseline rates Data Source: EHR reports of hospice or palliative care patients with clinical documentation of a discussion of spiritual and/or religious concerns that the patient/caregiver did not want to discuss. Process Milestone 2 Estimated Incentive Payment: $22,579	**Outcome Improvement Target 1** IT-13.5: Percentage of hospice or palliative care patients with chart documentation of a discussion of spiritual and/or religious concerns that the patient/caregiver did not want to discuss Improvement Target: TBD Data Source: EHR reports of hospice or palliative care patients with clinical documentation of a discussion of spiritual and/or religious concerns that the patient/caregiver did not want to discuss. Estimated Incentive Payment: $30,191	**Outcome Improvement Target 2** IT-13.5: Percentage of hospice or palliative care patients with chart documentation of a discussion of spiritual and/or religious concerns that the patient/caregiver did not want to discuss Improvement Target: TBD Data Source: EHR reports of hospice or palliative care patients with clinical documentation of a discussion of spiritual and/or religious concerns that the patient/caregiver did not want to discuss. Estimated Incentive Payment: $56,445

135237906.3.5	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.**	
United Regional Health Care System			135237906
Related Category 1 or 2 Projects::	135237906.2.2		
Starting Point/Baseline:	To be decided		
Year 2 (10/1/2012 – 9/30/2013)	**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: $25,701	Year 3 Estimated Outcome Amount: $22,579	Year 4 Estimated Outcome Amount: $30,191	Year 5 Estimated Outcome Amount: $56,445
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $134,916			

Category 3: Quality Improvements

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

RHP Project Number: 135237906.3.7 (135237906.3.6)

RHP Performing Provider: United Regional Health Care System/135237906

Outcome Measure Description

Category 3: Quality Improvements

- **Identifying Outcome Measure and Provider Information:** OD-6 Patient Satisfaction; IT-6.1 Percent improvement over baseline of patient satisfaction scores. 135237906.3.7 (135237906.3.6); United Regional Health Care System/135237906
- **Outcome Measure Description.** We have chosen this outcome measure to determine, through the survey process, how satisfied our patients are with how well their doctors are communicating.
- **Rationale:** Identifying Category 2 related project: 135237906.2.4 (135237906.2.3). Conduct Medication Management. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) domain: Communication with doctors. 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 be increasing the transparency of the quality of institutional care provided in return for the public investment.
  Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider – eventually leading to better outcomes and lower costs. Data from Press Ganey Associates has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. United Regional has historically had good performance in measures related to patient satisfaction; however there is opportunity for improvement. We anticipate that we will be able to raise patient satisfaction in how well their doctors communicate (standalone measure/domain). Goal : TBD improvement in patient's satisfaction with how well their doctors communicate. (Communication with Doctors domain in HCAHPS Survey)
- **Outcome Measure Valuation**:
  Community Needs identification CN.1, High rates of chronic disease, including cancer, heart disease, respiratory diseases, and obesity; Data Source: County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation.

Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions; Data Source: Texas Department of State Health Services, Center for Health Statistics.
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) domain: Communication with Doctors.

135237906.3.7 (135237906.3.6)	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
United Regional Health Care System			**135237906**
Related Category 1 or 2 Projects::	**135237906***.2.4 (*135237906.2.3)		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implantation plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $77,415	**Process Milestone 2** P-2 Establish baseline rates Data Source: Process Milestone 2 Estimated Incentive Payment: $112,627	**Outcome Improvement Target 1** IT-6.1 Percent improvement over baseline of patient satisfaction scores Numerator: Percent improvement in targeted patient satisfaction domain Denominator: Number of patients who were administered the survey Improvement Target: TBD Data Source: Patient survey Goal : TBD improvement in patient's satisfaction with how well their doctors	**Outcome Improvement Target 2** IT-6.1 Percent improvement over baseline of patient satisfaction scores Numerator: Percent improvement in targeted patient satisfaction domain Denominator: Number of patients who were administered the survey Improvement Target: TBD Data Source: Patient survey Goal : TBD improvement in patient's satisfaction with how well their doctors

135237906.3.7 (135237906.3.6)	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
United Regional Health Care System			**135237906**
Related Category 1 or 2 Projects::	**135237906***.2.4 (*135237906.2.3)		
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)**
		communicate Estimated Incentive Payment*:* $150,744	communicate Estimated Incentive Payment*:* $281,575
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $77,415	Year 3 Estimated Outcome Amount: $112,627	Year 4 Estimated Outcome Amount: $150,744	Year 5 Estimated Outcome Amount: $281,575
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $622,361			

Category 3: Quality Improvements

Right Care, Right Setting
IT-9.2 ED Appropriate Utilization

RHP Project Number: 112707803.3.1

RHP Performing Provider: Wilbarger General Hospital - 112707803

Outcome Measure Description:

Wilbarger General Hospital (WGH) recognizes the need to divert non-emergent cases from our ED in order to more appropriately serve those patients truly in an emergency and to make the healthcare system more efficient. Through our 1.1 Expand Primary Care Capacity project, we expect to be able to more efficient see patients with urgent care needs and through the nurse advice line reduce non-emergent ED utilization. We will work with our nurses and staff in DY 2 and 3 to begin proper training on how to best educate clinic and ED patients. We expect to also find out more details as to why people come to the ED and address those issues. Historical claims indicate we have approximately an 80% non-emergent utilization in our ED. We will establish an official baseline for the clients served in Category 1 and then measure their utilization. We expect to report reductions, which are TBD, in DY 4 and DY 5.

Rationale:

WGH has identified an issue with the non-emergent utilization of the ED. We will establish a baseline and then targets for DY 4 and DY 5 to reduce non-emergent ED utilization by those who we are able to see in the clinic or advise on the nurse advice line.

Outcome Measure Valuation:

WGH has identified an issue with the non-emergent utilization of the ED. Approximately 80 percent of visits are non-emergent medical needs. We know the ED is the most expensive setting for care and has the highest level of medical professionals on call in order to treat true emergencies. Utilizing the ED for routine primary and/or preventive care is not a cost effective nor efficient model. We will identify barriers for patients who are utilizing the ED for all their care needs and educate them on other care settings which are more efficient and cost effective. We expect to reduce our non-emergent ED claims within the patients seen and treated through our expanded primary care clinic and nurse advice line. As the county hospital, local funding will support this initiative as match.

112707803.3.1		Primary Care and Chronic Disease Management	
Wilbarger General Hospital			**112707803**
Related Category 1 or 2 Projects: 1.1.2.1	**112707803.1.1**		
Starting Point/Baseline: ZERO			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 implementation plans Process Milestone 1 Estimated Incentive Payment: $25,000	Process Milestone 2 P-2: Establish baseline rates Data Source: Registry Process Milestone 2 Estimated Incentive Payment: $25,000	**Outcome Improvement Target 1** IT-1.10: **Diabetes care: *HbA1c poor control (>9.0%)*[233]*- NQF 0059 (Standalone measure)*** Improvement Target: Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment: $38,500	**Outcome Improvement Target 2** IT-1.10 IT-1.10: **Diabetes care: *HbA1c poor control (>9.0%)*[233]*- NQF 0059 (Standalone measure)*** Improvement Target: Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 2 Estimated Incentive Payment: $92,000
Year 2 Estimated Outcome Amount: $25,000	Year 3 Estimated Outcome Amount: $25,000	Year 4 Estimated Outcome Amount: $38,500	Year 5 Estimated Outcome Amount: $92,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $180,500			

Section V. Category 4

Category 4: Population-Focused Improvements (Hospitals only)

Performing Provider: Electra Memorial Hospital-135034009

Domain Descriptions:

Electra Memorial Hospital has identified the following DSRIP projects.

135034009.1.4 (135034009.1.1) 1.1.2 Expand Primary Care Capacity/Expand Existing Primary Care Capacity Electra Memorial Hospital 135034009	Expansion of current clinic space to accommodate additional providers; extend clinic hours to provide primary care services at times convenient to patients in order to reduce emergency department utilization.	135034009.3.5 (135034009.3.1) OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization
135034009.1.5 (135034009.1.2), 1.9 - Expand Specialty Care Capacity Electra Memorial Hospital 135034009	Regionally lead a Specialty Care Capacity expansion in order to increase access to needed specialty care.	135034009.3.6 (135034009.3.2) OD-3 Potentially Preventable Re-Admissions - 30 day readmission rates IT 3.2 Congestive Heart Failure 30 day readmission rate
Pass 3 135034009.1.3., 1.1.1 Expand primary care capacity/Establish more primary care clinics	1.1.1 Expand primary care capacity/Establish more primary care clinics -Iowa Park	135034009.3.4 OD- 1 Primary Care and Chronic Disease Management

Electra Memorial Hospital 135034009		IT-1.7 Controlling high blood pressure (Standalone measure)
135034009.2.2 (135034009.2.1), 2.12 - Implement/Expand Care Transitions Programs	Implement Care Transitions	135034009.3.7 (135034009.3.3) OD-3 Potentially Preventable Re-Admissions - 30 day readmission rates
Electra Memorial Hospital 135034009		IT 3.1 All cause 30 day readmission rate

Category 4 domains and measures will be impacted by these interventions targeting patients who have a high-risk of admission, readmission, and ED utilization in the different specialty areas. Electra Memorial Hospital currently only has limited capacity to track these measures but will develop a plan of action to prepare to report measures that are statistically significant. 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	Electra is initiating two projects to increase access to primary care, one in Iowa Park and the other locally in Electra. We believe that increasing access to primary care will reduce PPAs.
Potentially Preventable Readmissions – 30 days	Electra is initiating a care transitions project which will use evidence based protocols when patients discharge from inpatient care. Improving discharge care and care coordination for patients will improve the PPR rate for providers. Through the increased access to specialty care, we also believe that better management of chronic condition in rural settings will also improve the PPR rate.
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 and Medication Management is expected to be impacted as patients are more engaged and direct their treatment plans through the Care Transition project.
Emergency Department	Electra is initiating two projects to increase access to primary care, one in Iowa Park and the other locally in Electra. We believe that increasing access to and the capacity of primary care will reduce PPVs. Reducing PPVs is expected to increase efficiencies and timeliness in our Emergency Department for our more critical patients. This could impact our NQF 0497 rate.
Children and Adult Core Measures (OPTIONAL)	N/A

- **Domain Valuation:**

  RHP 19 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and 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 Electra Memorial Hospital-135034009				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$367,174	$170,151		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$170,151	$182,036	$197,851
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$170,151	$182,036	$197,851
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			$182,036	$197,851

Amount				
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		$170,151	$182,036	$197,851
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		$170,151	$182,036	$197,851
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		$ 0.00	$0.00	$0.00
Grand Total Payments Across Category 4	$367,174	$850,755	$910,180	$989,255

Category 4: Population-Focused Improvements (Hospitals only)

- Performing Provider involved with Category 4 - United Regional Health Care System / 135237906.

Palliative Care
(Pass 1, Cat 2 Value = $1,204,052 + Cat 3 Value = $404,750. Total Value = $1,608,802):
Palliative care can engage patients and reduce health care costs over the long term. Incentive funds would assist in further and more comprehensive education of physicians, patients with chronic conditions and the community to foster better understanding of the program benefits, which would result in more patients receiving the most appropriate care at the right intervals of the progression of their condition.

Redesign for Cost Containment
(Pass 1, Cat 2 Value = $511,423 + Cat 3 Value = $218,431. Total Value = $729,854):
We intend to implement cost-accounting systems to measure intervention impacts. Cost accounting and clinical care information technology must be combined to determine the impact of the type, frequency and outcomes of hospital services in relation to the cost of providing them. Determining services which could be delivered in less costly settings without compromising patient outcomes will be explored. We will also determine baseline costs for interventions and episodes of care for acute and chronic conditions and re-measure the redesigned processes and compare to baselines. The goal will be to reduce the cost per adjusted discharge while delivering high quality care in the most appropriate health care setting.

Hospitals must look at patient population needs, access to care, intensity of care and cost of delivering services. Interventions which do not improve patient outcomes add unnecessary cost to patients, hospitals, insurance companies and government payers and will drain resources to provide testing and treatments which positively impact patient care and outcomes. Our focus will be patient centered health care which is proven to reduce costs, improve outcomes and improve patient perception of how well service is provided and effectively patient needs are met.

Expand Primary Care Capacity
(Pass 1, Cat 1 Value = $10,292,852 + Cat 3 Value = $3,739,090. Total Value = $14,031,942):
We expect to expand our existing clinic space, expand the hours of the clinic, and employ primary care providers and staff 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 addresses the current challenge many safety net hospitals face of patients presenting to the Emergency Department for primary care services and the limited number of providers available to provide those services. Patients currently have limited access to primary care providers other than a hospital's emergency department after hours and on weekends. Other projects in this region reflect similar needs, but do not

address this part of the region. By expanding clinic space to accommodate additional providers and extended hours, patients will have greater access to primary care, which should reduce emergency department encounters. Our goal is to increase clinic visits and clinic capacity and decrease non-emergent emergency department visits at United Regional.

Our plan contemplates the establishment of a Pediatric Walk-In Clinic, to open at 5 pm to help alleviate the non-emergent pediatric population we are seeing in our Emergency Department. This in turn should decrease wait times in our Emergency Department and improve patient satisfaction. This specifically addresses: Community Needs identification CN.2, High costs associated with preventable hospitalization admissions and readmissions; Data Source: Texas Department of State Health Services, Center for Health Statistics.

With incentive funds, we can enhance and expand our efforts to provide quality primary care for the uninsured, underinsured, Medicaid and Medicare populations. With all patient populations having access to primary care, chronic disease process can be better managed avoiding escalation of conditions to emergent intervention. This is a priority project for us because we have seen a % increase in our Emergency Department volume of which % make up non-emergent cases. It is also a goal to provide more preventive and primary care to keep individuals and families healthier and avoid more costly emergency department visits. The patient centered focus of this project will also help to improve the rate of Potentially Preventable Admissions and Potentially Preventable Readmissions.

Conduct Medication Management
(Pass 2, Cat 2 Value = $1,714,673 + Cat 3 Value = $622,361. Total Value $2,337,034)
The goal of conducting Medication Management is to provide information that facilitates the appropriate use of medications in order to control illness and promote health. Medication management is the monitoring of medications a patient takes to confirm that the patient is complying with a medication regimen, while also ensuring the patient is avoiding potentially dangerous drug interactions and other complications. This is especially important for patients taking large numbers of medications to address chronic illnesses and multiple diseases. Taking numerous medications is known as polypharmacy and it is particularly common among older adults, as they are more likely to need medications to manage an array of chronic conditions.
Keeping track of all of the medications currently in use by a patient is an important part of medication management. This can include creating printed lists describing medications, their dosages, and how they are being used. These lists can be kept in patient charts and provided to patients to help them track the drugs they use and understand why various medications are being prescribed.

Monitoring medication administration is also key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications. The specific purpose of this project area is to provide the platform to conduct Medication Management so that patients receive the right medications at the right time across the Performing Provider in order to reduce medication errors and adverse effects from medication use. Over the next five years, we expect to address the 2.11.2.a core component listed as: Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations; this is an evidence-based intervention designed to place the teams, technology and processes to avoid medication errors.

Domain	Description
(1) Potentially Preventable Admissions	Expanding Primary Care will improve patient access to care thereby improving outcomes; patients will find it easier to take advantage of health care services that will improve their overall health. Lifestyle behaviors can be addressed before they have resulted in adverse health outcomes and admissions. Having to wait weeks, and in some specialty areas months, to get an appointment is having an impact on improving the rate of potentially preventable admissions, potentially preventable readmissions, and patient care outcomes
(2) Potentially Preventable Readmissions – 30 days	Expanding Primary Care correlates to preventing readmissions. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Easier access to preventive screenings and health care services will mean that more people in our community receive intervention sooner. Increasing access to primary care services could reduce readmissions by allowing follow up with primary care physicians in a timely manner. Conducting Medication Management will reduce hospital readmissions by insuring patients are receiving the appropriate combination of medications and insuring they fully understand medications upon discharge.
(3) Potentially Preventable Complications	Conducting Medication Management will result in fewer complications for the patient, and better outcomes, by : improving patient understanding of medications at discharge, insuring appropriate medication therapy, coordinating with nursing for medication discharge counseling, participating in medication reconciliation, improving pain management, enhancing communications about medications, and providing on-going training and education to physicians and hospital staff on medication related topics.
(4) Patient-Centered Healthcare	Redesigning for Cost Containment will positively impact patient care and outcomes. Patient centered health care is proven to reduce costs. Peer review and public postings of quality indicators for providers drives lower cost and better health outcomes for patients. Palliative Care education of physicians, patients with chronic conditions and the community will foster better understanding of the program benefits, which would result in more patients receiving the most appropriate care at the right intervals of the progression of their condition. Increasing the number and percentage of palliative care consults, documenting and analyzing the conditions for which palliative care was consulted, and implementing a patient experience survey of patients and/or their families regarding the quality of care will ensure a greater understanding of how to best manage pain for specific

	conditions, what treatment preferences our patients have, and what spiritual and/or religious concerns our patients and their families might have.
(5) Emergency Department	Expanding Primary Care addresses the current challenge many safety net hospitals face of patients presenting to the Emergency Department for primary care services and the limited number of providers available to provide those services. Patients currently have limited access to primary care providers other than a hospital's emergency department after hours and on weekends. By expanding clinic space to accommodate additional providers and extended hours, patients will have greater access to primary care, which should reduce emergency department encounters. Our goal is to increase clinic visits and clinic capacity and decrease non-emergent emergency department visits at United Regional. Specifically, we want provide increased access to care for those who are uninsured and for Medicaid enrollees. Many times uninsured patients will avoid seeking health care services until they experience a medical emergency. With more access to care it will be easier for the uninsured and Medicaid enrollees to obtain health care services before emergencies arise. Conducting Medication Management will result in fewer unplanned emergency department visits. Pharmacist-provided medication therapy review and consultation in various settings results in reductions in physician visits, and emergency department visits.
(6) Children and Adult Core Measures (OPTIONAL)	N/A

Category 4: Population-Focused Measures United Regional Health Care System / 135237906				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$216,538	$100,318		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$87,805	$93,930	$102,098
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$100,318	$107,330	$116,650
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			$107,330	$116,650
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$100,318	$107,330	$116,650
Domain 5: Emergency Department				
Measurement period for report		DY 2	DY 3	DY 3

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$100,318	$107,330	$116,650
<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive		$0.00	$0.00	$0.00

Amount				
Grand Total Payments Across Category 4	$216,538	$501,592	$536,649	$583,248

Category 4: Population-Focused Improvements (Hospitals only)
Performing Provider: Wilbarger General Hospital - 112707803

Domain Descriptions:
Wilbarger General Hospital has identified the following DSRIP project.

112707803.3.1.1 , 1.1 Expand Primary Care Capacity Wilbarger General Hospital (112707803)	Expand primary care capacity by adding a physician and expanding the hours of the clinic to assure right care in the right setting at the right time.	112707803.3.1 OD-9 Right Care, Right Setting IT – 9.2 ED Appropriate Utilization

Category 4 domains and measures will be impacted by these interventions targeting patients who have a high-risk of admission, readmission, and ED utilization in the different specialty areas. Wilbarger General Hospital currently only has limited capacity to track these measures but will develop a plan of action to prepare to report measures that are statistically significant. 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
(1) Potentially Preventable Admissions	***Expanding Primary Care*** will improve patient access to care thereby improving outcomes; patients will find it easier to take advantage of health care services that will improve their overall health. Lifestyle behaviors can be addressed before they have resulted in adverse health outcomes and admissions. Having to wait weeks, and in some specialty areas months, to get an appointment is having an impact on improving the rate of potentially preventable admissions, potentially preventable readmissions, and patient care outcomes
(2) Potentially Preventable Readmissions – 30 days	***Expanding Primary Care*** correlates to preventing readmissions. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Easier access to preventive screenings and health care services will mean that more people in our community receive intervention sooner. Increasing access to primary care services could reduce readmissions by allowing follow up with primary care physicians in a timely manner.
(3) Potentially Preventable Complications	Though we will report this measure, we do not have a DSRIP project directly related to PPCs.
(4) Patient-Centered Healthcare	Though we will report this measure, we do not have a DSRIP project directly related to patient centered healthcare.
Emergency Department	***Expanding Primary Care*** will improve patient access to care and thereby decrease the number of ED visits.
Children and Adult Core Measures (OPTIONAL)	N/A

- **Domain Valuation:**

  RHP 19 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and 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 Wilbarger General Hospital - 112707803				
	Year 2 (10/1/2012 – 9/30/2013)	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	$8,500	$35,685		
Domain 1: Potentially Preventable Admissions (PPAs)				

Planned Reporting Period: 1 or 2		**2**	**2**	**2**
Domain 1 - Estimated Maximum Incentive Amount		**$8,921**	**$6,862**	**$8,299**
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		**2**	**2**	**2**
Domain 2 - Estimated Maximum Incentive Amount		**$8,921**	**$6,862**	**$8,299**
Domain 3: Potentially Preventable Complications (PPCs)				

Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			**2**	**2**
Domain 3 - Estimated Maximum Incentive Amount			**$6,862**	**$8,299**
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**

Measurement period for report				
Planned Reporting Period: 1 or 2		**N/A**	**N/A**	**N/A**
Domain 4 - Estimated Maximum Incentive Amount		**$8,291**	**$6,862**	**$8,299**
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 -		**$8,922**	**$6,862**	**$8,299**

Estimated Maximum Incentive Amount				
<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		**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		**$ 0.00**	**$0.00**	**$0.00**
Grand Total Payments Across Category 4	**$8,500**	**$35,685**	**$34,312**	**$41,495**

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	Leslie Hardin	Baylor County Hospital District
	T. Kim Lee	Bowie Memorial Hospital
	Steve Hartgraves	City of Graham d/b/a Graham Regional Medical Center
	Jeff Huskey	Clay County d/b/a Clay County Memorial Hospital
	Linda Hall	Chillicothe Hospital
	Jan Reed	Electra Hospital District
	Randy Bacus	Gainesville Hospital District
	Roddy Atkins	Helen Farabee Centers
	Frank Beaman	Jack County Hospital District
	Michael Kent	Muenster Memorial Hospital
	Lance Meekins	Nocona General Hospital District
	Michael Huff	Olney-Hamilton Hospital District
	Tony Maddox	Texoma Community Center
	Bob Carruthers	Throckmorton County Memorial Hospital
	Phyllis Cowling	United Regional Health Care System
	Jonathon Voelkel	Wilbarger General Hospital District

	Carol Lively	Hardeman County Memorial Hospital

Section VII. Addendums

RHP 19 Addendums

- Section VI Signature Page
- Medical Society Support Letter
- RHP 19 Newsletter
- Helen Farabee Supporting Documents
- Texoma Supporting Documentation
- Community Needs Assessment and Supporting Documents
- Pass 3B Documentation and Workbooks
- State Hospitals Documentation and Workbooks