Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

December 31, 2012

RHP 5/South Texas

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Section I. RHP Organization

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 (specify type of Anchor, e.g. public hospital, governmental entity)						
County governmental entity		1746000717 6 060	Non-state, public	Hidalgo County	Eddie Olivarez	1304 South 25th Avenue Edinburg, Texas 78542 eddie.olivarez@hchd.org 956-383-8858
IGT Entities (specify type of government entity, e.g. county, hospital district)						
County governmental entity		1746000717 6 060	Non-state, public	Hidalgo County	Eddie Olivarez	1304 South 25th Avenue Edinburg, Texas 78542 eddie.olivarez@hchd.org 956-383-8858
Public Hospital	021219301		State-owned	Rio Grande State Center	Olga Rodriguez Director, Center for Program Coordination and Health Policy, DSHS	1100 Austin, Texas 78756-3199 West 49th Street olga.Rodriguez@dshs.state.tx.us 512-776-7181

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)
CMHA (Community Mental Health Center)	1219891-02	1742944931 1 000	Non-state, public	Border Region Behavioral Health	Daniel G. Castillon	1500 Pappas Street Laredo, Texas 78041 danielc@borderregion.org 956-794-3003
Hospital District		1746000604 6 000	Non-state, public	Nueces County Hospital District	Jonny Hipp	555 N. Carancahua, Suite 950 Corpus Christi, Texas 78401-0835 jonny.hipp@nchdcc.org (361) 808-3300
Hospital District	136332705	1741794256 6 501	Non-state, public	Starr County Hospital District, DBA Starr County Memorial Hospital	Rafael Olivares	P O Box 78 Rio Grande City, Texas 78582 rol78582@yahoo.com (956) 487-9025
CMHA (Community Mental Health Center)	138708601	1741565510 3 006	Non-state, public	Tropical Texas Behavioral Health	Jim Banks	1901 S 24th Avenue Edinburg, Texas 78540 jbanks@ttbh.org 956-289-7292
UT Pan American		1746002942 8 000	State-owned	UT Pan American	Lydia P. Aleman	1201 W. University Dr. ITT 1.210 Edinburg, Texas 78539 Aleman@utpa.edu 956-665-2116
UT Health Science Center	085144601	1741586031 5 000	State-owned	UT Health Science Center - San Antonio	Dr. Joseph B McCormick	2102 Treasure Hills Blvd Harlingen, Texas 78550 McCormickj@uthscsa.edu 956-365-8823

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 (specify type of provider, e.g. public or private hospital, children's hospital, CMHC, that will receive DSRIP payments under the RHP plan, some of which may also receive UC)						
CMHC	121989102	1742944931 1 000	Non-state public	Border Region Behavioral Health Center	Daniel G. Castillon	1500 Pappas Street Laredo, Texas 78041 danielc@borderregion.org 956-794-3003
Private Hospital	160709501	1742802643 3 000	Private	Doctors Hospital at Renaissance	Israel Rocha	P O Box 3293 McAllen, Texas 78502 is.rocha@dhr-rgv.com 956-362-3088
Children's Hospital	132812205	1742577746 7 000	Private	Driscoll Children's Hospital	Shane Casady	3533 Alameda St Corpus Christi, Texas 78411 shane.casady@dchstx.org 361-694-6523
County Hospital	136332705	1741794256 6 501	Non-state, public	Starr County Memorial Hospital	Rafael Olivares	P O Box 78 Rio Grande City, Texas 78582 rol78582@yahoo.com 956-487-5561
CMHC	138708601	1741565510 3 006	Non-state public	Tropical Texas Behavioral Health	Jim Banks	1901 S 24th Avenue Edinburg, Texas 78540 jbanks@ttbh.org 956-289-7292

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)
UT Health Science Center	085144601	1741586031 5 000	State-owned	UT Health Science Center - San Antonio	Dr. Joseph B. McCormick	2102 Treasure Hills Blvd Harlingen, Texas 78550 McCormickj@uthscsa.edu 956-882-5152
UC - only Hospitals (list hospitals that will only be participating in UC)						
Private Hospital	112716902	1621656022 3 003	Private	Columbia Rio Grande Healthcare LP DBA: Rio Grande Regional Hospital	Charles Mallon, CFO	101 East Ridge Road McAllen, Texas 78503 charles.mallon@hcahealthcare.com 956-632-6101
Private Hospital	135035706	1741393060 7 000	Private	Knapp Medical Center	Dinah L. Gonzalez, CFO	P O Box 1110 Weslaco, Texas 78596 dinah.gonzalez@knappmed.org 956-969-5112
Private Hospital	094113001	1233069260 4 017	Private	McAllen Hospitals LP DBA: South Texas Health Systems	Lorenzo Olivarez Jr. CFO	1400 W Trenton Road Edinburg, Texas 78539 lorenzo.olivarez@uhsrgv.com 956-388-2126
Private Hospital	112679902	1742206635 1 002	Private	Mission Hospital, Inc. DBA: Mission Regional Medical Center	Javier Iruegas, CEO	900 South Bryan Mission, Texas 78572 jiruegas@missionrmc.org 956-323-9103
Public Hospital	021219301	3537537537 1 000	State-owned	Rio Grande State Center	Olga Rodriguez Director, Center for Program Coordination and Health Policy, DSHS	1100 West 49th Street Austin, Texas 78756-3199 Olga.Rodriguez@dshs.state.tx.us 512-776-7181

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)
Private Hospital	020947001	1621669572 2 501	Private	Valley Regional Medical Center	Susan Andrews	100 E. Alton Gloor Blvd Brownsville, Texas 78526 susan.andrews@hcahealthcare.com 956-350-7106
Private Hospital	294543801	1452663071 1 000	Private	Valley Baptist Medical Center Brownsville Hospital Co. LLC	Leslie Bingham	1040 W Jefferson Harlingen, Texas 78520 leslie.bingham@valleybaptist.net 956-698-5421
Private Hospital	292096901	1452662980 4 000	Private	Valley Baptist Medical Center Harlingen Hospital Co. LLC	Bill Adam, Sr. VP, CEO	2121 Pease Street Harlingen, Texas 78550 bill.adams@valleybaptist.net 956-389-1674
Other Stakeholders (specify type)						
County Medical Association				Cameron-Willacy Medical Society	Javier Vazquez, Executive Director	2224 77 Sunshine Strip Suite 96, PMB 117 Harlingen, Texas 78550 jmnc28@gmail.com 956- 421-5980
County Medical Association				Hidalgo Starr Medical Society	Amanda Rodriquez	1901 S 1st Street McAllen, TX 78503 hscms@att.net 956-994-3175
Regional Public Health Director				Hidalgo County Health & Human Services Department	Eddie Olivarez	1304 South 25th Avenue Edinburg, Texas 78542 eddie.olivarez@hchd.org 956-383-8858
Regional Public Health Director				Cameron County Department of Health and Human Services	Yvette Salinas	1390 West Expressway 83 San Benito, TX 78586 ysalinas@co.cameron.tx.us 956-247-3693

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 significant safety net provider -Hospital				Harlingen Medical Center	Tod Mann, CEO	5501 S Expressway 77 Harlingen, Texas 78550 tmann@primehealthcare.com 956-365-1000
Other safety net provider – FQHC				Nuestra Clinica del Valle	Lucy Ramirez	801 W. 1st Street San Juan, TX 78589 hchcc@hiline.net 956-787-8915
Other – Health Sciences Center				Texas A&M Health Science Center	Olga C. Gabriel, MPH	2101 South McColl McAllen, TX 78503 gabriel@srph.tamhsc.edu 956-668-6300
Other – Community Association				Lower Rio Grande Valley Development Council	Jose L. Gonzalez	301 W Railroad Weslaco, TX 78596 jgonzalez@lrgvdc.org 956-682-3481
Other – Hospital District				Willacy Hospital District	Jim Darling	623 S 15th Street Raymondville, Texas 78580 J.Darling@dhr-rgv.com 956-362-7293

Section II. Executive Overview of RHP Plan

Overview of Regional HealthCare Partnership 5/South Texas

The S9outh Texas counties of Regional Healthcare Partnership (RHP) 5 are Cameron, Hidalgo, Starr and Willacy. This rapidly growing population of the Lower Rio Grande Valley, home to 1.26 million residents, is relatively young, predominately Hispanic and is characterized by high poverty rates and high rates of adults without a high school education.

Among the counties of the Lower Rio Grande Valley, Cameron and Hidalgo are designated as urban counties, possessing 32% and 61% of the area's population, respectively. Starr and Willacy each carry a rural county designation, with only 5% and 2% of the area's population, respectively. The municipalities of the Lower Rio Grande Valley are diverse, including some urban areas, many rural communities, and numerous "colonias." Colonias are the unincorporated subdivisions found along the U.S.-Mexico border comprised of small housing lots with little or no infrastructure occupied by individuals and families with very low incomes. These "neighborhoods" pose a potentially serious challenge to the public health and quality of life of their residents, primarily due to their lack of appropriate infrastructure for wastewater and safe drinking water, crowded living conditions and lack of access to primary health services. The Lower Rio Grande Valley of South Texas has the highest concentration of colonias in Texas.

The economy of the region is heavily dependent on the health care and education sectors and local government for employment. There are 13 for-profit hospitals and two non-profit hospitals, but no major public safety net hospital. The region is home to three Federally Qualified Health Clinics with multiple satellite locations; two community mental health centers; local county health departments and private practitioners that form the health care safety net for the region. Approximately 1400 physicians provide direct care and 728 are primary care providers.

Key Health Challenges Facing RHP 5

The key health challenges of South Texas are rooted in extreme levels of economic and health disparities.

Diabetes and Overweight/Obesity

The unprecedented epidemics of chronic disease in RHP 5—particularly diabetes and related chronic conditions—are fueled by high levels of adult and childhood obesity. Based on a multi-year, random sample of 2000 Mexican American adults called the Cameron County Hispanic Cohort, or CCHC, researchers at the University of Texas School of Public Health, Brownsville, found that 31% of participants have diabetes and 81% are either obese (49%) or overweight (32%). Researchers estimated that 273,831 Mexican Americans in the RHP 5 have diabetes, which is the third leading cause of mortality in the region, behind heart disease and cancer.

Diabetes is an underlying component of over half of hospital admissions for heart attack, hypertension, sepsis and stroke, based on a 2011 analysis of admissions at six hospitals in RHP 5. This analysis found that diabetes contributes to more than 16,000 extra bed days per year at an additional cost of $49 million to $83 million annually.

High rates of diabetes are also associated with RHP 5 having the highest rates of tuberculosis in the country, because diabetes compromises the immune response to tubercle bacillus. RHP 5 requires strong systems of surveillance and care management for both conditions.

Other Chronic Diseases
RHP 5 has one of the highest renal dialysis rates in Texas and one of the highest rates of chronic liver disease (non-alcohol fatty liver disease). Furthermore, testing results from the CCHC study suggest that 292,271 adults in RHP 5 have hypertension but only half are being treated and that 441,634 adults have elevated cholesterol levels for which 85% are not receiving treatment.

Mental Health and Substance Abuse
Compared to national statistics, self-reported rates of fair or poor mental health in RHP 5 are much higher (20% v. 12%), as are rates of chronic depression (40% v. 27%). At the same time, the entire region has a shortage of mental health professionals, in a state that has the lowest per capita spending on mental health services in the country. Texans with a serious mental illness are eight times more likely to be incarcerated in jails than treated in hospitals, at tremendous public and personal cost.

Access Barriers to Care
A lack of access to and utilization of needed health care services—across the region—is exacerbated by low levels of health insurance. In a state with the highest uninsured rate in the country, uninsured rates are even higher in RHP 5, topping 80% among non-elderly Mexican American adults surveyed in the CCHC. Additionally, the region faces a shortage of primary care and dental professionals to serve a growing population, with only half to three-quarters of the physician-to-population ratios of Texas for primary care specialists (e.g., family practice, general practice, OB/GYN). The current delivery system does not have the capacity to identify individuals with or at risk for chronic conditions and to navigate them into appropriate programs to help prevent, diagnosis and manage their health conditions.

Patient-Centered Care
Residents of RHP 5 who participated in focus groups for 2011 community health needs assessment identified health education as a high priority for their communities. Helping patients with low health literacy understand their health conditions, treatment options, and how to navigate the health care system is critical to improving patient outcomes. Residents of RHP 5 are essentially asking for patient-centered care.

RHP 5's Vision for Healthcare Delivery System Transformation

The RHP 5 partners comprise a wide assortment of public and private institutions coming together to address the region's heavy burden of chronic disease and health disparities and its demonstrated need for enhanced access to primary and behavioral health care services. The overarching vision for the region includes the following goals:

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.

- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

RHP 5 DSRIP Projects to Support Delivery System Transformation

In response to community input from providers, local researchers and residents, based on regional meetings, local research results, needs assessments involving resident surveys and focus groups, as well as state and federally-supported health and demographic statistics on the region, RHP 5 has developed DSRIP projects designed to:

1. Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.
2. Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care.
3. Improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions as part of our region's transformation to a quality-based health care system.
4. Increase the capacity of safety net providers in the region to provide patient-centered care and care management, particularly for patients with chronic conditions, to improve health literacy, self-care management skills, and more effectively access or navigate the health care system appropriately.

The project listed in the summary table below are tailored to meet the unique needs of specific populations in our region and will be designed by local providers using best practices and proven strategies to improved patient outcomes and satisfaction.

RHP 5: Summary of Categories 1-2 Projects

Project Title (include unique RHP project ID number for each project.)	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			
[121989102].1.1 Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services Border Region Behavioral Health Center 121989102	This project (1.11.2) will establish telemedicine service in Starr County to provide access to psychiatric and medical services for AMH and CMH clients for residents in Starr County.	[121989102].3.1 IT 2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone measure)	$44,475
[121989102].1.2 Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas Border Region Behavioral Health Center 121989102	This project (1.14.1) will recruit, hire or contract, and train LPHAs, psychiatrists, RNs for residents in Starr County.	[121989102].3.2 IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone measure)	$1,045,158
[121989102].1.3 (Pass 2) Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system. Border Region Behavioral Health Center 121989102	This project (1.13.1) will define and address gaps in the current crisis management system.	[121989102].3.4 IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse (Standalone Measure)	$1,056,218
[160709501].1.1 Establish Primary Care/Internal Medicine Residency Training Program Doctors Hospital Renaissance 160709501	This project (1.2.4) will establish a new Internal Medicine residency training program at DHR: recruit program directors; conduct primary care gap analysis; write and submit PIF; pass review by RRC; recruit medical students; onboard 1st class of 6 in July 2015; recruit and onboard 2nd class of 6 in July 2016.	[160709501].3.1 IT-14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA	$10,851,520

Project Title (include unique RHP project ID number for each project.)	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
[160709501].1.2 Establish Primary Care/Family Medicine Residency Training Program Doctors Hospital Renaissance 160709501	This project (1.2.4) will establish a new Family Medicine residency training program at DHR: recruit program directors; conduct primary care gap analysis; write and submit PIF; pass review by RRC; recruit medical students; onboard 1st class of 4 in July 2015; recruit and onboard 2nd class of 4 in July 2016.	[160709501].3.2 IT 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA	$10,851,520
[160709501].1.3 Establish Ob/Gyn Residency Training Program Doctors Hospital Renaissance 160709501	This project (1.2.4) will expand high impact specialty care capacity in most impacted medical specialties. Establish a new Ob/Gyn residency training program at DHR: recruit program directors; conduct primary care gap analysis; write and submit PIF; pass review by RRC; recruit medical students; onboard 1st class of 3 in July 2015; recruit and onboard 2nd class of 3 in July 2016.	[160709501].3.3 IT 14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA	$10,851,520
[160709501].1.4 Establish General Surgery Residency Training Program Doctors Hospital Renaissance 160709501	This project (1.9.1) will expand high impact specialty care capacity in most impacted medical specialties. Establish a new General Surgery residency training program at DHR: recruit program directors; conduct primary care gap analysis; write and submit PIF; pass review by RRC; recruit medical students; onboard 1st class of 2 in July 2015; recruit and onboard 2nd class of 2 in July 2016.	[160709501].3.4 IT 14.1 Number of practicing specialty care practitioners per 100,000 individuals in HPSA or MUA	$10,851,520

Project Title (include unique RHP project ID number for each project.)	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
[160709501].1.5 (Pass 2) Expand Physician Assistant Studies Program Doctors Hospital Renaissance 160709501	Doctors Hospital at Renaissance will be working with UTPA to double their physician assistant program ensuring that they receive the best clinical rounding available according to their necessities and the circumstances of the region.	[160709501].3.5 IT-14.4 Percent of graduates who practice in a HPSA or MUA. [160709501].3.6IT – 14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA) [160709501].3.7 IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs base on a systematic survey [160709501].3.8 IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic	$11,686,435
[132812205].1.1 Increase, Expand, and Enhance Oral Health Services Driscoll Children's Hospital 132812205	This project (1.8.12) will implement an innovative and evidence based intervention that will lead to improvements in Oral Health services delivery for providers that have demonstrated need or unsatisfactory performance in this area.	[132812205].3.1 IT-7.10 Other outcome: Urgent dental care needs in children	$4,455,000
[136332705].1.1 Increase OB Primary Care Starr County Memorial Hospital 136332705	This project (1.1.2) will recruit a family practice physician that is also able to practice obstetrical care for the community. In addition to providing services at the rural clinic, he/she will be recruited to perform OB delivery services at Starr County Memorial Hospital.	[136332705].3.1 IT-1.10– Diabetes Care: HbA1c Poor Control	$1,353,550
[136332705].1.2 Expand Surgery Service Capacity Starr County Memorial Hospital 136332705	This project (1.9.3) will allow Starr County Memorial Hospital to contract a general surgeon to provide full-time surgical services in our facility.	[136332705].3.2 IT-1.13 – Diabetes: Care Foot Exam [136332705].3.3 IT-6.1 Patient Satisfaction [136332705].3.4 IT-4.1 Improvement in PPC rate [136332705].3.5 IT-4.4 Surgical Site Infections	$2,772,838

Project Title (include unique RHP project ID number for each project.)	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
[138708601].1.1 Expand Primary Care Capacity Tropical Texas Behavioral Health 138708601	This project (1.1.2) will expand behavioral health service capacity at all TTBH clinic locations to provide services to individuals currently on TTBH waiting lists.	[138708601].3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$13,765,914
[138708601].1.2 Expand Primary Care Capacity Tropical Texas Behavioral Health 138708601	This project (1.1.2) will increase access to Co-Occurring Psychiatric and Substance Use Disorder (COPSD) services for persons with co-occurring mental health and substance use diagnoses through the addition of 4 COPSD Specialists at each of TTBH's 3 main clinic locations.	[138708601].3.2 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$4,986,935
[138708601].1.3 Development of behavioral health crisis stabilization services as alternatives to hospitalization. Tropical Texas Behavioral Health 138708601	This project (1.13.2) will add 2 Mobile Crisis Outreach Team (MCOT) staff at each of TTBH's main clinics trained in the delivery of crisis services to individuals with co-occurring IDD and behavioral health needs; provide respite services in collaboration with Rio Grande State Center; provide emergency crisis respite in collaboration with Wood Group Crisis Respite Unit (with 1:1 staffing as needed); Facilitate behavior management for individuals with IDD who have co-occurring behavioral health needs, to prevent admission/readmission to inpatient psychiatric care.	[138708601].3.3 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$2,444,817
[138708601].1.4 (Pass 2) Introduce, Expand or Enhance Telemedicine/Telehealth Tropical Texas Behavioral Health 138708601	This project (1.7.1) will add equipment to connect all TTBH community-based and Mobile Crisis Outreach Team (MCOT) staff to the telemedicine/telehealth system and provide necessary training to increase the volume of electronic psychiatric consultations.	[138708601].3.8 [IT-6.1] Percent Improvement over baseline of patient satisfaction scores: (5) patient's overall health status/functional status (Standalone measure)	$2,035,950

Project Title (include unique RHP project ID number for each project.)	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
[085144601].1.1 Improving Primary Care Access through expansion of internal medicine residency UTHSCSA 085144601	The primary goal of this DSRIP project (1.2.4) is to increase the number of internal medicine faculty and residents in the existing internal medicine residency of Valley Baptist Medical System. Obtain RRC approval and recruit first 5 residents in July 2015. The project will train more workforce members to serve as primary care providers to help address the substantial primary care workforce shortage.	[085144601].3.1 IT-14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA	$11,877,837
[085144601].1.2 Expand high impact specialty care capacity in Behavioral Health UTHSCSA 085144601	The primary goal of this DSRIP project (1.9.1) will be to expand specialty care in behavioral health by establishing a psychiatry residency program that will address the severe shortage of behavioral health professionals and create a pipeline for the future.	[085144601].3.2 IT-14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA	$11,877,837
[085144601].1.3 New faculty for family medicine residency UTHSCSA 085144601	The primary goal of this project (1.2.3) is to increase the number of Family Medicine Faculty in an HPSA region thus increasing access and capacity. This will occur by providing more faculty to improve the quality and variety of training of family medicine residents.	[085144601].3.3 IT-14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA	$11,877,837
[111810101].1.1 (Pass 2) Implement a Chronic Disease Management Registry; Implement/enhance and use chronic disease management registry functionalities University of Texas Health Science Center –Houston (UTHealth) 111810101	This project (1.3.1) is designed to implement a chronic disease registry, specifically diabetes, in RHP 5. In doing so it will sustain and expand the Rio Grande Valley Health Information Exchange and create the first network of providers connected through the new HIE in RHP5, and provide a means to give integrated care to patients across a range of RHP5 providers.	[111810101].3.1 IT-1.10. HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure)	$5,321,849
Category 2: Program Innovation and Redesign			

Project Title (include unique RHP project ID number for each project.)	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
[121989102].2.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. Border Region Behavioral Health Center 121989102	This project (2.15.1) will identify clients with co-morbid conditions and provide integrated primary and behavioral services for residents in Starr County	[121989102].3.3 IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone measure)	$1,134,107
[121989102].2.2 (Pass 2) Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population. Border Region Behavioral Health Center 121989102	This project (2.13.1) will provide an intervention for a target behavioral health population to prevent unnecessary use of services in a specified setting.	121989102.3.5 IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse (Standalone Measure)	$1,584,326
[132812205].2.1 Implement Evidence-based Disease Prevention Programs Driscoll Children's Hospital 132812205	This project (2.6.2) will improve maternal and fetal medicine care to pregnant women who also are diabetics, individuals with asthma, tobacco or alcohol users, and other chronic conditions	[132812205].3.2 IT-8.9 Reduce the Neonatal Length of Stay for targeted population	$ 7,425,000
[132812205].2.2 (Pass 2) Implement Evidence-based Health Promotion Programs Driscoll Children's Hospital 132812205	This project (2.7.1) will establish a Fetal Echocardiogram Program.	[132812205].3.3 IT-8.9 Early Detection of Fetal Anomalies	$11,880,000
[136332705].2.1 (Pass 2) Process Improvement Methodology throughout the ED Starr County Memorial Hospital 136332705	This project (2.8.1) will apply new process through our facility to increase capacities and turnaround of our ED without sacrificing the quality and safety of our patient population. This project will improve our ED Throughput.	[136332705].3.6 IT-6.1 Percent Improvement over baseline of patient satisfaction scores [136332705].3.7 IT-3.3: Diabetes 30 day readmission rate	$1,113,750

Project Title (include unique RHP project ID number for each project.)	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
[138708601].2.1 Integrate Primary and Behavioral Health Care Services Tropical Texas Behavioral Health 138708601	This project (2.15.1) will add a Primary Care Physician (PCP), nurse and support staff at each of TTBH's 3 main clinic locations (serving Hidalgo, Cameron and Willacy Counties) to provide primary care services to the behavioral health population served.	[138708601].3.4 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$16,810,467
[138708601].2.2 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.). Tropical Texas Behavioral Health 138708601	This project (2.13.2) will: recruit and hire 18 certified Mental Health Officers to serve on a mental health taskforce serving all counties in TTBH's catchment area; increase opportunities to divert individuals with mental illness from the criminal justice system to treatment alternatives as appropriate.	[138708601].3.5 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$13,443,573
[138708601].2.3 Integrate Primary and Behavioral Health Care Services Tropical Texas Behavioral Health 138708601	This project (2.15.1) will: co-locate primary care services at TTBH's main clinic locations; reduce the use of local emergency departments for medical clearances required for psychiatric hospital admissions.	[138708601].3.6 OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores	$106,488
[138708601].2.4 Expand Chronic Care Management Models Tropical Texas Behavioral Health 138708601	This project (2.2.5) will add 1 Nurse Care Manager at each of TTBH's main clinics and implement a patient self-management program for specified individuals with co-morbid chronic medical and mental illnesses.	[138708601].3.7 OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores	$12,360,811

Project Title (include unique RHP project ID number for each project.)	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
[138708601].2.5 (Pass 2) 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.). Tropical Texas Behavioral Health 138708601	This project (2.13.2) will increase access to peer-provided behavioral health services through the addition of 1 veteran peer provider, 3 MH peer providers, 2 family partners and 1 program supervisor at each of TTBH's three main clinic locations and increase the percentage of individuals receiving peer provided services who also demonstrate improved functioning.	[138708601].3.9 [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores: (5) patient's overall health status/functional status (Standalone measure)	$ 7,239,960
[138708601].2.6 (Pass 2) 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.). Tropical Texas Behavioral Health 138708601	This project (2.13.2) will establish Peer-Run Drop-In Centers at TTBH's main clinic locations and increase the percentage of individuals receiving services at peer-run drop-in centers who demonstrate improved functioning.	[138708601].3.10 [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores: (5) patient's overall health status/functional status (Standalone measure)	$ 6,337,501
[138708601].2.7 (Pass 2) Establish/Expand a Patient Care Navigation Program Tropical Texas Behavioral Health 138708601	This project (2.9.1) will establish and provide family-centered, culturally sensitive and community-based mental health care navigation services to uninsured children with special health care needs and their families already enrolled in the Cameron County Department of Health and Human Services Children with Special Health Care Needs Case Management Program through a Mental Health Care Navigation Program. The program will improve access to integrated primary and mental health care, minimize the impact of mental health problems and significantly reduce the need for more costly interventions for this targeted group of children.	[138708601].3.11 IT-10.7 Rate 1: Decrease in percentage of Children with Special Health Care Needs and their family members who were assessed and identified to be at high risk for mental health conditions relative to prior DY. Rate 2: Increase in the number of Children with Special Health Care Needs and their family members evaluated for risk of mental health conditions relative to prior DY.	$5,070,000

Project Title (include unique RHP project ID number for each project.)	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
[138708601].2.8 (Pass 2) Establish/Expand a Patient Care Navigation Program Tropical Texas Behavioral Health 138708601	This project (2.9.1) will establish and provide family-centered, culturally sensitive and community based mental health care navigation services to women enrolled in the Cameron County Department of Health and Human Services (CCDHHS) Maternal and Child Health Program who are identified at high risk for postpartum depression, and their families, through a Postpartum Depression Intervention Care Navigation program. The project will improve mental health care outcomes and the experience of care for women at risk for postpartum depression and their families in Cameron County.	[138708601].3.12 IT-8.9 Rate 1: Decrease percentage of postpartum women and their family members identified to be at high risk for mental health conditions relative to the prior DY. Rate 2: Increase the number of postpartum women and their family members evaluated for risk of mental health conditions relative to the prior DY.	$3,549,000
[085144601].2.1 Implement medical homes in HPSA and other rural and impoverished areas. UTHSCSA 085144601	This project (2.1.3) will support the creation of patient centered medical homes in a community clinic (Su Clinica Familiar) located in an HPSA region.	[085144601].3.5 IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 (Standalone measure)	$4,519,209
[085144601].2.2 Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5 UTHSCSA 085144601	This project (2.2.1) is designed to expand proactive, ongoing care to keep patients with chronic diseases healthy. It will also empower them to self-manage their conditions. The ultimate goal is to prevent worsening health precipitating the need for Emergency Department or Inpatient care.	[085144601].3.6 IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure)	$13,036,178
[085144601].2.3 Establish/Expand a Patient Care Navigation Program based on a Mobile Clinic model UTHSCSA 085144601	This project (2.9.1) expands the use of an existing Mobile Clinic in a customized van providing primary care in underserved rural areas by enhancing and expanding its impact with Patient Navigators.	[085144601].3.7 IT-12.5 Other USPSTF-endorsed screening outcome measures (diabetes, hypertension and hypercholesterolemia)	$3,476,314

Project Title (include unique RHP project ID number for each project.)	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
[085144601].2.4 Implement Evidence-based Health Promotion Programs UTHSCSA 085144601	This project (2.6.1) will implement the evidenced-based Community Wide Campaign (CWC) which will include community health worker outreach, self-management education, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health.	[085144601].3.8 IT-1.7 Controlling high blood pressure NCQA-HEDIS 2012, NQF 0018 228 (Standalone measure)	$7,452,304

Section III. Community Needs Assessment

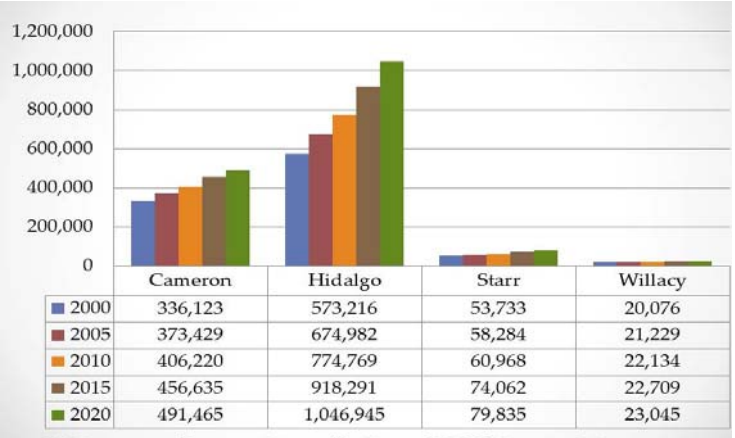
Demographics

RHP 5 is comprised of the four counties in the Rio Grande Valley of South Texas: Cameron, Hidalgo, Starr and Willacy (Figure 1.)

The population of RHP 5 was 1.26 million in 2010, an increase of 29% since 2000. Hidalgo County, which includes the McAllen-Edinburg-Mission metropolitan statistical area (MSA), has the largest population among the four counties (Figure 2). Population projections indicate that the rate of growth is expected to continue to increase rapidly over the coming years.

Figure 1. Counties of Region 5

Figure 2. Population Growth of the Counties of RHP 5



	Cameron	Hidalgo	Starr	Willacy
2000	336,123	573,216	53,733	20,076
2005	373,429	674,982	58,284	21,229
2010	406,220	774,769	60,968	22,134
2015	456,635	918,291	74,062	22,709
2020	491,465	1,046,945	79,835	23,045

Race/Ethnicity

The population of the counties of RHP 5 is predominately Hispanic, mostly Mexican American, ranging from 87% in Cameron County to 98% in Starr County, as of 2009.[1] By contrast 38% of the state's population is Hispanic. The proportion of African Americans across the region is under 1%, which is very different from many other Texas regions.

Language

Spanish is widely spoken in the region. Nearly all (96%) residents over age 5 in Starr County speak Spanish, with rate of 73% and 84% in Cameron and Hidalgo Counties, respectively.[2] Just under half of Willacy County residents speak Spanish (48%). In Texas, the rate is 29%.

Age and Gender

The population of RHP 5 is relatively young compared to Texas, for which the median age is 33.6. The median age of RHP 5 ranges from 28.3 in the populous Hidalgo County to 32.1 in the sparsely populated Willacy County. However, the region mirrors state and national trends of an aging population. In three of the four RHP 5 counties, the proportion of population that is female is between 51% and 52%, but in Willacy County, the rate is 46%, according to 2011 Census estimates.

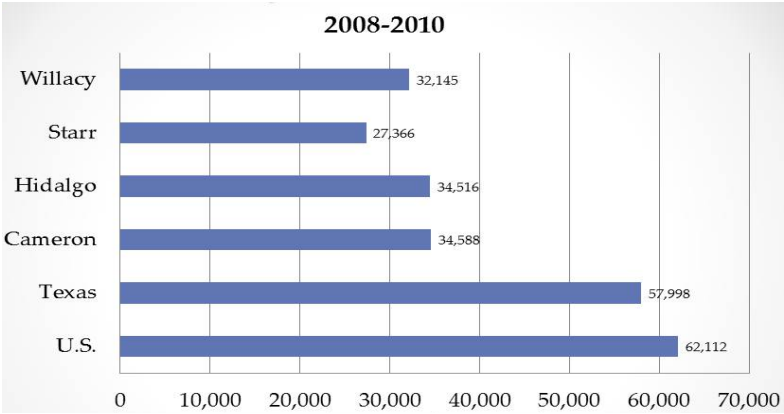
[1] Texas Department of State Health Services, Center for Health Statistics. See: https://www.dshs.state.tx.us/chs/healthcurrents/

[2] U.S. Census Bureau. See: http://quickfacts.census.gov/qfd/states/48/48427.html

Income

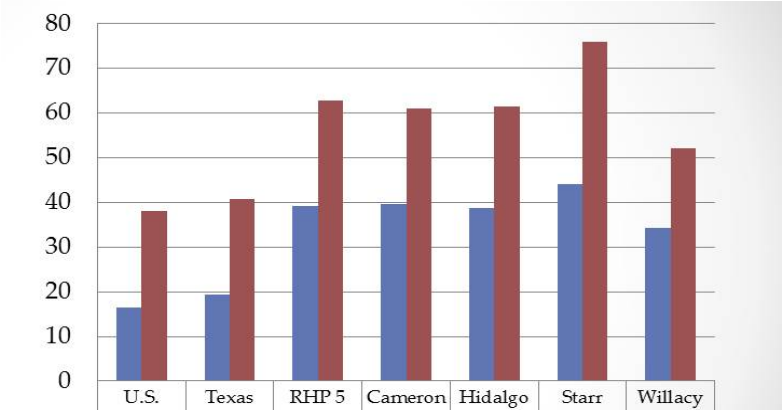
Median family income in RHP 5 ranges from $27,000 in Starr County to $34,500 in Hidalgo and Cameron Counties (Figure 3). This is between 45% and 59% of the Texas median income of $57,998, and 40% to 55% of the US median family income of $62,112. Nearly half (47%) of families in RHP 5 earn less than $25,000 annually.

Figure 3. Median Family Income of RHP 5 Counties, Texas and the U.S.



Additionally, 40% of all families live below the federal poverty line—twice the poverty rate for Texas and 2.5 times the U.S. poverty rate. The McAllen–Edinburg–Mission metropolitan statistical area ranks last among the nation's 361 MSAs, with a per capita income of $15,184.[3] Among families with a single female head of household, over 60% live below the poverty line, half again the proportion in Texas and the U.S. (Figure 4).

Figure 4. Percentage of Families Living below the Federal Poverty Level in RHP 5 Counties, Texas and the U.S., 2008-2010



Education

Educational attainment in RHP 5 is below that of Texas; it is also distributed unequally among the RHP 5 counties. The percentage of adults age 25 and older without a high school education ranges from 38% in Cameron County to 54% in Starr County, compared to 21% statewide (Table 1).[4] The proportion of adults with a high school education ranges from 23% in Starr County to 28% in Willacy County; the rate for Texas is 26%. Those with some college ranges from 13% in Starr County to 17% in Cameron County; the rate for Texas is 22%.

Table 1. Educational Attainment among RHP 5 Counties, 2005-2009

Adults Age 25 and Older Who:	Cameron	Hidalgo	Starr	Willacy	Texas
Did Not Complete High School	38%	41%	54%	45%	21%
Completed High School Graduate	24%	24%	23%	28%	26%
Have Some College	17%	16%	13%	14%	22%

Source: U.S. Census Bureau, American Community Survey, 2005-2009.

[3] Dynamic Growth in the Rio Grande Valley. Dallas Federal Reserve Bank, 2006. See: http://www.dallasfed.org/assets/documents/research/swe/2006/swe0602c.pdf

[4] Texas Department of Health Services, reporting on county data from the American Community Survey (2005-2009). See: https://www.dshs.state.tx.us/hcquery/report/?mode=demo&areas=31_266_255

Employment, Large Employers

Unemployment rates across RHP 5 ranged from 8.7% to 11.2% among adults age 16 and older in 2011.[5] The largest employers in the region, particularly in the McAllen-Edinburg-Mission MSA are in education (local school districts and higher education), health care (two medical centers) and government (city, county and U.S. Customs).[6] According to the Texas Workforce Commission (TWC), health care firms are among the top private sector employers in both the McAllen and Brownsville-Harlingen MSAs. For McAllen-Edinburgh-Mission, health care firms comprise seven of the area's ten largest private employers.[7]

Insurance Coverage

Total Population Covered by Medicaid

According to state data, for the period July 2010, about one-quarter of the populations of Cameron, Hidalgo and Willacy counties were enrolled in any form of Medicaid. For Starr County, the rate was nearly one-third, compared to 12% for Texas (Table 2).

Table 2. Number and Percentage of Population on Any Medicaid Program, RHP 5 Counties and Texas, 2010

	Cameron	Hidalgo	Starr	Willacy	Texas
Number	97,670	195,283	19,581	5,636	3,040,879
Percentage	24%	25%	32%	25%	12%

Source: Texas Health and Human Services Commission. Percentages derived from 2010 Census Bureau counts.

Uninsured Non-elderly Population

Within Texas, which has the highest under-65 uninsured rate in the country—26% in 2010—RHP 5 has even higher uninsured rates. According to federal statistics, only Willacy County has an under-65 uninsured rate that is less than 30%. Among the other three counties of RHP 5, the uninsured rates range between 36% and 38% (Table 3).[8]

Table 3. Number and Percentage of Non-elderly Uninsured, RHP 5 Counties and Texas, 2010

	Cameron	Hidalgo	Starr	Willacy	Texas
Number	134,358	265,156	19,259	4,779	5,820,793
Percentage	38%	38%	36%	29%	26%

Source: U.S. Census Bureau, 2010.

Sources of Coverage among Non-elderly Adults

Among non-elderly adults (ages 18 to 64), uninsured rates are higher than for the entire non-elderly population because children have more expansive eligibility criteria for obtaining Medicaid coverage compared to adults. A 2011 local community health assessment in the region found that uninsured rates were 61% for non-elderly adults in Willacy County, 47% in Hidalgo County and 37% for Cameron

[5] U.S. Census Bureau, American Community Survey 2009-2011 3-year estimates. See: http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

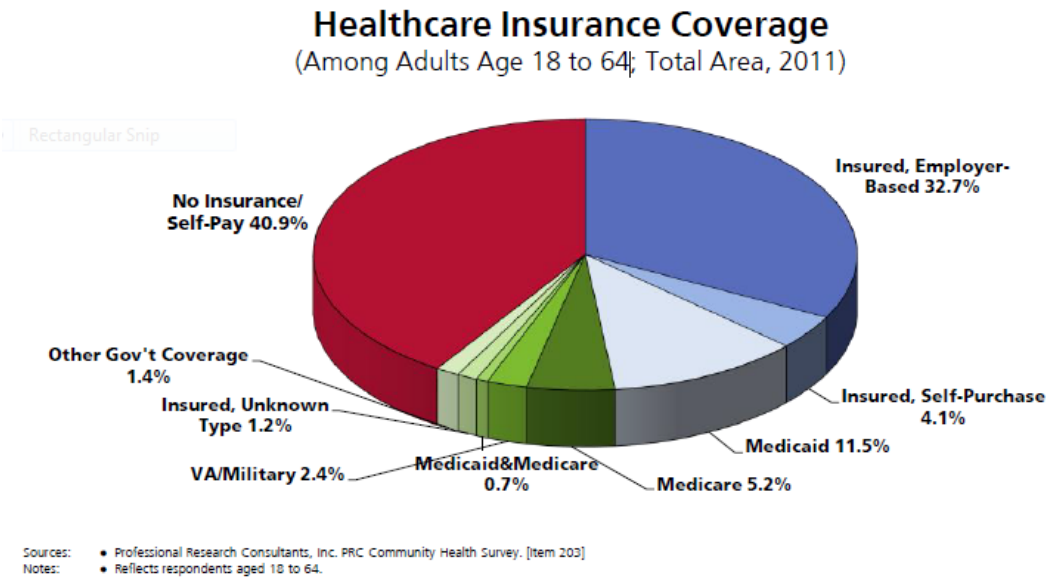
[6] McAllen Economic Development Corporation. Data from 2010. See: http://www.mcallenedc.org/mcallen-top-employers.php

[7] Texas Comptroller's Office. Undated. Texas in Focus: South Texas. http://www.window.state.tx.us/specialrpt/tif/southtexas/healthcare.html

[8] U.S. Census, Small Area Health Insurance Estimates, 2010. See: http://www.census.gov/did/www/sahie/data/interactive/

County non-elderly adults. The overall uninsured rate was 41% for the region, compared to 31% for the State of Texas.[9] Likewise, 60% of non-elderly adults reported having some kind of health coverage, but only one-third (33%) were covered by employer-sponsored insurance (ESI), as shown below (Figure 5). This compares to a statewide rate of 54% with ESI among non-elderly adults.[10]

Figure 5. Source of Coverage for Non-elderly Adult Respondents in a 2011 Health Needs Assessment Survey



Insurance Coverage among Mexican Americans along the U.S.- Mexican Border. The University of Texas School of Public Health in Brownsville has been conducting the Cameron County Hispanic Cohort (CCHC) study, since 2003. Results from face-to-face interviews with 2000 Mexican-Americans in the border community of Brownsville from 2003 to 2008, showed that only 20% of non-elderly adults had any insurance; 14% had private coverage, 5% had Medicaid and 2% had Medicare (Figure 6).[11]

Figure 6. Distribution of health insurance status among 2000 CCHC participants, by age and sex, 2003-2008.

Category	Insurance status			
	All types %	Private %	Medicaid %	Medicare %
All Participants	31.4	11.9	8.3	11.0
Males	36.0	14.4	8.5	13.0
Females	27.7	9.9	8.2	9.4
18-64 years	20.4	13.8	4.6	1.8
≥65 years	87.8	2.0	27.4	58.4

Healthcare Infrastructure

Health System Overview

RHP 5 includes 13 private, for-profit hospitals and two non-profit hospital systems. These hospitals provide a safety net for the region's population. There are three Federally Qualified Health Clinics

[9] 2011 PRC Community Health Report. This health needs assessment was sponsored by Valley Baptist Health System and conducted by Professional Research Consultants, Omaha, Nebraska. The survey included 400 adults in in Cameron County and 100 each in Willacy County and Hidalgo County. Residents of Starr County were not included.

[10] See the Kaiser Family Foundation website: http://www.statehealthfacts.org/profileind.jsp?ind=130&cat=3&rgn=45

[11] Fisher-Hoch SP, Vatcheva KP, Laing ST et al. Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a mexican american population, cameron county Hispanic cohort, 2003-2008. *Prev Chronic Dis* 2012;9:E135.

with satellite locations throughout RHP 5[12], as well as two local community mental health centers, and other clinics and private practitioners that constitute the remainder of the region's health care safety net. Specialty care is provided in RHP 5 where possible, but many people are referred to University of Texas Medical Branch at Galveston or other large medical centers, often through funds from the county indigent care program. These funds are limited and often consumed within a few months of each fiscal year. Finally, many people cross the border to Mexico for a range of services from diagnostic, to treatment including the purchase of prescription drugs that are available without prescription in border towns.

Health Professional Shortage Areas

RHP 5 has long been a health professional shortage area with particular difficulty in recruiting and retaining primary care and specialist physicians, nurses and physician assistants. All four counties of RHP 5 have "whole county" shortage area designations for dentists and mental health professionals (Table 4).[13] Starr and Willacy counties have whole county primary care health professional shortages, while the shortage in Cameron County is designated as "partial." Poverty, remoteness, lack of an academic health educational center, and cultural and language barriers all contribute to the difficulty in recruiting and retaining health care professionals in the region.

Table 4. Health Professional Shortage Area Designations in RHP 5, 2010

	Health Professional Shortage Area Designations		
	Primary Care	**Dental**	**Mental Health**
RHP 5 County			
Cameron	Partial County	Whole County	Whole County
Hidalgo	Not Designated	Whole County	Whole County
Starr	Whole County	Whole County	Whole County
Willacy	Whole County	Whole County	Whole County

Source: Texas Department of State Health Services, 2010

Health Care Providers

Below is a more detailed description of the health care workforce in RHP 5 for a variety of health care professionals, including but not limited to primary care, dental and mental health.[14] The region's rates per 100,000 population are compared to those of Texas.

Community Health Workers (CHW). In RHP 5 the rate of 18.1 community health workers (CHWs) per 100,000 population is higher than the Texas rate of 5.9 (Table 5). This is reflective of the longstanding presence of "Promotoras," who have a tradition of serving as CHWs in Hispanic communities in South Texas. CHWs are gaining stature throughout the country as having an important role to play in supporting patient-centered care. Several DSRIP projects for RHP 5 will feature the role of CHWs in improving the delivery of cost-effective health care.

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[12] Texas Department of State Health Services, Office of Primary Care. See: https://www.dshs.state.tx.us/chpr/fqhcmain.shtm

[13] Texas Department of State Health Services, 2010. See: http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=35614&id=66988&terms=shortage

[14] Texas DSHS Center for Health Statistics, 2011. See http://www.dshs.state.tx.us/chs/hprc/health.shtm
Rates were based on a population of 1,334,042 for RHP 5, and 25,883,999 for Texas.

Dentists. The supply of dentists in RHP 5 is second in deficit only to mental health professionals. There are only 21 dentists per 100,000 population—less than half the rate for Texas.

Nurses and Nurse Practitioners*.* There are 3,659 Licensed Vocational Nurses (LVN) in RHP 5 for a rate of 274 per 100,000 population; this is only slightly lower than the rate of 282 for Texas. However, for Registered Nurses (RNs) there are only 6,623 RNs or 497 per 100,000 population available, fully 30% below the rate of 713 in Texas. The situation is even worse for nurse practitioners in RHP 5 where the rate is about 14 per 100,000 population compared to about 26 per 100,000 in Texas.

Physician Assistants (PA). RHP 5 is equally or better supplied with PAs than Texas as a whole. As managed care becomes more common in RHP 5 we expect the numbers of PAs to increase.

Behavioral Health Professionals (psychiatrists, psychologists, social workers). Texas has one of the lowest ratios of psychiatrists to 100,000 population of any state in the nation. RHP 5 has 2.8 psychiatrists per 100,000 population—just 40% of the already low level of 6.8 in Texas; similarly there are 9.2 licensed psychologists per 100,000 in RHP 5 compared to 25.8 in Texas. RHP 5 has 40% of the rate of mental health professionals of the state.

Two participants in the focus groups that were part of the PRC community health needs assessment articulated a patient perspective on the poor state of mental health access in the Rio Grande Valley: [15]

> *"It's all crisis care, you know, so they have to get so sick they become dangerous. Even if you get hospitalized for a psychiatric problem, chances are you won't even get accepted to an in-patient facility because they're all full."*
>
> *"Mental health in two areas, one even people who have insurance have trouble getting mental health services. They end up waiting for months to see a psychiatrist or a counselor."*

Physicians. *A*s of September 2011 there are 1,378 physicians in RHP 5 providing direct patient care, among whom 728 provide primary care. There are 103 direct care physicians and 54.6 primary care physicians per 100,000 population in RHP 5. These rates are 40% and 20% less, respectively, than the Texas rate, despite the very high degree of health disparities and disease burden, particularly obesity and diabetes, in the population, as discussed below. RHP 5 is 20% lower in primary care physicians per 100,000 population compared to Texas (54.6 v. 69.5).

Table 5. Health Workforce Supply and Distribution RHP 5 and Texas, 2011

Category		N	Population/ Worker	Workers/ 100,000 Population	Ratio RHP 5/ Texas
Community Health Workers					
	RHP 5	241	5,535	18.1	3.10
	Texas	1,527	16,951	5.9	
Dentists					
	RHP 5	286	4,664	21.4	0.47
	Texas	11,751	2,203	45.4	
Nurses (LVNs)					

[15] 2011 PRC Community Health Report. Professional Research Consultants. p. 42.

Category		N	Population/ Worker	Workers/ 100,000 Population	Ratio RHP 5/ Texas
	RHP 5	3,659	365	274.3	0.97
	Texas	72,921	355	281.7	
Nurses (RNs)					
	RHP 5	6,623	201	496.5	0.70
	Texas	184,467	140	712.7	
Nurse Practitioners					
	RHP 5	190	7,021	14.2	0.55
	Texas	6,676	3,877	25.8	
Physician Assistants					
	RHP 5	281	4,747	21.1	1.00
	Texas	5,372	4,818	20.8	
Psychiatrists					
	RHP 5	37	36,055	2.8	0.41
	Texas	1,766	14,657	6.8	
Psychologists					
	RHP 5 (2010)	119	10,924	9.2	0.36
	Texas (2010)	6,547	3,876	25.8	
Direct Care MDs					
	RHP 5	1,378	968	103.3	0.63
	Texas	42,716	606	165	
Primary Care MDs					
	RHP 5	728	1,832	54.6	0.79
	Texas	17,996	1,438	69.5	

Source: Texas Department of State Health Services, Center for Health Statistics, 2011

There are 39 family medicine physicians, or 2.9 per 100,000 population in RHP 5—30% fewer compared to the rate for Texas (Table 6).[16] Similarly, there are 15.5 family practice physicians per 100,000 population, fully 25% lower than the Texas rate of 20.2 per 100,000 population.

RHP 5 has half the rate of general practitioners per 100,000 population compared to Texas. Pediatrics is the only area where there RHP 5 has parity or exceeds Texas in physicians per 100,000 population (13.8 v. 12.8). The supply of physicians in Internal Medicine and OB/GYN specialties lags behind Texas by 30% and 25%, respectively. The rate of Geriatrics specialists in RHP 5 is in parity with the State's rate.

[16] Texas Department of State Health Services, 2011. See: http://www.dshs.state.tx.us/chs/hprc/tables/2011-Primary-Care-Physicians-by-County-of-Practice-and-Specialty/. Rates were based on a population of 1,334,042 for RHP 5, and 25,883,999 for Texas.

Table 6. Primary Care Physicians by Specialty, RHP 5 and Texas, 2011

	Family Medicine	Family Practice	General Practice	Pediatrics	Internal Medicine	Obstetrics and Gynecology	Geriatrics	Total
Number of Physicians								
RHP 5	39	207	18	184	191	86	2	728
Texas	1053	5216	664	3321	5293	2188	33	17,996
Physicians per 100,000 population								
RHP 5	2.9	15.5	1.3	13.8	14.3	6.4	0.1	54.6
Texas	4.1	20.2	2.6	12.8	20.4	8.5	0.1	69.5
Ratio: RHP 5/ Texas	0.71	0.77	0.50	1.08	0.70	0.75	1.00	0.79

Source: Texas Department of State Health Services, 2011.

Hospital Bed Capacity and Ownership Status

Hospitals in RHP 5 range in size from 48 beds to over 800 beds across three counties (Table 7). Many are full service hospitals but none has a trauma unit designated under level 3.[17]

Table 7. Inpatient Hospitals and Medical Centers in the Counties of RHP 5, 2012

Hospitals and Medical Centers	Beds	Trauma Level	Status
Cameron County			
Valley Baptist Health System	866	III	For Profit
Harlingen Med Center	112		For Profit
Valley Regional Hospital	214	III	For Profit
Solara Hospital	41		
South Texas Rehabilitation Hospital	40		For Profit
Total Beds Cameron County	**1273**		
Hidalgo County			
Mission Regional Medical Center	297	IV	Non-Profit
Doctors Hospital at Renaissance	530	III	For Profit
Edinburg Regional medical Center	213		For Profit
McAllen Heart Hospital	60		For Profit
McAllen Medical Center	441		For Profit
Rio Grande Regional Hospital	320	III	For Profit
Solara Hospital	78		For Profit
Knapp Medical Center	227	III	Non-Profit
South Texas Behavioral Center	134		
Total Beds Hidalgo County	**2300**		
Starr County			

[17] Texas Department of Regulatory Services, October, 2012. See: http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec

Hospitals and Medical Centers	Beds	Trauma Level	Status
Starr County Memorial Hospital	**48**	IV	Non-profit, Hospital District
Willacy County			
Total Beds Willacy County	**0**		
Total Inpatient Beds RPH 5	**3621**		

Source: Texas Department of State Health Services, Dept. of Regulatory Services, 2012.

Health Service Costs

The costs of health services are heavily weighted toward Medicare and Medicaid in RHP 5. Because of the lack of access to preventive health services and the high burden of chronic diseases, people in RHP 5 are often seen in crisis in emergency departments with advanced manifestations of chronic disease; this drives up the overall cost of treatment and adds to the burden of indigent care that hospitals and health systems provide.

For example, based on admissions data from hospitals in RHP 5, Table 8 shows that the estimated annual impact of diabetes on length of hospitalization is substantial and accounts for 2,126 extra days in the ICU, and 14,087 extra days from medical/surgical bed days. The estimated annual excess costs of these extra bed days, as a result of diabetes, range from $49 million to $83 million.

Table 8. Estimated Annual Excess Hospital Days and Cost Due to Diabetes among RHP 5 Hospitals, 2011

	No. of Patients (N) and Average Length of Stay (ALOS) in Days			
	Diabetes		No Diabetes	
Type of Admission	N	ALOS	N	ALOS
ICU Admissions	2,934	8.38	3,565	7.66
Medical/Surgical Admissions	18,830	5.69	24,562	4.94
All Admissions (ICU and Med/Surg)	20,666	4.18	26,828	3.54
	Annual Excess Utilization and Cost Due to Diabetes			
	Extra Hospital Days per Year	Estimated Cost Per Day	Low Estimate	High Estimate
ICU Admissions for Patients with Diabetes	2,126	$12000-$18000	$25,517,831	$38,276,746
Medical/Surgical Admissions for Patients with Diabetes	14,194	$1650-$3161	$23,243,292	$44,528,513
All Admissions: Total Annual Estimated Excess Cost			$48,761,123	$82,805,260

Source: University of Texas Health Science Center-San Antonio; analysis of date from six hospitals in RHP 5, 2011.

Key Health Challenges in RHP 5

Overall Health Status

Based on self-reported health status results from the 2011 community health assessment in RHP 5, 82% of those surveyed said their health was excellent, very good or good; 28% said their health was

fair to poor, which is much higher than the Texas and national averages of 17% each. Among Willacy County residents surveyed, 40% rated their health status as fair or poor.[18]

Leading Causes of Mortality

The five leading causes of death for adults in the counties of RHP 5 are heart disease, cancer, diabetes, strokes, accidents (including motor vehicle) (Figure 7).[19] Other leading causes include septicemia, liver disease, renal disease, Alzheimer's disease, suicide and homicide. These statistics do no fully reflect the extent to which diabetes and obesity likely contribute to these causes of death.

Figure 7. Leading Causes of Mortality for RHP 5, 2008

Rank	1	2	3	4	5	6	7
Cause	Heart	Cancer	Diabetes	Stroke	Accidents	Lung disease	Septicemia
Rate/100K	181.53	127.56	31.58	31.30	26.10	21.87	16.03
Rank	8	9	10	11	12	13	
Cause	Liver disease	Kidney Disease	Alzheimer	Hyper-tension	Suicide	Homicide	
Rate/100K	15.80	15.47	8.90	5.22	5.21	4.39	

Diabetes

Results from the Cameron County Hispanic Cohort (CCHC) study, a population-based, randomly selected surveillance survey that directly measured diabetes among 2000 participants showed a large pool of undiagnosed patients with diabetes; the overall prevalence of diabetes in RHP 5 is about 31% of adults. This rate is much higher than results from the Behavioral Risk Factor Surveillance System (BRFSS) which find that 14.3% of adults self-report having diabetes, compared to 9.7% for Texas and 9.3% for the U.S.[20] The CCHC estimate is more likely to reflect the full extent of the prevalence of diabetes in RHP 5 since it is not self-reported but rather, measured in a population-based, randomly selected surveillance study of the population.

Table 9. Hospital Admissions in RHP 5, by Diagnosis and Proportion with Type 2 Diabetes, 2011

Major Reason for Admission	Total Admissions	Admissions for which Patient has Diabetes	
		N	%
1. Hypertension	7,899	4,326	54.8
2. Renal Disease	5,394	3,561	66.0
3. Heart Failure	3,391	2,152	63.5
4. Sepsis	3,075	1,648	53.6
5. Cancer	2,138	683	31.9

[18] 2011 PRC Community Health Report. Professional Research Consultants, Omaha, Nebraska. The survey included 400 adults in Cameron County and 100 each in Willacy County and Hidalgo County. Residents of Starr County were not included.

[19] Texas Department of Health, Texas Vital Statistics, 2008.

[20] Behavioral Risk Factor Surveillance System Prevalence and Trends Data: Texas 2010, from the Centers for Disease Control and Prevention (CDC). Data are for Public Health Region 11, which (includes all the RHP 5 counties and several others in South Texas. Query page from the Texas Dept. of State Health Services: http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm

Major Reason for Admission	Total Admissions	Admissions for which Patient has Diabetes	
		N	%
6. Stroke	1,639	837	51.1
7. Depression	1,187	509	42.9
8. Heart Attack	1,178	686	58.2
9. Leg or Foot Ulcer	712	472	66.3
10. Peripheral Neuropathy	649	577	88.9
11. Alzheimer's Disease	604	292	48.3
12. Birth <36 weeks	472	3	0.6

Source: University of Texas School of Public Health, Brownsville.

Because diabetes is often well down the list of ICD-9 diagnoses it is very often missed in reporting on hospital admissions. The estimated impact of diabetes on hospital care in RHP is illustrated, below, based on local researchers' analyses from six hospitals in the region (Table 9). For each major reason for admission, the number and percentage for which the patient also has diabetes was examined. The analysis showed that two-thirds of renal disease and nearly two-thirds of heart failure admissions include patients who also have diabetes. More than half of admissions for heart attack, hypertension, sepsis, stroke are for patients who also have diabetes.

Overweight and Obesity

Results from the 2011 health needs assessment for the region found 76% of adults to be overweight or obese, compared to 66.5% for Texas and 70% for the U.S.[21] Obesity is implicated in many diseases, including diabetes, heart disease, and cancers. Programs to reduce obesity and prevent the onset of diabetes can play a major role, along with early detection in preventing other illnesses.

Figure 8. Rates of overweight, obesity and diabetes among 2000 CCHC Respondents and Mexican Americans, Nationally

	Cameron County Hispanic Cohort	Nationally (NHANES 1999-2002)	
	Total	All US %	Mexican Americans %
BMI			
Overweight (BMI 25-29)	33.2	34.1	39.0
Obese (BMI≥30)	48.5	32.3	36.8
Extreme obesity (BMI≥40)	7.9	4.8	4.5
2010 Diabetes definition			
Diagnosed Diabetes	13.7	8.3%	10.4%
Undiagnosed Diabetes	17.0	3.0%	3.0%
Total diabetes	30.7	11.3%	13.4%

Overweight and Obesity among Mexican American Adults. Figure 8 shows the prevalence of obesity to be 48.5% of the adult population among participants in the Cameron County Hispanic Cohort (CCHC) Study, compared to 36.8% of Mexican Americans nationally.[22] Altogether, over 80% of the population of RHP 5 is estimated to be obese or overweight, and therefore at high risk for other medical conditions especially diabetes. Rates of diagnosed and undiagnosed diabetes in the predominately Mexican American community of RHP 5 is 30% compared to 13.4% for Mexican Americans nationally. Well over 30% of CCHC respondents said they had no physical activity in the past month compared to 24% in Texas. Less than

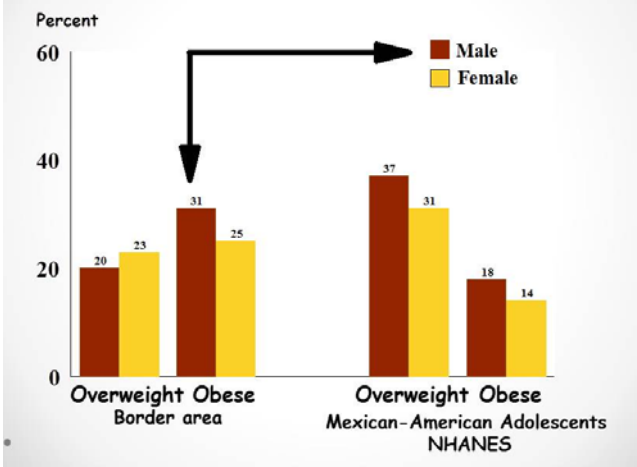
[21] 2011 PRC Community Health Report.

[22] Fisher-Hoch SP, Rentfro AR, Salinas JJ et al. Socioeconomic status and prevalence of obesity and diabetes in a Mexican American community, Cameron County, Texas, 2004-2007. *Prev Chronic Dis* 2010;7:A53.

half of respondents reported physical activity levels that meet the minimum recommended requirements.

Overweight and Obesity among Mexican American Adolescents. More than half of RHP 5 (border area) adolescents are overweight or obese, which contributes to diabetes and other health issues throughout youth and into adulthood. More adolescents are obese than overweight (Figure 9).[23]

Figure 9. Overweight and obesity among Mexican-American Adolescents in RHP 5



Other Chronic Diseases

Cardiovascular Disease. The death rate from acute cardiovascular diseases such as heart attacks and strokes is substantially lower in RHP 5 compared to Texas and the nation. However, heart failure is among the top diseases resulting in hospitalization in RHP 5, as noted above. It appears that heart failure is very common, and likely underdiagnosed. Similar to diabetes, people can go for some time with insidious heart failure without a proper diagnosis. Based on data from the ongoing CCHC study in South Texas, as many as 30% of Mexican American adults in the region have evidence of heart failure.[24,25,26]

Kidney Disease. Renal disease is the second leading cause of hospital admissions in RHP 5, as noted in Table 9, above. Renal dialysis rates in RHP 5 are also among the highest in Texas.[27] Chronic kidney disease and end-stage renal disease are significant health problems in RHP 5, responsible for premature death, a major source of suffering, poor quality of life and high costs.[28]

Chronic Liver Disease. South Texas has one of the highest rates of chronic liver disease in the country.[29] Among participants in the CCHC study, 47% have elevated liver enzymes. Two recent publications from this population strongly point to non-alcoholic fatty liver disease (NAFLD) as the likely culprit.[30,31] NAFLD leads to non-alcoholic steatohepatitis, cirrhosis and liver cancer.[32]

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[23] Rentfro AR, Nino JC, Pones RM et al. Adiposity, biological markers of disease, and insulin resistance in Mexican American adolescents, 2004-2005. *Prev Chronic Dis* 2011;8:A40

[24] Fisher-Hoch SP, Vatcheva KP, Laing ST et al. 2012.

[25] Laing ST, Smulevitz B, Vatcheva KP et al. High Prevalence of Subclinical Atherosclerosis by Carotid Ultrasound among Mexican Americans: Discordance with 10-Year Risk Assessment using the Framingham Risk Score. *Echocardiography* 2012.

[26] Queen SR, Smultevitz BE, Rentfro AR et al. Electrocardiographic Abnormalities among Mexican Americans: Correlations with Diabetes, Obesity and the Metabolic Syndrome. *World Journal of Cardiovascular Diseases*. In press.

[27] U.S.Department of Health and Human Services. CDC WONDER online databases.

[28] Perez A, Anzaldua M, McCormick J, Fisher-Hoch SP. High frequency of chronic end-stage liver disease and hepatocellular carcinoma in a Hispanic population. *J Gastroenterol Hepatol* 2004;19:289-295.

[29] Ibid.

[30] Li Q, Qu HQ, Rentfro AR et al. PNPLA3 Polymorphisms and Liver Aminotransferase Levels in a Mexican American Population. *Clin Invest Med* 2012;35:E237.

[31] Pan JJ, Qu HQ, Rentfro A, McCormick JB, Fisher-Hoch SP, Fallon MB. Prevalence of metabolic syndrome and risks of abnormal serum alanine aminotransferase in Hispanics: a population-based study. *PLoS One* 2011;6:e21515.

Elevated Cholesterol. The 2011 PRC Community Health Report found that 31% of respondents reported a physician had told them they had high cholesterol. In the Cameron County Hispanic Cohort (CCHC), 48% of the Mexican American participants tested had elevated cholesterol levels.

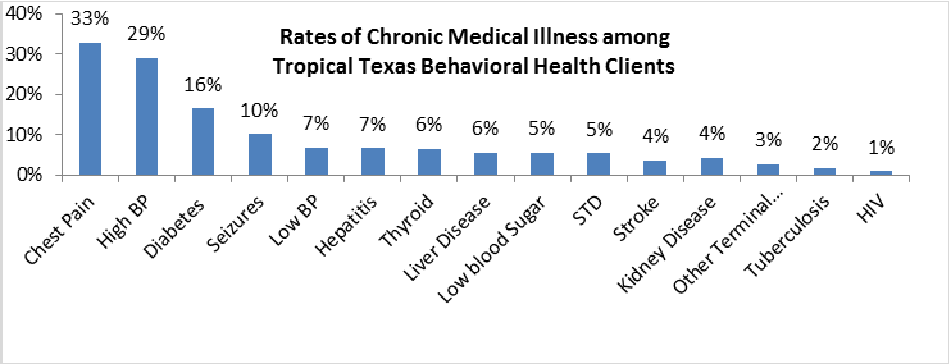
Based on CCHC Study results, researchers estimate that 273,831 Mexican Americans in the RHP 5 have diabetes, for which 56% are not being treated; 292,271 have hypertension for which 50% are not being treated; and 441,634 have elevated cholesterol for which 85% are not receiving treatment.[33]

Mental Health and Substance Abuse

One-fifth of those recently surveyed in the region considers their mental health to be fair or poor, compared to less than 12% in the United States.[34] Additionally, 39% said they had experienced chronic depression (two or more years in their lives when they felt depressed or sad on most days) compared to 27% in the U.S.

Mental health and physical health are closely connected and mental illness is also often accompanied by underlying chronic medical conditions. This is illustrated in Figure 10, which presents survey results from clients of Tropical Texas Behavioral Health (TTBH), a performing provider in RHP 5. Substance abuse is also a common disorder among individuals with severe mental illness, highlighting the need to increase prevention efforts and improve access to treatment for substance abuse and co-occurring disorders.

Figure 10 Rates of self-reported chronic disease among clients of Community Mental Health Center in RHP 5, 2012



Expanding the behavioral health workforce is critical in a region with a severe shortage of mental health professionals. Untreated mental illnesses and substance use disorders increase state spending in other areas including: emergency rooms, hospitals, jails, prisons, and detention centers, education, and homeless shelters.[35] Texans with a serious mental illness are eight times more likely to be incarcerated in jails than treated in hospitals, according to the National Alliance on Mental Illness. Texas spends $38 per capita (2009) on mental health services compared to the U.S. average of $123 per capita, making Texas last in state per capita spending for treatment of mental illness.[36] Community-based services are cost-effective in lessening costs in other areas of state expenditures. Integrating behavioral health services with physical health services is an important priority for improving the coordination and quality of care for individuals with co-occurring conditions.

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32 Angulo P. Nonalcoholic fatty liver disease. *N Engl J Med* 2002;346:1221-31.

33 See citations 25-27.

34 2011 PRC Community Health Report.

35 The National Council for Community Behavioral Health Care (n.d). See: http://www.namitexas.org/homecontent/Spill_Over_Effect_on_State_Budgets.pdf

36 Kaiser Family Foundation. (n.d.). State Mental Health Agency (SMHA), per capita mental health services expenditures, FY 2009. See: http://www.statehealthfacts.org/comparemaptable.jsp?yr=90&typ=4&ind=278&cat=5&sub=149&sortc=1&o=a

Infectious Diseases and Disease Prevention

One of the important issues in the RHP 5 population is the increased susceptibility to infectious diseases found in people with diabetes, particularly concerning tuberculosis, influenza, and pneumonia. This region has the highest rates in the nation. In 2009, the prevalence of tuberculosis was 12.8 cases per 100,000 population compared to 6.2 in Texas and 4.4 in U.S. Diabetes is the biggest risk factor for tuberculosis in our area and it accounts for about one-third of TB cases.[37,38] At the same time, only 45% of elderly adults in the region have had pneumococcal vaccine compared to 69% in Texas and 68% in the U.S. Among non-elderly adults (18 to 64) only 35% received flu vaccinations compared to 52% nationally.

Oral Health

Only 48% of adults in RHP 5 saw a dentist or dental clinic during the past year, well under the rate for Texas (62%) or the U.S. (67%).[39] Being male, under 65 and living in poverty were risk factors for lower rates of dental care. The proportion of children who visited a dentist over the past year was 85%, above the state rate of 79%.[40] Higher pediatric rates are a result of children under age of 21 having better access to Medicaid than adults. Only 35% of adults in the region (ranging from 17% to 38% among the RHP 5 counties) have dental insurance compared to 61% in the U.S. It is commonplace for residents in RHP 5 with dental problems to visit the hospital emergency room or seek dental care in Mexico. However, due to the recent escalation of violence fewer people now go to Mexico.

Emergency Department Utilization

Just under 7% of adults surveyed for the 2011 Community Needs Report reported going to a hospital emergency room more than once in the past year for their own health. Of those using the ER, 23% said the visit was due to a reason other than an emergency or life-threatening situation, such as making a visit during after-hours or on the weekend, or not having another place to go.[41] Additionally, 10% of respondents in a 2012 survey of community mental health center clients in RHP 5 reported using the ER for non-emergencies, such as getting a check-up or seeking sick care.[42]

Health Education and Patient-Centered Care

Participants in the focus groups that were part of the PRC community health needs assessment were asked individually to identify their top five health priorities for their community. Health Education was ranked number 4, behind diabetes and obesity, mental health, and substance abuse concerns. In focus group discussions, participants described a high level of health illiteracy in the community. They emphasized a strong need for patients to get more follow up support about their medications and other ways to actively engage in their own care, as illustrated by this comment:[43]

> *"Patients don't understand their medical problem; they don't understand their treatment plan; they don't understand the goals; and they don't understand how the medical system works."*

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37 Fisher-Hoch SP. Diabetes and tuberculosis: a twenty-first century plague? *Int J Tuberc Lung Dis* 2011;15:1422.

38 Restrepo BI, Camerlin AJ, Rahbar MH et al. Cross-sectional assessment reveals high diabetes prevalence among newly-diagnosed tuberculosis cases. *Bull World Health Organ* 2011;89:352-359 PMCID: PMC3089389.

39 2011 PRC Community Health Report.

40 2011 PRC Community Health Report.

41 Ibid.

42 Tropical Texas Behavioral Health Center. Survey of 2,150 clients across multiple sites, July 2012.

43 2011 PRC Community Health Report.

Delivery System Reform Initiatives

Within RHP 5, only one of the performing provider has received federal funding to support recent health care reform initiatives under CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMSHA funding or CDC state grants. Tropical Texas Behavior Health is participating in the Substance Abuse Prevention and Treatment Block Grant initiatives sponsored by SAMSHA and will apply for funding in January 2013 to receive EHR incentive payments. Additionally, the Center of Excellence on Diabetes in Americans of Mexican Descent at the University of Texas School of Public Health, Brownsville, is supported by a grant from the National Institute for Minority Health and Health Disparities.

Expected Changes During the Waiver Period of FFY 2012 – FFY 2016

There is every reason to believe that the population growth of the area will continue, particularly given the situation south of the border that is causing many citizens or legal residents to come to the US. With the passage of federal health care reform, there could be an improvement in insurance coverage and access to care over the next four years due to the expansion of Medicaid eligibility if Texas proceeds with implementation. If plans to start a new medical school in this region materialize, this effort would enhance the DSRIP residency expansion projects in producing more locally trained medical professionals who remain in the area.[44]

Approach and Sources Used to Complete Needs Assessment

The goal of this RHP 5 Needs Assessment was to guide the health care reform strategic planning process by providing information to guide stakeholder decisions in selecting DSRIP projects for the region. In this process we engaged the community and key partners to identify health concerns, priorities, strengths, and opportunities for DSRIP projects.

Key sources of demographic, health care infrastructure, and health survey information that supported this Needs Assessment came from the Texas Department of State Health Services (DSHS), Center for Health Statistics, which is a major source of information for local community health assessment and public health planning. The Center's website is a repository of federal health surveys that have demographic, health and workforce statistics available at the state, MSA or county level, as well as state-based surveys and vital statistics at the state and county level.

The *2011 Community Health Report*, prepared by Professional Research Consultants (PRC), and sponsored by Valley Baptist Health System, which is located in RHP 5, also provided recent statistics on self-reported health care coverage, health status and disease diagnoses, and results from focus groups, as referenced throughout this needs assessment.

Since 2003, the University of Texas School of Public Health, Regional Campus at Brownsville, has been conducting the *Cameron County Hispanic Cohort* study of 2000 Mexican Americans residing in the Brownsville metropolitan area. Results from published research in peer-reviewed journals was incorporated into the Needs Assessment to highlight the high burden of chronic conditions and lack of insurance coverage among this particularly poor and vulnerable population.

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[44] "Cigarroa Unveils Plans for Rio Grande Medical School," *San Antonio Business Journal*, August 17, 2012. See: http://www.bizjournals.com/sanantonio/news/2012/08/17/cigarroa-unveils-plans-for-rio-grande.html

Several other locally conducted analyses contributed to the Needs Assessments. The University of Texas School of Public Health, Regional Campus at Brownsville analyzed admissions from six participating hospitals in RHP 5 to better understand the impact of diabetes on inpatient hospital utilization and costs in the region. Tropical Texas Behavioral Health, a community mental health center in RHP 5, conducted a survey of clients across multiple clinic sites to examine rates of co-occurring conditions, client's reliance on the ER for non-emergencies, and other health care issues.

The Needs Assessment also drew on policy, research and or advocacy organizations that collect and report various state health coverage, access, cost and utilization statistics from federal and state resources. Examples include the Kaiser Family Foundation and the National Alliance on Mental Illness to provide background on mental health.

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	Shortage of primary and specialty care providers and inadequate access to primary or preventive care	Texas Department of State Health Services, 2011. http://www.dshs.state.tx.us/chs/hprc/tables/2011-Primary-Care-Physicians-by-County-of-Practice-and-Specialty/ Texas Department of State Health Services, 2010, for health care workforce shortage designations made by HRSA. See: http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=35614&id=66988&terms=shortage Behavioral Risk Factor Surveillance System Prevalence and Trends Data: Texas 2010, from the Centers for Disease Control and Prevention (CDC) http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm Published articles by the University of Texas School of Public Health, Brownsville, from the Cameron County Hispanic Cohort, 2003-2008.
CN.2	Shortage of behavioral health care professionals and inadequate access to behavioral health care	Texas Department of State Health Services, 2011. http://www.dshs.state.tx.us/chs/hprc/tables/2011-Primary-Care-Physicians-by-County-of-Practice-and-Specialty/ 2011 PRC Community Health Report. Professional Research Consultants, Omaha, Nebraska. Tropical Texas Behavioral Health Survey of 2,150 clients in July 2012. State-based research conducted by the National Alliance on the Mentally Ill (NAMI).
CN.3	Inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions	UT School of Public Health, Brownsville, analyses of hospital admissions among six participating hospitals in RHP 5, 2011. Tropical Texas Behavioral Health Survey of 2,150 clients in July 2012. 2011 PRC Community Health Report. Professional Research Consultants, Omaha, Nebraska.
CN.4	Lack of Patient-Centered Care	2011 PRC Community Health Report. Professional Research Consultants, Omaha, Nebraska.

Section IV. Stakeholder Engagement

A. RHP Participants Engagement

Since October 2011, Performing Providers and IGT entities in RHP 5 have been actively engaged in stakeholder communications about the 1115 waiver, DSRIP projects and UC payments, as described below. The anchor, Hidalgo County, has led most of these communication efforts. In addition to the activities described below, RHP 5 providers have been participating in a weekly conference call since August 2012, to discuss progress in defining the Pass 1 DSRIP projects for RHP 5 and completing this RHP 5 Plan. Plans for ongoing engagement are also described below.

Hidalgo County, Anchor
In October of 2011, the Hidalgo County Judges offices met to discuss the 1115 waiver and the possibility of Hidalgo County being appointed the anchor.

Starting in November of 2011, Hidalgo County began holding monthly meetings at the county's Health and Human Services Department. At these meetings, providers from RHP 5 discuss the status of the 1115 Waiver, contributions to IGT, agreements, and regional health plans related to their projects and proposals for Region 5. Starting in the spring of 2012, Hidalgo County increased the frequency of its meetings with the providers of the 1115 Waiver Group. In April, May, July, August and September, the group met three times each month. In October 2012 the group met once and held discussion via four conference calls organized by the Anchor.

We have posted the draft and final draft versions of the RHP5 plan on the RHP5 website, www.southtexasrhp.com and on the Cameron County Department of Health website, www.hchd.org.

Future Plans

Hidalgo County anticipates that the RHP 5 group will continue to meet monthly to discuss RHP plan updates in 2013. RHP 5 will also hold semi-annual learning collaborative meetings with performing providers. Hidalgo County will continue to provide updates on the RHP 5 Plan and 1115 Waiver developments on the RHP 5 website, www.southtexasrhp.com, and on the Cameron County Department of Health website, www.hchd.org, to make RHP 5 planning documents readily available to RHP 5 participants.

Cameron County Department of Health and Human Services (CCDHHS)
In January 2012, the Cameron County Health and Human Services Department (CCDHHS) held a DSRIP Projects Planning Meeting for its supervisors.

In March 2012, CCDHHS participated in a conference call and meeting with HHSC and RHP 5 performing providers to review the 1115 Waiver.

In April 2012, CCDHHS hosted two Medicaid 1115 subcommittee meetings; hosted a South Texas Region Webinar to outline key information about the Waiver and DSRIP Projects; held a DRSIP Projects Planning meeting for HHS supervisors; and attended an Executive Waiver Committee Meeting.

In May 2012, CCDHHS participated in an Executive Waiver Committee meeting and conference call with Texas HHSC.

In addition to the anchor and CCDHHS, IGT entities and local university, hospital and behavioral health centers organized meetings to consider IGT match-funding to support potential project collaborations. Examples are described below.

University of Texas Health and Sciences Center San Antonio (UTHSCSA)
In April 2012, University of Texas Health Sciences Center San Antonio (UTHSCSA), HHSC and RHP 5 providers met at Harlingen Valley Baptist Medical Center (VBMC) to discuss general waiver plans and answer questions from RHP 5 providers.

In May 2012, representatives from UTHSCSA, VBMC, South Texas Health System (STHS), and Doctor's Hospital (DHR) met to discuss graduate medical education, and part of this discussion was the relationship of the 1115 waiver to medical education in Texas. In late May 2012, UT representatives for relevant RHPs in Texas met at the UT System Office in Austin to discuss the role of UT in the 1115 waiver.

In June 2012, UTHSCSA representatives from RHP 5 met on two occasions: first, with Valley Primary Care Network directors to discuss the potential role of the primary care clinics in 1115 waiver programs; second, with CCDHHS representatives to discuss Cameron County Performing Provider roles and partnerships.

In July 2012, representatives from UTHSCSA, along with the Regional Academic Health Center (RAHC) Harlingen met to discuss increasing access to primary care and specialty care through the expansion of residency programs under the 1115 waiver. Also in July, a UTHSCSA representative from RHP 5 and UTHSCSA faculty met with Verite consultants, VBMC Harlingen, and RAHC to discuss the creation of a new psychiatry residency and an expansion of an existing internal medicine residency program as part of the RHP 5 plan.

In August 2012, UTHSCSA sent representatives to a two day meeting with HHSC to outline the protocol for the 1115 waiver plan. Also in August, 32 people from Cameron County Department of Health and Human Services met at the UT School of Public Health-Brownsville campus to plan a project for integrated chronic disease management in RHP 5, working with an existing integrated care organization (ICare). Representatives from UTHSCSA participated in two phone conferences in August: one with Mr. Eddie Olivares, RHP 5 Anchor Leader, to discuss a needs assessment in the region; and one with Ms. Yvette Salinas, Director of Cameron County Department of Health and Human Services, to discuss organizing a Cameron County community meeting to discuss the waiver process.

In September 2012, UTHSCA representatives were involved in 13 participant engagement activities: nine in-person meetings to discuss the details of 1115 waiver projects; three phone conferences to discuss project details and the RHP's community needs assessment; and one HHSC webinar with updates on protocol details.

In October 2012, faculty, system personnel, and other representatives from UTHSCSA met with representatives from RHP 5 on two occasions to finalize and discuss new plans to increase access to primary care through expanded and new residency programs.

Future Plans

UTHSCSA anticipates that it will hold monthly or quarterly reviews of projects with leaders of Valley Baptist Medical Center, Cameron County Department of Health and Human Services, participating city representatives, and leaders of Su Clinica Familiar. It also anticipates that quarterly, there will be a review of the overall 1115 Waiver programs at the Regional Academic Health Center and UTHSCSA.

Rio Grande Regional Hospital

In January 2012, administrators at Rio Grande Regional Hospital discussed the status of the 1115 Waiver Program and the regional plan at the hospital's weekly Tuesday morning senior management meeting.

Future Plans

Rio Grande's administrators anticipate that they will discuss the status of the waiver and regional plan at future weekly morning management meetings.

B. Public Engagement

The RHP 5 anchor, Hidalgo County, and Cameron County Department of Health and Human Services (CCDHHS) have led many public meetings around the four-county region to educate local public officials and other stakeholders about opportunities and plans in implementing the 1115 waiver in RHP 5. The University of Texas Health Science Center San Antonio has also held public meetings and forums to build public awareness and understanding. Hidalgo County will continue to engage stakeholders on a regular basis throughout the next year, as described below.

Hidalgo County, Anchor

Hidalgo County has provided several opportunities for the public to learn about and provide input in the 1115 Waiver plans and processes in RHP 5. In March 2012, Hidalgo and the Texas HHSC held a public hearing in Cameron County. In May, Proyecto Azteca sponsored a meeting with Mr. Eddie Olivarez, RHP 5 Anchor Lead, Ann Cass, Executive Director of Proyecto Azteca, and the Equal Voices Group. In August 2012, the county held a public forum at Texas A&M Health Sciences Center. In late September and then again in early October, Hidalgo presented on the 1115 Waiver RHP plan sections 1-3 at the Commissioners Court. In early November, Hidalgo County held two public hearings on a draft of the RHP 5 Plan. Notification of public hearings were posted on several sites with the statement that read, "Region 5 is planning to hold two Public Hearings for public comment on the Regional Healthcare Partnership Plan for Region 5 prior to submission to the Texas Department of Health & Human Services Commission on December 31, 2012. The Public Hearing is for all interested parties to provide comment on the RHP plan."

Future Plans

Going forward, Hidalgo County will hold quarterly public meetings at the county's Health and Human Services Department to provide updates on the 1115 Waiver RHP Plan for Region 5. It will also continue to update www.southtexasrhp.com and www.hchd.org on a daily basis.

Cameron County Health and Human Services Department
In October of 2011, Cameron County Judge, Carlos Cascos, met with Texas HHSC officials to discuss the upcoming changes regarding the Texas 1115 Medicaid Waiver Program.

In November 2011, CCDHHS officials attended an RHP 5 forum with Hidalgo County, HHSC, and other officials where the groups collaborated on developing DSRIP projects, learned about the waiver transformation process in California, and ultimately produced a draft for the Texas DRSIP project menu.

Also in December 2011, CCDHHS presented to Cameron County Commissioners Court on the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Proposal.

In March 2012, CCDHHS held three meetings with hospitals, local governments, and health officials to discuss 4-year planning for the 1115 Waiver. CCDHHS also presented on the Texas Medicaid 1115 Waiver before the City of Rio Hondo Council, and held a public hearing on the 1115 Waiver at the end of the month.

In April 2012, CCDHHS held a county-wide public hearing and presented on the Waiver at four separate city council meetings.

In May 2012, CCDHHS presented on the 1115 Waiver before six city council meetings.

In July 2012, CCDHHS participated in a county-wide public hearing on the 1115 Waiver at Regional Academic Health Center.

In August 2012, attended the HHSC RHP planning summit agenda; and engaged in a county-wide public hearing on the 1115 Waiver.

In November 2012, CCDHHS placed a public notice about the 1115 Waiver in the Cameron County Newspaper, Valley Morning Star, and Brownsville Herald. CCDHHS also held a public hearing in November.

University of Texas Health and Sciences Center San Antonio (UTHSCSA):
In February 2012 and again in April 2012, the UT School of Public Health and the Community Advisory Board included the 1115 Waiver as an agenda in their meeting at the Brownsville Community Health Center.

Section V. DSRIP Projects

A. RHP Plan Development

Based on the Texas DSRIP Program Funding and Mechanics Protocol (FMP) requirements, RHP 5 is classified as a Tier 4 region. As a Tier 4 regional healthcare partnership, Region 5 is required to select a minimum of 4 projects from Category 1 and 2 combined, with at least 2 of the 4 projects selected from Category 2. This RHP 5 Plan meets these requirements with at least 16 Category 1 and 11 Category 2 projects.

All of the projects are targeted to serve individuals and families on Medicaid and medically indigent individuals in RHP 5 communities, and have been selected from the RHP Planning Protocol.

Approach to Developing and Selecting Projects

The selection of Pass 1 projects was a community-wide effort that involved dozens of individuals representing all 4 counties in the region. In anticipation of the Texas Health and Human Services Commission (HHSC) receiving approval of its 1115 waiver, the planning process began in November 2011. Stakeholders continued to meet in early 2012 to initiate local planning and discussions related to DSRIP, to discuss the opportunities and requirements of DSRIP, inform the public about the 1115 waiver, as described above, and identify activities that would need to be completed in order to develop a regional plan, as HHSC began providing information about DSRIP requirements.

With region-wide input from stakeholders, Region 5 began reviewing community needs and identifying current documentation for a Region 5 community needs assessment. A list of specific needs was developed, some of which were common throughout all areas of the region and others that were specific to particular locales. Through these discussions and meetings, Region 5 stakeholders collaborated to identify common goals and needs, and ways in which projects could be constructed to leverage existing infrastructure and maximize the use of regional partnerships.

Stakeholder participation played a key role in the identification and selection of projects. This process occurred over an extended period and began with a review of community needs and identification of specific projects that providers, consumers, local government officials, and health care advocates identified as priority concerns. As more information became available from the State, participants began focusing more closely on project ideas that met the DSRIP participation criteria. Some projects were dismissed when they were no longer included in the RHP Planning Protocol or could not meet the protocol requirements; others underwent significant revisions in order to meet the requirements. The Section VII. Addendum attachments include a list of projects that were considered but not included in this RHP 5 Plan.

Based on community needs and availability of funding, Performing Providers made project selection decisions and began drafting Pass 1 projects. As needed, Performing Providers met with stakeholders to develop specific project components and finalize drafts for submission to the Anchor. Based on requirements within each county and/or public entities participating in the region, project proposals were also subject to review and approval by various governmental organizations with interests in the

region, before being finalized to include in the Pass 1 submission. Pass 1 projects were posted for public review and comment on the Anchor's website.

Currently the plan has Pass 1 and Pass 2 projects only, Pass 3 projects were not presented for submittal. Pass 2 projects were placed after the November 16th, when the performing providers were notified of an additional opportunity to submit additional projects under Pass 2. Pass 2 projects were also posted for public review and comment on the Anchor's website.

RHP Goals and Community Needs

The community needs assessment has played a critical role in the development of Region 5's efforts to focus on projects that will truly transform the delivery of health care to the individuals and communities served in RHP 5. Throughout stakeholder discussions and identification of community needs, a key criterion used to evaluate various project options was the ability to fulfill specific needs. To further support the planning process, the following overarching goals were established with an emphasis on ensuring patients receive the most efficacious care possible in the right place and at the right time. These goals include:

- Leveraging and improving on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increasing access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transforming health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

As part of this Plan's development, Performing Providers' project proposals include identification of how their project is related to specific community needs identified through the community needs assessment and how the projects support other initiatives within the region. The identification of community needs guided the selection of projects during phases of plan development. Throughout the planning and drafting phases, participants focused on inclusion of project components and implementation activities that can address needs based on the local healthcare conditions and system infrastructure. The Anchor facilitated sharing of information and scheduling of meetings to enable collaboration throughout the planning process. As a result, Region 5 stakeholders believe that the selected projects will significantly improve the delivery of health care throughout the region, and will result in healthier lives and lower health care costs over time.

Seeking Transformation
Providers selected and designed their projects to fulfill these goals by building on existing resources and new opportunities that can be leveraged in transforming the healthcare delivery system in South Texas. Therefore, the Plan includes a number of projects to expand the availability of the medical workforce in the Rio Grande Valley, through new or expanded residency programs and new hiring, to begin to address the region's severe shortage of health professionals in primary care and various specialties. Plans for a new medical school in RHP 5 will enhance the value these projects bring to the community and create valuable synergy in retaining future medical providers in South Texas. All of the projects are integrated in their focus on expanding access to primary and specialty care, particularly for individuals with chronic illnesses, including behavioral health conditions, in a region with a very high rate of unmet needs, as evidenced by high rates of diabetes and obesity, for example. Adopting patient-centered care and evidence-based practices are central to these projects and future learning collaboratives.

Category 4 Reporting Exemption
Starr County Memorial Hospital is exempt from Category 4 Reporting based on the criteria provided in paragraph 11e. in the Program Funding and Mechanics Protocol.

No Duplication of Federal Funding
DSRIP payments to RHP 5 projects will not duplicate federal initiatives funded by the U.S. Department of Health and Human Services. Current or anticipated initiatives are described above in the Needs Assessment.

B. Project Valuation

Valuation of projects was based on a number of factors, which varied across projects. As outlined in the Program Funding and Mechanics Protocol, performing providers worked with stakeholders and the anchor to identify factors that could impact the value of a project. While the anchor did not prescribe a specific methodology or process, participants used the same guidelines and factors to determine overall project values and milestone values. While each of these factors was individually considered for each project, it is the unique combination of factors that ultimately determines the valuations and contributes to variation among projects.

The following identifies and describes the primary factors considered for project valuation:

Project Scope
Project values reflect the level of complexity and comprehensiveness of an individual project, the various components that are required in implementation, as well as the number of staff involved in planning and implementation. Projects with a larger scope of activities or that involve multiple levels of activity and coordination may reflect higher values.

Community Benefit
Project values will reflect the extent to which the project will both directly and indirectly impact the community as a whole, in the initial or short term and in the long term. For example, improving access to behavioral health care services may reduce the number of patients arrested for criminal violations, which increases costs in the criminal justice system. While these are indirect benefits of

expanding health care services, they represent significant community benefits that enhance quality of life for the entire community and reduce public costs for other services.

Cost Avoidance
Cost avoidance is a critical component that is hard to estimate until baseline information is established. In establishing expected value, providers are relying on existing population data, cost information associated with typical episodes of care for the population served, long term impact of the project intervention, and based on published research, a very general estimation of future costs that may be avoided as a result of the services provided through the project.

Priority Community Needs
All projects address identified community needs, and many projects address multiple community needs. Project values take into account the intensity of the community need and the potential number of individuals who may be served by the project, and the priority of the project across the spectrum of community needs within the region.

Type of Provider
Each Performing Provider was responsible for ensuring that its projects meet the Program Funding and Mechanics Protocol funding distribution requirements across Categories 1-4 throughout years 2-5 of the waiver. These requirements vary for Hospital Performing Providers and Non-Hospital Performing Providers, which could contribute to variations in values of similar projects among various Performing Providers.

Populations Served
Each project will vary in the type of population served and the number of individuals, depending, in part, on the local community in which the project is located and the population typically served by the provider. The value of the project also takes into account anticipated population growth and the potential to serve larger numbers of people over time.

Most importantly, project values among Performing Providers for similar projects are impacted by the level of IGT funds allocated to a Performing Provider and the number of projects selected by the provider. Providers with lower allocations and lower levels of IGT available will obviously be more restricted in their project values, particularly if they are involved in multiple projects. These Performing Providers also usually serve smaller populations, which is a factor that impacts differences in values across Performing Providers with similar projects.

Likewise, Performing Providers with higher allocations and higher levels of IGT generally serve larger numbers of people and will, therefore, often have higher associated values. These projects also may be larger in scope and complexity, and may have more significant community benefit based on the size of the population served. Each of these factors can contribute to variations in value among Performing Providers with similar projects.

C. Category 1: Infrastructure Development

The following narratives describe each Pass 1 Category 1 project of Performing Providers, in alphabetical order of provider.

Border Region – Category 1: Infrastructure Development

Performing Provider/TPI: Border Region Behavioral Health Center/121989102

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

Unique RHP Project Identification Number: 121989102.1.1

Project Summary:
Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5. In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 combined enrolled in approximately 500. The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other. Intervention(s): This project purchases telemedicine hardware and maintenance to expand this service to all counties served by Border Region Behavioral Health Center. Need for the project (include data as appropriate): Telemedicine will be employed to increase accessibility to specialized services in a an area chronically short of licensed health provider. Lack of licensed professional health workers in South Texas is well documented. This delays service delivery and prohibits expansion. Telemedicine will permit sharing of staff with areas that experience a shortage and expand the types of specialties available, either through staff positions or contract telemedicine specialty providers. Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): Telemedicine will be available to all Starr County, Region 5 clients served. Annually, about 850 unique individuals are served, of which 50% have Medicaid and the remaining are indigent. Category 1 or 2 expected patient benefits: Clients will be afforded a wider variety of specialized consultations and wait times for services will decrease, unnecessary inpatient hospitalization can be avoided new programs can be initiated to target persons with behaviors health issues and co-morbid physical diagnoses. It is estimated that 67 children and 78 adults per month will utilize telemedicine for counseling and pharmacological management. As waiver programs for crisis management & prevention and integrated medicine are developed utilization is expected to increase. Expected impact: DY2 - 130 clients/month DY3 - 145 client/month DY4 160 clients/month DY 5 180 clients/month Category 3 outcomes expected patient benefits: Possibly preventable admission will be reduced. Patients will experience greater access to specialty care in their community, thereby reducing inpatient hospitalizations and criminal justice involvement.

Project Option: 1.11.2 Implement technology assisted services to support, coordinate or deliver behavioral health services (From psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers)

Project Description:

Border Region Behavioral Health Center will expand telemedicine services to all counties of Border Region's rural service area, one of which is in Region 5.

These services will be available for children and adults and will include psychiatric evaluation, medication management and crisis intervention. Because the region is sparsely populated, it is a challenge to provide accessible behavioral health services to the population. The availability of behavioral health providers is extremely limited. Via telemedicine is the only way some parts of Region 5 will have access to behavioral health care.

Goals and Relationship to Regional Goals:

This project supports the Regional Goal of expanding access to specialty services, many of which may only be available via telemedicine services for the foreseeable future. Region 5 has only 41% the rate of psychiatrists per 100,000 workers as the rest of Texas.

By building on the current system operating in Webb County, Region 20, this project leverages and improves on existing programs and infrastructure.

Telecommunication technology also permits participation mentoring for providers and assists in nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology.

Telemedicine will be an important component in transforming health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes.

Border Region Behavioral Health Center plans to expand access to behavioral health services via telemedicine. The goals of this project are to:

- Improve the time between initial request for services and first appointment
- Decrease transportation costs of traveling providers and clients for crisis intervention
- Reduce staff time lost to travel and ensure more service delivery and improved billing of staff time
- Enables clients from Starr County to benefit from additional services available after implementation of Project Option 1.14.1 and 2.15.1

Challenges and how addressed:

The first challenge in expanding telemedicine service to Starr County will be to ensure new technologies purchased have compatibility with the telemedicine infrastructure currently in use at the Border Region main office in Webb County (Region 20). Components and vendors will be selected with this requirement. Components will be tested upon receipt to ensure compatibility and

not impede the implementation timeline for this project. Vendors will also be evaluated on their ability to provide on-site maintenance and on component exchange time.

Staff will need to be trained in the areas of equipment operations, clinical protocols and billing documents, as it is expected none will have experience in telemedicine. Training will be provided by IT staff, clinical staff and billing/data entry staff.

The long distance from the Webb County main office to the clinic in Starr County will present challenges to on-site maintenance. To reduce delays in telemedicine service delivery, contracts with Region 5 technicians from the Harlingen/McAllen/Edinburg area may supplement the main office IT personnel.

Patient/staff acceptance of telemedicine may also present a challenge. Input from patients and staff will be collected and reviewed to determine if additional supports are required to win acceptance for the system.

5 year expected outcome:

We expect to see an increase in the number of patients accessing/receiving behavioral health services through telemedicine and, due to the increased availability and ease of access, we also expect to see increased patient satisfaction with telemental services.

Expected impact: DY2 - 130 clients/month DY3 - 145 client/month DY4 160 clients/month DY 5 180 clients/month

Starting Point/Baseline:

Border Region currently has in place Telemedicine technology to support Laredo and nearby communities. This project will expand telemedicine technology to Starr County, which currently has no capacity for telemedicine.

Rationale:

This project is required to make other proposed projects feasible. Given the physical distance from the metropolitan areas of Laredo and McAllen/Harlingen (themselves designated as Health Professional Shortage Areas), and given that DSRIP incentive payments are insufficient to fund professional positions full time, the only way to achieve improved access to specialty providers is via telemedicine.

Even without funding of the additionally proposed projects (expand workforce and implement integrated primary and behavioral healthcare), telemedicine will improve services for clients currently being served. Children and adolescents have no access to a Child Psychiatrist and no timely psychiatric assessment is available in crisis situations.

Project Components:

Border Region Behavioral Health Center will address all of the project components:

- Border Region will utilize the administrative and clinical protocols in place for Laredo in all counties
- Telemedicine has been piloted in Laredo
- Qualified behavioral health providers and peers will be identified and trained to provide provider to patient, provider to provider and peer to peer connections.
- Modifiers to track telehealth encounters are already in use.
- Fulfilled–Data collection and reporting are already in place.
- Interventions that impact on specialty services will be reviewed for increased treatment compliance, lowered waiting times for services, and factors which limit participation for safety-net populations.
- The program may be scaled up, as per review findings above, for services related to the safety-net population's other health needs and extended to other community providers
- Patient satisfaction data will be collected and analyzed weekly. Patient specific inpatient admission trends, as well as overall county inpatient trends, will be collected. This information will provide feedback regarding the effectiveness of the services at preventing hospitalization and be used for possible system improvements.

Milestones and Metrics:

The following milestones and metrics were chosen for the Border telemedicine project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-4 (P-4.1); P-8 (P-8.1); P-11 (P-11.1)

Improvement Milestones and Metrics: I-15 (I-15.1)

Unique community need identification number the project addresses:

This project relates to Community Need Number 2, shortage of behavioral health professionals and inadequate access to behavioral health care.

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

Starr county behavioral health services are limited due to the lack of licensed providers. With only one psychiatrist (past retirement age) and limited licensed counselor contracts, and no RN, access to the system is not timely, and treatment options are limited. This project represents a major investment in bringing more qualified providers into the region.

Residents of Starr County have no access to telemedicine services or to the specialty providers telemedicine makes possible. With telemedicine, child psychiatry services and timely crisis evaluation become possible. If DSRIP projects for enhancing the workforce and integrated primary and behavioral health are approved, telemedicine will be the cornerstone of bringing more specialty

services to Starr County. It is estimated that telemedicine will be used for counseling and pharmaceutical management by 67 children and 78 adults per month once fully implemented . As waiver programs are developed in crisis management and integrated medicine telemedicine utilization will increase. Crisis services, which currently average about 3 per day in Starr County will use telemedicine for after hours crisis to help avoid preventable admissions. There were 336 Starr County after hours crisis in FY12.

Related Category 3 Outcome Measure(s):

Outcome Domain IT 2.4 – Potentially Preventable Inpatient Admissions

Telemedicine technology will help our Community Mental Health clinic in Starr County deliver outpatient services at the same level as the Laredo clinic. The Laredo clinic has telemedicine technology operatives. Adult clients at the Region 5 office of Border Region Behavioral Health Center receive 35% less psychiatric visits per year per client than individuals in Laredo do. Child Clients in Region 5 receive 30% fewer visits per client than those in Laredo do. By providing more care in the outpatient setting via telemedicine, Border Region will be able to reduce preventable inpatient admissions.

Inpatient admission rates to state behavioral health hospitals for adults and children in Starr County are 12% higher than rates in Webb County.

Relationship to other Projects:

This project supports both other Border projects being requested. Patients in outlying counties may participate in the integrated primary/behavioral health project if they meet the criteria for the patient panel. All consumers will be able to access in house and contracted specialty care providers made available under the Workforce enhancement initiatives.

Telemedicine for mental health care has been demonstrated to have the same level of patient satisfaction as face-to-face visits and should prove satisfactory for consumers in this region. (Patient Satisfaction with Telemedicine Consultation in Primary Care: Comparison of Ratings of Medical and Mental Health Applications, Callahan, et. Al. Telemedicine Journal Volume: 4 Issue 4: January 29, 2009).

Relationship to Other Performing Providers' Projects in the RHP:

This project is unique to the Border region of Starr County as this county currently does not have telemedicine services. Other performing providers have not included this as a project option.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Starr County, located across the Rio Grande River from Mexico, is home to 62,000 people. The population is spread out over its 1,225 square miles, with a population density of 50 persons per square miles. This geographic dispersion, limits access to both physical and behavioral health care on a routine basis, resulting in neglected conditions which usually begin their resolution at the Emergency Room. 2010 data from the Texas Health and Human Services Commission reports almost 10,000 (9,987) emergency room visits.

This project should increase access to less intensive levels of care. This will represent a more complete utilization of dollars already allotted rather than increasing costs. Costs of intensive crisis care, both physical and psychiatric should be decreased.

Value will result from savings due to decreased transportation costs from licensed personnel traveling over great distances and being unavailable for patients during the travel time. Furthermore, there is a savings in locum tenen (temporary, contract) physicians because contracting with telemedicine physicians is cheaper than contracting for physicians.

121989102.1.1	1.11.2	1.11.2 A-H	Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services	
[Border Region Behavioral Health Center]				121989102.1.1
Related Category 3 Outcome Measure(s):	121989102.3.1	IT-2.4	Potentially Preventable Admissions- Behavioral Health/ Substance Abuse Admission Rate	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-4 Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment **Metric 1** P-4.1.Inventory of new equipment purchased **Data Source:** Review of inventory or receipts for purchase of equipment **Baseline**: No equipment or lines exist in Starr County. **Goal:** Establish working telemedicine hardware. Provide services to 60 children and 70 adults per month upon initiation of services. Data Source: Center inventory Anasazi Client Encounter system. Milestone 1 Estimated Incentive Payment *(maximum amount):* $ $10,428	**Milestone 2** P-8 Training for providers/peers on use of equipment /software Metric 1 P-8.1. Documentation of completions of training on use of equipment/ software **Data Source:** Training roster. **Baseline:** 67 children and 78 adults per month**/Goal:** 75 children and 86 adults per month. Data Source: Anasazi Client Encounter system. Milestone 2 Estimated Incentive Payment: $10,971	**Milestone 3** P-11: Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and / or telemonitoring services for treatment of mental illness or alcohol and drug dependence. Metric 1 P-11.1: ~~TBA~~ increase in number of individuals residing in underserved areas of the health partnership region who have used telemedicine, telehealth and telemonitoring services for treatment of mental illness or alcohol and drug dependence. **Goal:** 15% increase in telemedicine encounters **Data Source:** Anasazi Client Encounter system Milestone 3 Estimated Incentive Payment: $11,736	**Milestone 4** [I-15]: Satisfaction with telemedicine services Metric 1 [I-15.1]: % of consumer, peer and provider surveys indicate satisfaction with telemedicine services **Goal**: TBA 85% **Data Source:** batched and analyzed survey data Milestone 4 Estimated Incentive Payment: $ $11,339

121989102.1.1	1.11.2	1.11.2 A-H	Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services
[Border Region Behavioral Health Center]			121989102.1.1
Related Category 3 Outcome Measure(s):	121989102.3.1	IT-2.4	Potentially Preventable Admissions- Behavioral Health/ Substance Abuse Admission Rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $10,428	Year 3 Estimated Milestone Bundle Amount: $10,971	Year 4 Estimated Milestone Bundle Amount: $11,736	Year 5 Estimated Milestone Bundle Amount: $11,339
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ $44,475			

Performing Provider/TPI: Border Region Behavioral Health Center/121989102
Project Title: Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas
Unique RHP Project ID number: 121989102.1.2
Project Option 1.14.1

Project Summary:
Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5. In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 combined enrolled is approximately 500 enrolled at any given time. The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other. Intervention(s): This project concentrates on the procuring licensed personnel to provide services directly to clients and expand services – including the new services proposed under this waiver. Professions needed include psychiatrists, nurses, Licensed Professional Counselors and Care Coordinators. These services may be hired directly or acquired through contract. The expanded staff/consultants will promote access to behavioral health services through the implementation of telemedicine services, integrated primary and behavioral health services, and crisis management and prevention. Need for the project (include data as appropriate): Lack of licensed professional health workers in South Texas is well documented. This delays service delivery and prohibits expansion. Telemedicine will permit sharing of staff with areas that experience a shortage and expand the types of specialties available, either through staff positions or contract telemedicine specialty providers. Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): All of the 850 patients (adults and children – unduplicated annual count) seen annually will may benefit from greater access to specialty care if need indicates. Specifically targets clients in crisis or at risk of crisis and clients with co-morbid physical symptoms. Category 1 or 2 expected patient benefits: Clients will be afforded a wider variety of specialized consultations and wait times for services will decrease. An increase in 10% per year in adult consumers seen and 20% per year in children seen is expected for DY3-5. Expected impact (additional patients served): DY2 - no increase, DY3 - 60, DY4- 69, DY5 - 83 Category 3 outcomes expected patient benefits: Possibly preventable admission will be reduced. Patients will experience greater access to specialty care in their community, thereby reducing inpatient hospitalizations and criminal justice involvement and ER visits

Project Description:
This project is designed to address the lack of licensed Behavioral Health providers and other Behavioral Health workers residing in and serving Region 5. Licensed positions have been historically under-filled. New initiatives and changes in the health care law will exacerbate this situation unless new efforts can be initiated to recruit and train behavioral health care and primary care workers. The project will involve hiring a physician, an RN, a coordinating case worker, and a LPHA (licensed practitioner of the healing arts), and a telemedicine 0.11 child psychiatrist and 0.11 adult psychiatrist. The expanded staff/consultants will enable the delivery of telemedicine services, integrated primary and behavioral health services, and crisis management and prevention.

Border Region will begin this effort by analyzing the delivery system to quantify and prioritize areas of need. This process will include input from local stakeholders on how to best attract or recruit and train the positions identified. Contracted telemedicine resources will be investigated as viable alternatives to face-to-face encounters.

Quality Improvement processes will be included in the project regarding program performance to develop and test new solutions. Results will be shared with programs and findings may be exported to other providers/programs with similar problems.

This project begins in DY2 with gap analysis and is expected to begin hiring/contracting new providers in DY3.

Goals and Relationship to Regional Goals:
This workforce expansion project has been developed in response to input from community providers, researchers, and residents; needs assessments involving resident surveys and focus groups; and state and federally-supported health and demographic statistics on the region. It addresses the RHP 5 need for projects designed to expand the workforce of qualified primary care and specialty care providers and thus reduce delays in care seeking and inappropriate emergency department utilization, as well as improve patient satisfaction.
Goals of this project are to enhance access and reduce shortages in behavioral health; improve integration of Border Region-Starr county services into the overall health delivery system; improve consumer choice; and increase availability of effective, lower-cost alternatives to inpatient care thus preventing inpatient admission where possible and promoting recovery from behavioral health disorders.

An increase in the number of licensed professional will improve access, making clients initial access to care more timely. This will decrease waiting lists and promote community care before people's needs reach crisis levels, thus avoiding inpatient care. More counseling and behavioral therapies will be available for those with identified needs.

Challenges:

- Competition for licensed people from school system

- Difficulty attracting people to live in borderlands.
- Lack of patient data on access to care provided by other agencies.

In addition to expanding behavioral health workers, primary care providers will be provided with training to assist them in addressing the behavioral health needs of individuals beyond the scope of their usual practice. We will coordinate training and provide opportunities for ongoing support to attract and retain the professionals required in support of this project.

This project will meet these challenges in six ways:

- Enable Border Region to offer salaries competitive with hospitals and schools for licensed personnel.
- Expand recruitment efforts.
- Expand consultant contracts for specialty providers.
- Provide professional training opportunities for staff to stay abreast of latest developments in service delivery.
- Tuition assistance/loan forgiveness
- Cultivate local professionals to enhance retention

5 Year Expected Outcome for Provider and Patients:
Border Region expects to track and monitor the number of behavioral health providers servicing this population and see an increase in the number of professionals providing these services. Through our gap analysis we will identify the priority areas and increase staff accordingly.

Through improved access into the system and new provider services available, the total number of adult clients should increase by 6% and 11% for children DY3 over DY2. In DY4 & DY5 growth is expected to level off to 5% for adults and 10% for children. The number of services provided to adults and children combined is expected to experience a growth rate of 6% each year.

Expected impact (additional patients served): DY2 - no increase, DY3 - 60, DY4- 69, DY5 - 83

Starting Point/Baseline:
Typically in this Region, one part-time contract Licensed Practitioner of the Healing Arts is available for approximately 520 clients at a given time. No child psychiatrist is available for the over 175 clients in the children's program. Children and adults are served by the same psychiatrist.
One Licensed Vocational Nurse provides the nursing services for the behavioral health clients in Region 5.

The Starr County clinic provided 14,885 behavioral health services in FY 2012 and unduplicated count of 892 clients.

Rationale:
Overall there is a lack of behavioral health staff serving Region 5. Staff shortages cause frequent delays in service delivery and screening for services. LPHAs are needed for authorization, CBT and utilization review.
Project 2.15.1 for integrating primary and behavioral health care will create additional demand for LPHA, Intensive Case Manager, nursing and medical staff. Additional staff such as Community Health Workers will also be utilized. The part time LPHA on contract is used only for service authorization. Other specialties required for effective treatment, such as a Family Partner for Children's services are not available. No RN is available for Active Community Treatment services.

Current needs for licensed staff for programs in place identified as:

Child Psychiatrist: .1 FTE (via telemedicine)
Adult Psychiatrist .1 FTE (via telemedicine)
LPHA: 1 FTE
RN: .5 FTE (via telemedicine)
LVN: 2 FTE

Project Components:

a. Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and the issues contributing to the gaps. This will be addressed in Milestone 1, conduct a gap analysis.
b. Develop a plan to remediate gaps identified and data reporting mechanism to assess progress toward goal. Border Region will develop a plan for remediation of needs addressed by the gap analysis. The plan will specify recruitment targets by specialty over time, and specific recruitment strategies. For primary care staff that may be hired or contracted, training will be provided in behavioral health client and service delivery, as well as principals and protocols for the integration project. This project component is addressed in Milestone 2, remediation plan,
c. Assess and refine strategies implemented using quantitative and qualitative data. Qualitative and quantitative data will be collected as a routine part of Milestone 4, 8 &12, Evaluate and Continuously Improve Strategies. As appropriate, strategies may be exported to other needs identified in the gap analysis for serving the safety-net population.

Milestones & Metrics:
The following milestones and metrics were chosen for the workforce enhancement initiative based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1), P-2(P-2.1) to define workforce needs and put in place a remediation plan; P-4 (P-4.1) as a CQI tool for evaluating the continued implementation of the plan; P-5 (P-5.1), to measure project implementation in DY; P-9 (p-9.1) to learn from other providers with similar projects and challenges. This will be done in collaboration with RHP 5 anchor and performing providers.
- Improvement Milestones and Metrics: I-11 (I-11.1, I-11.2) to determine the effectiveness of workforce enhancement on consumer satisfaction with the workforce and to determine if enhancement as any effect on bed day utilization.

Unique community need identification number the project addresses:

- CN.1 - Shortage of primary and specialty care providers and inadequate access to primary or preventive care
- CN.2 - Shortage of behavioral health care professionals and inadequate access to behavioral health care

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

This project changes the focus of the current clinic from medication management and case management to a clinic with a greater array of clinical interventions and selection of providers. Telemedicine with appropriate nursing assistance will be available, clinic centered crisis management will help reduce dependence on law enforcement, and the hospital and cognitive behavioral therapy can be offered for ACT clients.

Related Category 3 Outcome Measure(s):

Outcome Domain 2 – Potentially Preventable Inpatient Admissions. (IT 2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate) With additional behavioral health services, populations in Region 5 should be able to avoid preventable inpatient admissions. As national statistics demonstrate, on average more than 68% of adults with a mental disorder have at least one medical condition and 29% of those with a medical disorder also have a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders.

Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population[45]. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness.

Relationship to other Projects:

This project relates to 1.11.2 - Implement technology assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified provider, and to 2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. It is expected that some specialty providers will be available only via

[45] Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioral disorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group,

telemedicine and trainings may be done with the same technology infrastructure. This will be especially true for provider and clients in the outlying counties of Jim Hogg and Zapata. Project 2.15.1 will rely on personnel hired or contracted and trained through this project almost entirely. Current DSHS state contract does not provide for treatment of primary care needs.

Relationship to Other Performing Providers' Projects in the RHP:
This project is unique to the region but does provide the increased access and availability to behavioral health care services as other projects planned for this region. This project specifically aims to reduce the community shortage of behavioral health care professionals.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
Psychiatric inpatient costs attributed to Starr county are approximately $586, 730 per year and reflect a combination of State Hospital and private psychiatric care. Approximately 70 admissions come from Starr County annually with an average length of stay of 5.7 days. Inpatient cost per day is $595 per based on Center for Medicare Services research (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell_2005_3.pdf).

Patient data is not reported by the local medical hospital (48 beds), but if usual regional data is applied for treatment of diabetes, it can be anticipated 25% of this population also suffers from behavioral health issues. Diabetes may complicate and increase the cost of psychiatric inpatient stays as well.

121989102.1.2	1.14.1	1.14.1.A-C	Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas
Border Region Behavioral Health Center			121989102.1.2
Related Category 3 Outcome Measure(s): 121989102.3.2	121989102.3.2	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone P.1-1 Conduct gap analysis **Metric 1** P 1.1 Baseline analysis of behavioral health patient population, including demographics, proximity of sources of care, ED utilization, State hospitals, co-morbidities, capacity **Baseline: :** Demographic data and provider profiles data is available, though not analyzed to date**./Goal** Match service needs to available providers to determine needed provider strength**.** **Data Source:** HPSA data, provider licensing and enrollment data, Claims and encounter data, survey and focus group data	**Milestone 4** P-4 Evaluate and continuously improve strategies **Metric 1** P-4.1 Project planning and implementation documentation describes plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement **Baseline:** This will be the initial PSDA QI cycle based gap analysis**/Goal:** Produce two examples of rapid-cycle improvement **Milestone 4** Estimated Incentive Payment: $ 85,938	**Milestone 7:** P-9 Participate in face-to-face learning at least three times per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric 1 P-9.1** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Goal:** Providers participate in at least 3 face-to-face meetings/seminars hosted by RHP **Data Source:** Documentation of semiannual meetings including agendas, presentation slides and/or meeting notes.	**Milestone 11:** P-9 Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric** 1 P-9.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Goal:** Providers participate in at least 4 face-to-face meetings/seminars hosted by RHP **Data Source:** Documentation of semiannual meetings including agendas, presentation slides and/or meeting notes.

121989102.1.2	1.14.1	1.14.1.A-C	Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas	
Border Region Behavioral Health Center				121989102.1.2
Related Category 3 Outcome Measure(s): 121989102.3.2	121989102.3.2	IT-2.4	Potentially Preventable Admissions	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 81,689 **Milestone** 2: Remediation plan. **Metric:** Remediation plan which addresses elements relating to shortages identified in gap analysis. Baseline: Pending gap analysis Goal: Completion/distribution and training on Remediation plan completed. Data Source: Completed Plan on file, training records. **Milestone 2** Estimated Incentive Payment *(maximum amount):*	**Milestone 5** P-5 Number of behavioral health providers serving medically indigent public health clients **Metric 1** 5.1 Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis. **Baseline:** Workforce totals for region stated in Region 5 Community Needs document. **Goal:** 10 % increase in adult patients served by licensed staff over DY2, 20% increase for children Total number of services delivered is 8% greater than previous DY.	**Milestone 7** Estimated Incentive Payment: $ 68,950.25 **Milestone 8** P-4 Evaluate and continuously improve strategies **Metric 1** P-4.1 Project planning and implementation documentation describes plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement **Goal:** Four examples of projects demonstrating improvement from rapid-cycle improvements **Milestone 8** Estimated Incentive	**Milestone 11** Estimated Incentive Payment: $ 66,618.75 **Milestone 12** P-4 Evaluate and continuously improve strategies **Metric 1** P-4.1 Project planning and implementation documentation describes plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement **Goal:** Five examples of projects demonstrating improvement from rapid-cycle improvements

121989102.1.2	1.14.1	1.14.1.A-C	Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas	
Border Region Behavioral Health Center				121989102.1.2
Related Category 3 Outcome Measure(s): 121989102.3.2	121989102.3.2	IT-2.4	Potentially Preventable Admissions	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
$81,689 **Milestone 3:** P-9 Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-9.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline:** RHP has organized conference calls and webinars since the beginning of the 1115 Waiver initiative. **Goal:** Promote continuous learning and exchange between providers. **Data Source:** Documentation of semiannual meetings including agendas, presentation slides and/or	**Data Source:** Border Region Human Resources documents and Provider Contracts, Border Region client encounter database Milestone 5 Estimated Incentive Payment: $ 85,938 **Milestone 6:** P-9 Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric** 1 P-9.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline:** RHP has organized conference calls and webinars since the beginning of the 1115 Waiver initiative. **Goal:** Providers participate in at least 2 face-to-face	Payment: $ 68,950.25 **Milestone 9** P-5 Number of behavioral health providers serving medically indigent public health clients **Metric 1** 5.1 Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis. **Goal:** 100% increase number of licensed providers for medically indigent public health clients served over DY2 baseline. 5 % increase in adult patients served by licensed staff over DY3, 15% increase for children. Total number of services delivered is	**Milestone 12** Estimated Incentive Payment: $ 66,618.75 **Milestone 13** P-5 Number of behavioral health providers serving medically indigent public health clients **Metric 1** 5.1 Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis. **Goal:** 200% increase number of licensed providers for medically indigent public health clients served over DY2 baseline. 5 % increase in adult patients served by licensed staff over DY4, 15%

121989102.1.2	1.14.1	1.14.1.A-C	Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas	
Border Region Behavioral Health Center				121989102.1.2
Related Category 3 Outcome Measure(s): 121989102.3.2	121989102.3.2	IT-2.4	Potentially Preventable Admissions	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
meeting notes. **Milestone 3** Estimated Incentive Payment *(maximum amount):* $ 81,689	meetings/seminars hosted by RHP. **Data Source:** Documentation of semiannual meetings including agendas, presentation slides and/or meeting notes. **Milestone 6** Estimated Incentive Payment: $ 85,938		8% greater than previous DY. **Data Source:** Webb County Indigent Health Program Diagnosis and provider billing records, Border Region referral records, Border Region client encounter database **Milestone 9** Estimated Incentive Payment: $ 68,950.25 **Milestone 10** 1-11 Consumer satisfaction with Care **Metric 1** I-11.1 % People reporting satisfaction with care. **Goal:** 85% of clients report satisfaction with care. **Data Source:** Provider registration and survey data.	increase for children. Total number of services delivered is 8% greater than previous DY. **Data Source:** batched and analyzed survey data, Border Region client encounter database Milestone 13 Estimated Incentive Payment: $ 66,618.75 **Milestone 14** I-11 Consumer satisfaction with Care **Metric 1** I-11.1 % People reporting satisfaction with care **Goal:** 85% of clients report satisfaction with care. **Metric 2** I-11.2 % State Psychiatric Facility Bed Utilization

121989102.1.2	1.14.1	1.14.1.A-C	Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas	
Border Region Behavioral Health Center				121989102.1.2
Related Category 3 Outcome Measure(s): 121989102.3.2	121989102.3.2	IT-2.4	Potentially Preventable Admissions	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			<u>Metric 2</u> I-11.2 % State Psychiatric Facility Bed Utilization **Baseline:** 70 in DY1 **Goals:** 10% decrease decease from DY1. **Data Source:** DSHS CARE system records **Milestone 10** Estimated Incentive Payment: $68,950.25	**Baseline:** 70 in DY1 **Goals:** 20 % decrease decease from DY1. **Data Source:** DSHS CARE system records I-11.2-% State Psychiatric Facility Bed Utilization 20% decrease from DY1 (70 admissions) Data Source: DHSH CARE client data system **Milestone 14** Estimated Incentive Payment: $ 66,618.75
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):*	Year 3 Estimated Milestone Bundle Amount: $257,814		Year 4 Estimated Milestone Bundle Amount: $275,801	Year 5 Estimated Milestone Bundle Amount: $266,475

121989102.1.2	1.14.1	1.14.1.A-C	Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas	
Border Region Behavioral Health Center				121989102.1.2
Related Category 3 Outcome Measure(s): 121989102.3.2	121989102.3.2	IT-2.4	Potentially Preventable Admissions	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
$245,067				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,045,158				

Provider Name/TPI: Border Region Behavioral Health Center/121989102
Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

Unique Project Identifier: 1219891.02.1.3 (Pass 2)

Project Summary:
Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5. In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 combined enrolled in approximately 500. The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other. Intervention(s): This project conducts a gap analysis of crisis services, designs a plan with the aim implementing less intense alternatives to state hospitals use or incarceration. Need for the project (include data as appropriate): Current inpatient admission (over 500 per year center-wide – 70 from Region 5 from Starr County) exceed budget allocations and the system must be analyzed to determine where changes can be made to prevent admissions. New ideas must be tried and evaluated for their effectiveness in preventing admissions. Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): The target population for this project is the patients in crisis, of which about 70 per year are currently being served by inpatient admission. Approximately 50% of these are Medicaid covered and 50% indigent at time of admission. Category 1 or 2 expected patient benefits: Patients in crisis receive crisis assessment and initial treatment at Border Region as opposed to the Emergency Department. Patients in crisis are afforded alternatives to inpatient hospitalization for treatment of their crisis episode. Patients will enjoy more days in their community setting, fewer family related expenses and less days lost from work. Expected impact (total patients per year): DY2 - no impact, DY3- 80, DY4-90, DY5-100 Category 3 outcomes expected patient benefits: Reduced Emergency Department visits for the behavioral health/substance abuse population. Patients wont have to compete with other emergency room visitors for access to services for their needs, access to behavioral health services will be improved.

Project Description:
Border Region Behavioral Health Center will define and address gaps in the current crisis management system. New intervention methodologies will be

implemented as alternatives to ER utilization and state hospital inpatient admission. The gaps analysis will describe the current crisis management interventions and options available and compare them to evidence-based programs which are demonstrating effectiveness nationally.

New alternative interventions to hospitalization will be selected and modified as appropriate to the region. Staff, in addition to be involved in the design, will receive training on the agreed upon plan.

This project will also include reducing the impact of crisis events on local law enforcement, and minimizing client into the criminal justice system.

Staff participate in learning initiatives and collaborations among the RHP members. Training is provided in new techniques of Quality Improvement such as "Raise the floor" initiatives.

Goals and Relationship to Regional Goals:

Minimize involvement of corrections systems in crisis management and prevention. Reduce Corrections systems involvement by 10% by end of DY4.
Provide alternatives to inpatient hospitalization at a cost no greater than 80% of hospitalization.
Decrease possibly preventable admission to State Hospitals
Minimize use of hospital ER resources
Develop new intervention systems as alternatives to hospitalization.
This project incorporates resources from the other projects to make it effective and has the same over-arching goals of reducing potentially preventable admissions.

Challenges:

The partners implied in this project (criminal justice, Schools, hospitals) are historically disinclined to offer resources to this issue, even if it means crisis management will be more efficiently managed community-wide.

Geographic isolation of Starr County results in additional burdens for officials or staff who must transport to Laredo (120 miles distant) or San Antonio (150 miles more). This distance factor also impedes Continuity of Care services provided by Starr County staff while the client is receiving impatient services.

Frequency of crisis calls is increasing.

Increase speed and rate of the intake process so individuals in crisis don't further decompensate while waiting for initial assessment.

To address these challenges Border Region will:

- Initiate stakeholders meetings as part of the gap analysis to identify strategies productive community partnerships.

- Employ telemedicine technology to reduce the number of hospital admissions which could have been handled by other means

- Expand use of Mobil Crisis Intervention teams

- Partner with Starr Memorial Hospital to perform medical clearance at Border Region, Starr County crisis clinic.

- Increasing crisis frequency is being addressed in project 2.13.1 on crisis prevention.

P-9 milestone Participate in face-to-face learning (meetings, seminars), at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects

5 year expected outcome:
Behavioral health crisis patients are served in a number of alternative setting to inpatient hospitalization or incarceration. These alternatives are delivered at lower cost and are effective in preventing future admission to more expensive alternatives.

Each service, criminal justice, education & hospitals and community behavioral health understands its role in crisis management and has procedures, which all their members are trained in and apply.

Options for treating people in crisis will be expanded and include outpatient options and triaging and medical clearance will be performed at Border Region, replacing the Emergency department in this function.

Expected impact (total patients per year): DY2 - no impact, DY3- 80, DY4-90, DY5-100

Starting Point/Baseline:
Currently, Border Region, Starr County clinic experiences about 70 crisis inpatient admissions per year. Hospital emergency rooms are the point of

first contact between persons in crisis and Behavioral Health workers in most cases.

Rationale:
Current crisis management systems are insufficient to meet the burgeoning numbers of persons presenting themselves for crisis. Admissions and associated costs of inpatient admissions are rising to unsustainable levels. New approaches are needed to assure that more people in crisis can remain in the community. The selected project option affords the resources to perform gap analysis of the crisis delivery system, and design and test new approaches based on evidence – based research.

Project Components:
Border Region Behavioral Health Center will address all of the project components:

a) Convene community stakeholders who can support the development of crisis stabilization to conduct gap analysis of the current system for mild exacerbations that could be treated in the community– This will be addressed through milestone P-1 Conduct stakeholders meeting among consumers, family members, law enforcement, medical staff and social workers from emergency departments and psychiatric hospitals, EMS and relevant community behavioral health services.

b) Analyze current system of crisis stabilization including capacity of each service, utilization patterns, eligibility criteria and discharge criteria. Addressed in Milestone 2, gap analysis will be conducted to determine where needs do not align with assignment of resources, which need were previously unidentified and suggest which new approaches may be the best suited alternatives to systems currently in place.

c) Address behavioral health needs of patient currently receiving crisis services in jails, EDs & psychiatric hospitals. Determine types and volumes of services needed to resolve crisis in community setting. This addressed in Milestone 2 in the gap analysis. Data is being analyzed from encounters of the Jail Diversion program, Continuity of Care encounter (follow-along by Border Region while patient is present) as well as functional status before and after inpatient hospitalization.

d) Explore potential crisis alternative services models and determine acceptable models for implementation. This is addressed in Milestone 3 - Develop and implement plans for needed crisis services. Literature review of evidenced-based practices will be discussed in Plan Do Study Act sessions to determine best fit for needs defined in the gap analysis.

e) Review interventions impact on access to and quality of behavioral health opportunities to scale off or part of the intervention to a broader patient population. Identify key challenges associated with expansion of the interventions including special considerations for safety-net populations. This will be addressed with combinations of Milestone 4 - development of an operations manual and QI activities from the corresponding category 3 project and Milestone 3 which will be reviewing procedures for relevance and effectiveness.

Unique community need identification number the project addresses:
This project relates to Community Need Number 2, shortage of behavioral health professionals and inadequate access to behavioral health care.

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

Crisis stabilization has presented a moving target over the years. Interventions used in the past and currently do not address the growing need for BH crisis interventions. Community agencies have frequently convened over the years to address issues they have with each other's role in crisis management, but have never committed to joint planning, oversight and revision of approaches. This model would conventionalize these efforts and enhance the existing delivery system reform initiative.

Related Category 3 Outcome Measure(s): OD-9 IT 9.2

Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

Part of this project will target the triage of persons in crisis to resources of Border Region rather than local emergency departments. This outcome measure will serve as evidence that community members are utilizing this service and not relying historically utilized resources.

A decrease in Emergency Room utilization will indicate that crisis interventions performed by Border Region are effective both managing existing crisis and educating the community in the availability of our services.

Relationship to other Projects:
This project relates to all other projects being proposed in this waiver:

After hours or when licensed personnel are not available it will utilize the telemedicine hardware (1.11.2)

Staff resources, whether FTE or contract, made available through the workforce expansion project will be among the key resources providing the various components of crisis service delivery. (1.14.1)

Medical clearance in crisis triage may be performed with resources from the integration of primary/behavioral health project (2.15.1)

Persons in crisis evaluated as not needing inpatient care will be served through initiatives developed under project 2.13.2 which will address crisis prevention and reduction on an outpatient basis.

Relationship to Other Performing Providers' Projects in the RHP:
TBD

Plan for Learning Collaborative:
Border Region plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Reduced costs in the areas of ER costs, psychiatric inpatient days, criminal justice expenses, lost school attendance, reduced transportation costs (at least half of inpatient admissions must be treated in San Antonio or facilities at least 150 miles from service area), lost time and wages from client's employment, more efficient operations of behavioral health enter due to a decrease in Management by Crisis and improved overall client satisfaction due to other clients not having to wait while staff and doctors attend to crises.

1219891-02.1.3	***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.**
[Border Region Behavioral Health Center]			121989102
Related Category 3 Outcome Measure(s):	*OD-9*	*IT-9.2*	ED appropriate utilization (Standalone Measure) Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1 Conduct Stake holders meeting among consumers, family member, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS and relevant community behavioral health services **Metric 1**: Number of meeting and participants **Baseline**: 0. **Goal:** Stakeholder community is successfully invested and produces actionable input. **Data Source:** Attendance lists Documented input from stakeholders. **Milestone 1** Estimated Incentive Payment *(maximum amount)* $140,049 **Milestone 2** P-2 Conduct mapping and gap analysis of current crisis	**Milestone 3 P-3** Develop implementation plans for needed crisis services Metric 1: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based gap analysis and assessment of needs. **Data Source:** Documented action plan for crisis stabilization alternatives **Baseline:** Standard interventions prescribed in DSHS contract with state.**/Goal:** Action plan is developed **Milestone 3** Estimated Incentive Payment: $89,553 **Milestone 4** P-5 Develop administration of operation protocols and clinical guidelines for crisis services..	**Milestone 6 I-10** Criminal Justice Admission/readmissions **Metric 1** 10-1 % decrease in preventable admission & readmissions into Criminal Justice system. **Goal:** 10% decrease preventable incarcerations. **Data Source:** Jail Diversion Encounter data, Criminal justice records **Milestone 6** Estimated Incentive Payment: $134,328 **Milestone 7** P-9 Participate in face-to-face learning (meetings, seminars), at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects	**Milestone 8** [I-11]: Costs avoided by using lower cost alternative settings **<u>Metric 1</u>** [I-11.1]: Costs avoided by comparing utilization of lower costs alternative settings with higher cost settings such as ER, jail, hospitalization **Goal**: Costs avoided attributable to project are equal or greater than 20% of higher cost settings. **Data Source:** batched and analyzed survey data Milestone 8 Estimated Incentive Payment: $ 119,403 **Milestone 9** P-9 Participate in face-to-face learning (meetings, seminars), at least twice per year with other providers and the RHP to promote

system. Metric 1 Produce a written analysis of current crisis system. **Baseline:** No gap analysis performed as yet. **/Goal:** Produce gap analysis document and train staff in its implementation **Data Source:**. Gap analysis document, training rosters **Milestone 2** Estimated Incentive Payment: $140,049	**Data Source:** Internal policy and procedures documents and operations manual. **Baseline:** Crisis policy manual exists for current procedures **GOAL:** Produce a faithful description of operations which can be used to help transport of scale successful programs to other aspects of the Border Regions' crisis services. **Metric 1:** Completion of policies and procedures manual. **Milestone 4** Estimated Incentive Payments: $ 89,552 **Milestone 5** P-4: Hire and train staff to implement identified crisis stabilization services. **Metric 1**. Number of staff trained and hired **Baseline:** All current staff trained in crisis management. Training curricula for current programs in place. **Goal**: Trained staffs are in position to implement crisis stabilization plan. **Data Source:** Human resources records of personnel, training curricula	**Metric 1 P-9.1** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline:** Collaborative learning not previously practiced. **Goal:** Applicable Ideas for improvement are incorporated into management and clinical plans. **Data source:** Documentation of face-to-face meetings or seminars organized by the RHP. **Metric 2** P-9.2 Implement "raise the floor" improvement initiatives established at the semi-annual meeting. **Baseline:** "Raise the floor initiatives not previously practiced. **Goal:** Applicable Ideas for improvement are incorporated into management and clinical plans. **Data source:** Documentation of face-to-face meetings or seminars organized by the RHP. **Milestone 7** Estimated Incentive Payment: $134,329	collaborative learning around shared or similar projects **Metric 1 P-9.1** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline:** Collaborative learning not previously practiced. **Goal:** Applicable Ideas for improvement are incorporated into management and clinical plans. **Data source:** Documentation of face-to-face meetings or seminars organized by the RHP. **Milestone 9** Estimated Incentive Payment: $119,403

	Milestone 5 Estimated Incentive Payment: $89,552		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 280,098	Year 3 Estimated Milestone Bundle Amount: $268,657	Year 4 Estimated Milestone Bundle Amount: $268,657	Year 5 Estimated Milestone Bundle Amount: $238,806
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,056,218			

- ***Performing Provider: Doctors Hospital at Renaissance***
- ***Project Name: Establish Primary Care/Internal Medicine Residency Training Program***
- ***Project Identifier: 160709501.1.1***

Provider:	Doctors Hospital at Renaissance (DHR) is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.
Intervention(s):	This project will create a primary care/ Internal Medicine residency program at DHR in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the primary care physician workforce in RHP 5.
Need for the project:	There are 55 primary care physicians per 100,000 population in RHP 5 compared to 70 per 100,000 statewide. This project will greatly increase the pipeline for new primary care physicians and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community.
Target population:	The target population is the entire RHP 5 where about 45% of people live in poverty and more than 25% are Medicaid beneficiaries. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations.
Category 1 or 2 expected patient benefits:	New program faculty will increase access to primary care with annual counts of 2,000 visit slots in DY3, 4,000 in DY 4, and 6,000 in DY5. After the residency program is accredited in 2014, residents will be recruited to begin training and providing care to patients in 2015. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, chronic disease management, and quality improvement.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Project Option 1.2.4 - Establish Primary Care/Internal Medicine Residency Training Program

Unique Project ID: 160709501.1.1
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

PROJECT DESCRIPTION:
Doctors Hospital at Renaissance proposes to establish a primary care/Internal Medicine residency training program.

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Internal Medicine residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, the resident trainees, and the graduates of the training program will expand the primary care workforce. Allaying the shortage of primary care providers will increase access to care in the appropriate time and place, reduce inappropriate and costly emergency department utilization, increase patient satisfaction, and improve the health of the community.

When fully implemented in 2017, the new Internal Medicine residency will have the capacity to train as many as 24 residents – 8 residents in each of three classes. The DHR Internal Medicine residency training program will complement other new residency programs at DHR in Family Medicine, Obstetrics & Gynecology, and General Surgery to fulfill DHR's goal to become a teaching hospital for the region. DHR's new Internal Medicine residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:
This project has the following goals**:**

- To create an Internal Medicine Residency program with faculty, residents, and graduates who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a continuity clinic for the residency program to focus on transitions of care, reduce hospital readmissions and function as a patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and
- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combining the resources of DHR as a major safety net hospital and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The Internal Medicine Residency Review Committee (IM-RRC) meets to review proposals only a few times each year. Residency programs must be accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the Internal Medicine Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including the patient-centered medical home model and chronic care disease management to address the unique needs of RHP 5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of six to eight Internal Medicine residents will have joined the initial cohort of six to eight residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2018. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-65% of their time to clinical care. Primary care capacity and patients' access to primary care will increase as the program matures to full, maximum build-out of 24 Internal Medicine residents at DHR (8 PGY1; 8 PGY2; and 8 PGY3).
Because some of the faculty for the new training program will be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we

project in the metrics that an additional/incremental 2,000 primary care visit slots will be provided by new faculty physicians each year DY3 through DY5, for an annual total of 6,000 visit slots by the end of DY 5. Because the residency program will be brand new, we project that we will fill six of the maximum eight first-year training slots each year in DY4 and DY5. By the end of DY5, we expect 6 PGY1 and 6 PGY2 residents in training at DHR. The residents will provide patient care in half-day clinic sessions as required by RRC standards. The number of sessions will increase from DY4 to DY 5 as the number of residents increase along with the maturity of their experience.

STARTING POINT/BASELINE

DHR currently hosts no residency programs. In all of RHP 5, existing UTHSCSA residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center in Hidalgo County. Valley Baptist also sponsors directly a separate family medicine program with 15 residents.

DHR is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve health care access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.

RATIONALE

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 220 and 91, respectively.) From 2001 to 2011, the Texas physician workforce grew 32%, exceeding the population growth of 25%. Primary care physician workforce, however, grew only 25% in the same period, barely keeping pace with population growth. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges (AAMC) to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates in Texas. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 per 100,000 statewide.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South

Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the AAMC Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:
This project has several components:

- Identify high impact services and gaps in care, coordination, and ambulatory capacity
- Recruit Internal Medicine Program Directors and core faculty in calendar years 2013 and 2014
    - Program Director and Associate Program Director: 75% academic time for program development/accreditation activities and 25% patient care/clinical time
    - Core faculty: 35% academic time and 65% clinical time; after residents arrive in July 2015, 50% academic time and 50% clinical time
- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- Provide Clinical Safety & Effectiveness (CS&E) training to faculty and DHR staff
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for Internal Medicine at DHR
- Complete and submit the Program Information Form (PIF) to the RRC by February 2014
- Attain ACGME approval for the program via RRC meeting in September 2014
- Recruit prospective Internal Medicine residents in the fall of 2014
- Enroll the first class of Internal Medicine residents in July 2015
- Enroll the second class of Internal Medicine residents in July 2016

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, RHP 5 has very few residency programs, and no residency training programs exist at DHR. The faculty for the Internal Medicine residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs affiliated with other hospitals in RHP 5.

Data Driving this Project:
The need for enhanced primary care in this health disparity population is extensively documented. Data published by the United States Census Bureau in 2012 show that 88% (Cameron County) and 91% (Hidalgo County) of the population is Mexican American or Latino in origin and that 35% live

below the poverty line, compared with 17% for Texas and 14% nationally (http://quickfacts.census.gov/qfd/states/00000.html). Currently about 65% of RHP 5 residents have health insurance of some kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from UT's locally recruited, randomized community cohort show that the prevalence of obesity is 48% and that 8% are morbidly obese. The prevalence of diabetes is an alarming 31% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55%) and hypertension (50%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):
OD-14 Primary Care Workforce

Stand-alone:
IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: Bundle of 3: (for internal tracking only)
IT - 14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice. However, because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-65% of their time to clinical care, they will have an impact on the number of practicing primary care physicians per 100,000 individuals in RHP 5.

Relationship to other Projects:
This project is related to the following DHR projects:

- 160709501.1.2 Establish Primary Care/Family Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Relationship to Other Performing Providers' Projects in the RHP:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support the Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for DHR physicians and staff to participate in the CS&E course and projects.

Project Valuation:
This project's impact on RHP 5's large Medicaid and indigent population will be profound. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. Creating residency training programs in RHP 5 that will attract graduates of the growing local medical school who are highly likely to remain the area post-residency will positively impact the long-term number of practicing primary care physicians per 100,000.

DHR has chosen to dedicate the majority of its Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region in Hidalgo County. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

Unique Identifier: 160709501.1.1	***RHP PP Reference Number:*** 1.2.4	***Project Component(s):***	***Establish primary care/Internal Medicine Training Program***	
Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment: $1,193,867 **Milestone 2** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.2]: Hire primary care faculty members. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire three faculty physicians including the Program Director, Associate Program Director, and one Core Faculty member by 9/30/2013. Data Source: HR documents. Milestone 2 Estimated Incentive Payment: $1,193,867	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.1]: Expand the primary care residency training programs. Baseline: Program does not exist at beginning of DY 2. Goal: Submit the application, the Program Information Form (PIF), no later than 2/2014 for Residency Review Committee (RRC) 9/2014 meeting. Data Source: Training program documentation. Metric 2 [P-2.2.]: Hire additional core faculty members and precepting faculty in the various specialties required for accredited programs. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire an additional 2 core faculty members as compared to DY 2. Data Source: HR documents. Milestone 3 Estimated Incentive Payment: $787,228 **Milestone 4** [P-9]: Develop/disseminate clinical teaching tools for primary care. Metric 1 [P-9.1]: Clinical teaching		**Milestone 7** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents. Metric 1 [P-10.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at DHR at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $640,931 **Milestone 8** [P-3]: Expand positive primary care exposure for residents. Metric 1 [P-3.1] Develop mentoring program with primary care faculty and new residents. Baseline: No mentoring program exists in DY 2 or DY3. Goal: Develop and implement mentoring program. Data Source: Mentoring program curriculum and/or program participant list. Metric 2 [P-3.2] Train residents in the medical home model, chronic care	**Milestone 12** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Cohort 1 begins in July 2015 of DY 4. Goal: Enroll second cohort of 6 as of 7/15/2016. Total residents in Cohorts 1 and 2 = 12 at end of DY5. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: Enroll second cohort of 6 as of 7/15/2016. Total residents in Cohorts 1 and 2 = 12. Data Source: Program enrollment records. Milestone 12 Estimated Incentive Payment: $422,044 **Milestone 13** [I-15]: Increase primary care training in Continuity Clinics. Metric 1 [I-15.1]: Increase number of Continuity Clinic sessions available

Unique Identifier: 160709501.1.1	***RHP PP Reference number:*** 1.2.4	***Project Component(s):***	***Establish primary care/Internal Medicine Training Program***	
Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	tools. Baseline: No clinical teaching tools exist at the beginning of DY2. Goal: Documentation and dissemination of clinical teaching tools. Data source: Clinical teaching tools documents/ materials. Milestone 4 Estimated Incentive Payment: $787,228 **Milestone 5** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2; faculty recruitment begins in DY2. Goal: Annual count of 2,000 additional primary care patient visit slots attributable to new faculty physicians. Data Source: Clinical faculty schedules. Milestone 5 Estimated Incentive Payment: $787,228 **Milestone 6** [I-14] Increase the number of faculty staff completing educational courses.		model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: No training exists in DY2. Goal: Implement training per the metric. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. Metric 3 [P-3.3] Include residents in quality improvement projects. Baseline: No training exists in DY2. Goal: At least 3 residents of 6 who arrive July 2015 participate in QI efforts by 9/30/2015. Data source: Curriculum or QI project documentation. Milestone 8 Estimated Incentive Payment: $640,930 **Milestone 9** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Goal: Enroll first cohort of 6 residents as of 7/15/2015. Data Source: Program enrollment	for primary care residents. Baseline: No training program or Continuity Clinic in DY2. Goal: Increase Continuity Clinic sessions for residents from 3 half-day sessions per month for 2 months for 6 trainees in Cohort 1 in DY4 to 3 sessions per month for 12 months for Cohort 1 and 3 sessions per month for 2 months for Cohort 2 in DY 5. Data Source: Number of resident clinic sessions from clinical schedules. Milestone 13 Estimated Incentive Payment: $422,045 **Milestone 14** [P-4] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Metric 1 [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Baseline: no curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. Data Source: Curriculum and practicum documentation. Milestone 14 Estimated Incentive Payment: $422,044 **Milestone 15** [I-14] Increase the

Unique Identifier: 160709501.1.1	***RHP PP Reference Number:*** 1.2.4	***Project Component(s):***	***Establish primary care/Internal Medicine Training Program***	
Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E in DY2. Goal: Two faculty staff complete the CS&E training. Data Source: Certificates of completion. Milestone 6 Estimated Incentive Payment: $787,229		records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: 6 PGY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $640,930 **Milestone 10** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two more faculty staff complete the CS&E training in DY4; cumulative total for DY3-DY4 is 4. Data Source: Certificates of completion. Milestone 10 Estimated Incentive Payment: $640,930 **Milestone 11** [I-X] Increase primary care access provided by new faculty physicians	number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two more faculty staff complete the CS&E training in DY5; cumulative total for DY3-DY5 is 6. Data Source: Certificates of completion. Milestone 15 Estimated Incentive Payment: $422,045 **Milestone 16** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to faculty physicians. Baseline: No faculty visit slots exist in DY2; faculty recruitment begins in DY2. Goal for DY5: Annual count of 6,000 primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY 4. Data Source: Clinical faculty schedules. Milestone 16 Estimated Incentive

Unique Identifier: 160709501.1.1	***RHP PP Reference Number:*** 1.2.4	***Project Component(s):***	***Establish primary care/Internal Medicine Training Program***	
Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist in DY2; faculty recruitment begins in DY2. Goal: Annual count of 4,000 primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY 3. Data Source: Clinical faculty schedules. Milestone 11 Estimated Incentive Payment: $640,930	Payment: $422,044
Year 2 Estimated Milestone Bundle Amount: $2,387,734	Year 3 Estimated Milestone Bundle Amount: $3,148,913		Year 4 Estimated Milestone Bundle Amount: $3,204,651	Year 5 Estimated Milestone Bundle Amount: $2,110,222
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,851,520				

- ***Performing Provider: Doctors Hospital at Renaissance***
- ***Project Name: Establish Primary Care/Family Medicine Residency Training Program***
- ***Project Identifier: 160709501.1.2***

Provider:	Doctors Hospital at Renaissance (DHR) is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.
Intervention(s):	This project will create a primary care/ Family Medicine residency program at DHR in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the primary care physician workforce in RHP 5.
Need for the project:	RHP 5 has 55 primary care physicians per 100,000 population compared to 70 per 100,000 statewide. This project will greatly increase the pipeline for new primary care physicians and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community.
Target population:	The target population is the entire RHP 5 where about 45% of people live in poverty and more than 25% are Medicaid beneficiaries. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations.
Category 1 or 2 expected patient benefits:	New program faculty will increase access to primary care with annual counts of 2,000 visit slots in DY3, 4,000 in DY 4, and 6,000 in DY5. After the residency program is accredited in 2014, residents will be recruited to begin training and providing care to patients in 2015. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, chronic disease management, and quality improvement.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Project Option 1.2.4 - Establish Primary Care/Family Medicine Residency Training Program

Unique Project ID: 160709501.1.2
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

PROJECT DESCRIPTION:
Doctors Hospital at Renaissance proposes to establish a primary care/Family Medicine residency training program.

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Family Medicine residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, the resident trainees, and the graduates of the training program will expand the primary care workforce. Allaying the shortage of primary care providers will increase access to care in the appropriate time and place, reduce inappropriate and costly emergency department utilization, increase patient satisfaction, and improve the health of the community.

When fully implemented in 2017, the new Family Medicine residency will have the capacity to train as many as 18 residents – 6 residents in each of three classes. The DHR Family Medicine residency training program will complement other new residency programs at DHR in Internal Medicine, Obstetrics & Gynecology, and General Surgery to fulfill DHR's goal to become a teaching hospital for the region. DHR's new Family Medicine residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County and the Valley Baptist-sponsored Family Medicine residency program..

Goals and Relationship to Regional Goals:
This project has the following goals**:**

- To create a Family Medicine Residency program with faculty, residents, and graduates who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a Family Practice Center for the residency program to focus on transitions of care, reduce hospital readmissions and function as a patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and
- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combining the resources of DHR as a major safety net hospital and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The Family Medicine Residency Review Committee (FM-RRC) meets to review proposals only a few times each year. Residency programs must accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the Family Medicine Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including the patient-centered medical home model and chronic care disease management to address the unique needs of RHP 5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of four to six Family Medicine residents will have joined the initial cohort of four to six residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2018. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-50% of their time to clinical care. Primary care capacity and patients' access to primary care will increase as the program matures to full, maximum build-out of 18 Family Medicine residents at DHR (6 PGY1; 6 PG2; and 6 PGY3).
Because some of the faculty for the new training program will be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we

project in the metrics that an additional/incremental 2,000 primary care visit slots will be provided by new faculty physicians each year DY3 through DY5, for an annual total of 6,000 visit slots by the end of DY 5. Because the residency program will be brand new, we project that we will fill four of the maximum six first-year training slots each year in DY4 and DY5. By the end of DY5, we expect 4 PGY1 and 4 PGY2 residents in training at DHR. The residents will provide patient care in half-day clinic sessions as required by RRC standards. The number of sessions will increase from DY4 to DY 5 as the number of residents increase along with the maturity of their experience.

STARTING POINT/BASELINE

DHR currently hosts no residency programs. In all of RHP 5, existing UTHSCSA residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center. Valley Baptist also sponsors directly a separate family medicine program with 15 residents.

DHR is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.

RATIONALE

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 220 and 91, respectively.) From 2001 to 2011, the Texas physician workforce grew 32%, exceeding the population growth of 25%. Primary care physician workforce, however, grew only 25% in the same period, barely keeping pace with population growth. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges (AAMC) to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates in Texas. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 per 100,000 statewide.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the AAMC Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:
This project has several components:

- Identify high impact services and gaps in care, coordination, and ambulatory capacity
- Recruit Family Medicine Program Directors and core faculty in calendar years 2013 and 2014
    - Program Director and Associate Program Director will have 75% academic time for program development/accreditation activities and 25% patient care/clinical time
    - Core faculty will have 35% academic time and 65% clinical time
- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- Provide Clinical Safety & Effectiveness training to faculty and DHR staff
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for Family Medicine at DHR
- Complete and submit the Program Information Form (PIF) to the RRC by February 2014
- Attain ACGME approval for the program via RRC meeting in October 2014
- Recruit prospective Family Medicine residents in the fall of 2014
- Enroll the first class of Family Medicine residents in July 2015
- Enroll the second class of Family Medicine residents in July 2016

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, RHP 5 has very few residency programs, and no residency training programs exist at DHR. The faculty for the Family Medicine residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs at other hospitals in RHP 5.

Data Driving this Project:
The need for enhanced primary care in this health disparity population is extensively documented. Data published by the United States Census Bureau in 2012 show that 88% (Cameron County) and

91% (Hidalgo County) of the population is Mexican American or Latino in origin and that 35% live below the poverty line compared with 17% for Texas and 14% nationally (http://quickfacts.census.gov/qfd/states/00000.html). Currently about 65% of RHP 5 residents have health insurance of some kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from UT's locally recruited, randomized community cohort show that the prevalence of obesity is 48% and that 8% are morbidly obese. The prevalence of diabetes is an alarming 31% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55%) and hypertension (50%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):
OD-14 Primary Care Workforce

Stand-alone:
IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: Bundle of 3: (for internal tracking only)
IT - 14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice. However, because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-65% of their time to clinical care, they will have an impact on the number of practicing primary care physicians per 100,000 individuals in RHP 5.

Relationship to other Projects:
This project is related to the following DHR projects:

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Relationship to Other Performing Providers' Projects in the RHP:

The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for DHR physicians and staff to participate in the CS&E course and projects.

Project Valuation:
This project's impact on the Medicaid and indigent population will be profound. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. Creating residency training programs in RHP 5 that will attract graduates of the growing local medical school who are highly likely to remain the area post-residency will positively impact the long-term number of practicing primary care physicians per 100,000.

DHR has chosen to dedicate the majority of Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region in Hidalgo County. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

Unique Identifier: ***160709501.1.2***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Family Medicine Training Program***
Performing Provider Name: Doctors Hospital at Renaissance			TPI - 160709501
Related Category 3 Outcome Measure(s):	160709501.3.2	IT-14.1	Number of practicing primary care physicians per 100,000

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment: $1,193,867 **Milestone 2** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2. 2]: Hire primary care faculty members. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire three faculty physicians including the Program Director, Associate Program Director, and one Core Faculty member by 9/30/2013. Data Source: HR documents. Milestone 2 Estimated Incentive Payment: $1,193,867	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.1]: Expand the primary care residency training programs. Baseline: Program does not exist at beginning of DY 2. Goal: Submit the application, the Program Information Form (PIF), no later than 2/2014 for Residency Review Committee (RRC) 10/2014 meeting Data Source: Training program documentation. Metric 2 [P-2.2.]: Hire additional core faculty and precepting faculty in various specialties, as required for accredited programs. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire an additional 2 core faculty members as compared to DY 2. Cumulative total of 5 new faculty DY2-DY3. Data Source: Human Resources documents. Milestone 3 Estimated Incentive Payment: $787,228 **Milestone 4** [P-9]: Develop/disseminate clinical teaching	**Milestone 7** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents. Metric 1 [P-10.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $640,931 **Milestone 8** [P-3]: Expand positive primary care exposure for residents. Metric 1 [P-3.1] Develop mentoring program with practicing primary care faculty and new residents. Baseline: No mentoring program exists in DY2 or DY3. Goal: Develop and implement mentoring program. Data Source: Mentoring program curriculum and/or program participant list. Metric 2 [P-3.2] Train residents in the medical home model, chronic care	**Milestone 12** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Cohort 1 begins in DY 4. Goal: Enroll second cohort of 4 as of 7/15/2016. Total residents in Cohorts 1 and 2 = 8 at end of DY5. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: Enroll second cohort of 4 as of 7/15/2016. Total residents in Cohorts 1 and 2 = 8. Data Source: Program enrollment records. Milestone 12 Estimated Incentive Payment: $422,044 **Milestone 13** [I-15]: Increase primary care training in Family Practice Center. Metric 1 [I-15.1]: Increase number of Family Practice Center sessions

Unique Identifier: ***160709501.1.2***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Family Medicine Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI - 160709501
Related Category 3 Outcome Measure(s):	160709501.3.2	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	tools for primary care. Metric 1 [P-9.1]: Clinical teaching tools. Baseline: No clinical teaching tools exist at the beginning of DY2. Goal: Documentation and dissemination of clinical teaching tools. Data source: Clinical teaching tools documents/ materials. Milestone 4 Estimated Incentive Payment: $787,228 **Milestone 5** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2; faculty recruitment begins in DY2. Goal: Annual count of 2,000 additional primary care patient visit slots attributable to new faculty physicians. Data Source: Clinical faculty schedules. Milestone 5 Estimated Incentive Payment: $787,228 **Milestone 6** [I-14] Increase the		model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: No training exists in DY2. Goal: Implement training per the metric. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. Metric 3 [P-3.3] Include residents in quality improvement projects. Baseline: No training exists in DY2. Goal At least 2 residents of 4 who arrive July 2015 participate in QI efforts by 9/30/2015. Data source: Curriculum or QI project documentation. Milestone 8 Estimated Incentive Payment: $640,930 **Milestone 9** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Goal: Enroll first cohort of 4 residents as of 7/15/2015. Data Source: Program enrollment	available for primary care residents. Baseline: No training program or Family Practice Center in DY2. Goal: Increase Continuity Clinic sessions for residents from 3 half-day sessions per month for 2 months for 6 trainees in Cohort 1 in DY4 to 3 sessions per month for 12 months for Cohort 1 and 3 sessions per month for 2 months for Cohort 2 in DY 5. Data Source: Number of resident clinic sessions from clinical schedules. Milestone 13 Estimated Incentive Payment: $422,045 **Milestone 14** [P-4] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Metric 1 [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Baseline: no curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. Data Source: Curriculum and practicum documentation. Milestone 14 Estimated Incentive Payment: $422,044 **Milestone 15** [I-14] Increase the

Unique Identifier: ***160709501.1.2***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Family Medicine Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI - 160709501
Related Category 3 Outcome Measure(s):	160709501.3.2	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E in DY2. Goal: Two faculty staff complete the CS&E training. Data Source: Certificates of completion. Milestone 6 Estimated Incentive Payment: $787,229		records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: 4 PGY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $640,930 **Milestone 10** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two more faculty staff complete the CS&E training in DY4; cumulative total for DY3-DY4 is 4. Data Source: Certificates of completion. Milestone 10 Estimated Incentive Payment: $640,930 **Milestone 11** [I-X] Increase primary care access provided by new faculty physicians	number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two more faculty staff complete the CS&E training in DY5; cumulative total for DY3-DY5 is 6. Data Source: Certificates of completion. Milestone 15 Estimated Incentive Payment: $422,045 **Milestone 16** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to faculty physicians. Baseline: No faculty visit slots exist in DY2; faculty recruitment begins in DY2. Goal for DY5: Annual count of 6,000 primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY 4. Data Source: Clinical faculty schedules.

Unique Identifier: ***160709501.1.2***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Family Medicine Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI - 160709501
Related Category 3 Outcome Measure(s):	160709501.3.2	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist in DY2; faculty recruitment begins in DY2. Goal: Annual count of 4,000 primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY 3. Data Source: Clinical faculty schedules. Milestone 11 Estimated Incentive Payment: $640,930	Milestone 16 Estimated Incentive Payment: $422,044
Year 2 Estimated Milestone Bundle Amount: $2,387,734	Year 3 Estimated Milestone Bundle Amount: $3,148,913		Year 4 Estimated Milestone Bundle Amount: $3,204,651	Year 5 Estimated Milestone Bundle Amount: $2,110,222
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $10,851,520				

- ***Performing Provider: Doctors Hospital at Renaissance***
- ***Project Name: Establish Primary Care/Obstetrics & Gynecology Residency Training Program***
- ***Project Identifier: 160709501.1.3***

Provider:	Doctors Hospital at Renaissance (DHR) is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.
Intervention(s):	This project will create a primary care/ Obstetrics & Gynecology residency program at DHR in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the primary care physician workforce in RHP 5.
Need for the project:	There are 55 primary care physicians per 100,000 population in RHP 5 compared to 70 per 100,000 statewide. This project will greatly increase the pipeline for new primary care physicians and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community.
Target population:	The target population is the entire RHP 5 where about 45% of people live in poverty and more than 25% are Medicaid beneficiaries. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations.
Category 1 or 2 expected patient benefits:	New program faculty will increase access to primary care with annual counts of 2,000 visit slots in DY3, 4,000 in DY 4, and 6,000 in DY5. After the residency program is accredited in 2014, residents will be recruited to begin training and providing care to patients in 2015. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, chronic disease management, and quality improvement.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Project Option 1.2.4 - Establish Primary Care/Obstetrics & Gynecology Residency Training Program

Unique Project ID: 160709501.1.3
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

PROJECT DESCRIPTION:
Doctors Hospital at Renaissance proposes to establish a primary care/Obstetrics & Gynecology residency training program.

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Obstetrics & Gynecology residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, the resident trainees, and the graduates of the training program will expand the primary care workforce. Allaying the shortage of primary care providers will increase access to care in the appropriate time and place, reduce inappropriate and costly emergency department utilization, increase patient satisfaction, and improve the health of the community.

When fully implemented in 2018, the new Obstetrics & Gynecology residency will have the capacity to train as many as 16 residents – 4 residents in each of four classes. The DHR Obstetrics & Gynecology residency training program will complement other new residency programs at DHR in Internal Medicine, Family Medicine, and General Surgery to fulfill DHR's goal to become a teaching hospital for the region. DHR's new Obstetrics & Gynecology residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:
This project has the following goals**:**

- To create an Obstetrics & Gynecology Residency program with faculty, residents, and graduates who will increase patients' access to primary care;
- To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a continuity clinic for the residency program to focus on women's health, perinatal care, and transitions of care, reduce hospital readmissions and function as a patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and
- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combining the resources of DHR as a major safety net hospital and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The Obstetrics & Gynecology Residency Review Committee (OG-RRC) meets to review proposals only a few times each year. Residency programs must be accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the Obstetrics & Gynecology Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including the patient-centered medical home model and chronic care disease management to address the unique needs of RHP 5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of three to four Obstetrics & Gynecology residents will have joined the initial cohort of three to four residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2019. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-50% of their time to clinical care. Primary care capacity and patients' access to primary care will increase as the program matures to full, maximum build-out of 16 Obstetrics & Gynecology residents at DHR (4 PGY1, 4 PGY2, 4 PGY3, and 4 PGY4).
Because some of the faculty for the new training program will be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we project in the metrics that an additional/incremental 2,000 primary care visit slots will be provided by

new faculty physicians each year DY3 through DY5, for an annual total of 6,000 visit slots by the end of DY 5. Because the residency program will be brand new, we project that we will fill three of the maximum four first-year training slots each year in DY4 and DY5. By the end of DY5, we expect 3 PGY1 and 3 PGY2 residents in training at DHR. The residents will provide patient care in half-day clinic sessions as required by RRC standards. The number of sessions will increase from DY4 to DY 5 as the number of residents increase along with the maturity of their experience.

STARTING POINT/BASELINE

DHR currently hosts no residency programs. In all of RHP 5, existing UTHSCSA residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center. Valley Baptist also sponsors directly a separate family medicine program with 15 residents.

DHR is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.

RATIONALE

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 220 and 91, respectively.) From 2001 to 2011, the Texas physician workforce grew 32%, exceeding the population growth of 25%. Primary care physician workforce, however, grew only 25% in the same period, barely keeping pace with population growth. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges (AAMC) to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates in Texas. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 per 100,000 statewide.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and

graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the AAMC Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:
This project has several components:

- Identify high impact services and gaps in care, coordination, and ambulatory capacity
- Recruit Ob/Gyn Program Directors and core faculty in calendar years 2013 and 2014
    - Program Director and Associate Program Director will have 75% academic time for program development/accreditation activities and 25% patient care/clinical time
    - Core faculty will have 25% academic time and 75% clinical time
- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- Provide Clinical Safety & Effectiveness training to faculty and DHR staff
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for Ob/Gyn at DHR
- Complete and submit the Program Information Form (PIF) to the RRC by April 2014
- Attain ACGME approval for the program via RRC meeting in October 2014
- Recruit prospective Ob/Gyn residents in the fall of 2014
- Enroll the first class of Ob/Gyn residents in July 2015
- Enroll the second class of Ob/Gyn residents in July 2016

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, RHP 5 has very few residency programs, and no residency training programs exist at DHR. The faculty for the Obstetrics & Gynecology residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs in RHP 5.

Data Driving this Project:
The need for enhanced primary care in this health disparity population is extensively documented. Data published by the United States Census Bureau in 2012 show that 88% (Cameron County) and 91% (Hidalgo County) of the population is Mexican American or Latino in origin and that 35% live below the poverty line compared with 17% for Texas and 14% nationally

(http://quickfacts.census.gov/qfd/states/00000.html). Currently about 65% of RHP 5 residents have health insurance of some kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from UT's locally recruited, randomized community cohort show that the prevalence of obesity is 48% and that 8% are morbidly obese. The prevalence of diabetes is an alarming 31% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55%) and hypertension (50%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):
OD-14 Primary Care Workforce

Stand-alone:
IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: Bundle of 3: (for internal tracking only)
IT - 14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice.

Because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-75% of their time to clinical care, they will have an impact on the number of practicing primary care physicians per 100,000 individuals in RHP 5.

Relationship to other Projects:
This project is related to the following DHR projects:

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/ Family Medicine Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Relationship to Other Performing Providers' Projects in the RHP:

The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for DHR physicians and staff to participate in the CS&E course and projects.

Project Valuation:
This project's impact on the Medicaid and indigent population will be profound. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. Creating residency training programs in RHP 5 that will attract graduates of the growing local medical school who are highly likely to remain the area post-residency will positively impact the long-term number of practicing primary care physicians per 100,000.

DHR has chosen to dedicate the majority of Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region in Hidalgo County. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

Unique Identifier: ***160709501.1.3***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Obstetrics & Gynecology Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.3	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment: $1,193,867 **Milestone 2** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2. 2]: Hire primary care faculty members. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire two faculty physicians including the Program Director Associate Program Director by 9/30/2013. Data Source: HR documents. Milestone 2 Estimated Incentive Payment: $1,193,867	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.1]: Expand the primary care residency training programs. Baseline: Program does not exist at beginning of DY 2. Goal: Submit the application, the Program Information Form (PIF), no later than 4/2014 for Residency Review Committee (RRC) 10/2014 meeting Data Source: Training program documentation. Metric 2 [P-2.2.]: Hire additional core faculty as required for accredited programs. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire an additional 2 core faculty members as compared to DY 2. Data Source: HR documents. Milestone 3 Estimated Incentive Payment: $787,228 **Milestone 4** [P-9]: Develop/disseminate clinical teaching tools for primary care. Metric 1 [P-9.1]: Clinical teaching tools. Baseline: No clinical teaching tools		**Milestone 7** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents. Metric 1 [P-10.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $640,931 **Milestone 8** [P-3]: Expand positive primary care exposure for residents. Metric 1 [P-3.1] Develop mentoring program with primary care faculty and new residents. Baseline: No mentoring program exists in DY 2 or DY3. Goal: Develop and implement mentoring program. Data Source: Mentoring program curriculum and/or program participant list. Metric 2 [P-3.2] Train residents in the medical home model, chronic care model and/or disease registry use;	**Milestone 12** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees, as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Cohort 1 begins in July 2015 of DY 4. Goal: Enroll second cohort of 3 as of 7/15/2016. Total residents in Cohorts 1 and 2 = 6 at end of DY5. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: Enroll second cohort of 3 as of 7/15/2016. Total residents in Cohorts 1 and 2 = 6. Data Source: Program enrollment records. Milestone 12 Estimated Incentive Payment: $422,044 **Milestone 13** [I-15]: Increase primary care training in Continuity Clinics. Metric 1 [I-15.1]: Increase number of Continuity Clinic sessions available for primary care residents.

Unique Identifier: ***160709501.1.3***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Obstetrics & Gynecology Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.3	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	exist at the beginning of DY2. Goal: Documentation and dissemination of clinical teaching tools. Data source: Clinical teaching tools documents/materials. Milestone 4 Estimated Incentive Payment: $787,228 **Milestone 5** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2; faculty recruitment begins in DY2. Goal: Annual count of 2,000 additional primary care patient visit slots attributable to new faculty physicians. Data Source: Clinical faculty schedules. Milestone 5 Estimated Incentive Payment: $787,228 **Milestone 6** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety &		have primary care trainees participate in medical homes by managing panels. Baseline: No training exists in DY2. Goal: Implement training per the metric. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. Metric 3 [P-3.3] Include residents in quality improvement projects. Baseline: No training exists in DY2. Goal: At least 2 residents of 3 who arrive July 2015 participate in QI efforts by 9/30/2015. Data source: Curriculum or QI project documentation. Milestone 8 Estimated Incentive Payment: $640,930 **Milestone 9** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Goal: Enroll first cohort of 3 residents as of 7/15/2015. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the	Baseline: No training program or Continuity Clinic in DY2. Goal: Increase Continuity Clinic sessions for residents from 3 half-day sessions per month for 2 months for 3 trainees in Cohort 1 in DY4 to 3 sessions per month for 12 months for Cohort 1 and 3 sessions per month for 2 months for Cohort 2 in DY 5. Data Source: Number of resident clinic sessions from clinical schedules. Milestone 13 Estimated Incentive Payment: $422,045 **Milestone 14** [P-4] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Metric 1 [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Baseline: no curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. Data Source: Curriculum and practicum documentation. Milestone 14 Estimated Incentive Payment: $422,044 **Milestone 15** [I-14] Increase the number of faculty staff completing educational courses.

Unique Identifier: ***160709501.1.3***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Obstetrics & Gynecology Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.3	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E in DY2. Goal: One faculty staff to complete the CS&E training. Data Source: Certificates of completion. Milestone 6 Estimated Incentive Payment: $787,229		number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: 3 PGY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $640,930 **Milestone 10** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two more faculty staff complete the CS&E training in DY4; cumulative total for DY3-DY4 is 3. Data Source: Certificates of completion. Milestone 10 Estimated Incentive Payment: $640,930 **Milestone 11** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty	Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two more faculty staff complete the CS&E training in DY5; cumulative total for DY3-DY5 is 5. Data Source: Certificates of completion. Milestone 15 Estimated Incentive Payment: $422,045 **Milestone 16** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to faculty physicians. Baseline: No faculty visit slots exist in DY2; faculty recruitment begins in DY2. Goal for DY5: Annual count of 6,000 primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY 4. Data Source: Clinical faculty schedules. Milestone 16 Estimated Incentive Payment: $422,044

Unique Identifier: ***160709501.1.3***	***Reference number:*** ***1.2.4***	***Project Component(s):***	***Establish primary care/Obstetrics & Gynecology Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI: 160709501
Related Category 3 Outcome Measure(s):	160709501.3.3	IT-14.1	Number of practicing primary care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			physicians. Baseline: No faculty visit slots exist in DY2; faculty recruitment begins in DY2. Goal: Annual count of 4,000 primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY 3. Data Source: Clinical faculty schedules. Milestone 11 Estimated Incentive Payment: $640,930	
Year 2 Estimated Milestone Bundle Amount: $2,387,734	Year 3 Estimated Milestone Bundle Amount: $3,148,913		Year 4 Estimated Milestone Bundle Amount: $3,204,651	Year 5 Estimated Milestone Bundle Amount: $2,110,222
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,851,520				

- ***Performing Provider: Doctors Hospital at Renaissance***
- ***Project Name: Establish General Surgery Residency Training Program***
- ***Project Identifier: 160709501.1.4***

Provider:	Doctors Hospital at Renaissance (DHR) is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.
Intervention(s):	This project will create a General Surgery residency program (high impact specialty) in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the physician workforce in RHP 5.
Need for the project:	Hidalgo County has a population of 842,000 and 26 practicing general surgeons compared to El Paso County with a population of 791,000 and 43 practicing general surgeons. This project will greatly increase the pipeline for new physicians in a high-impact specialty and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community.
Target population:	The target population is the entire RHP 5 where about 45% of people live in poverty and more than 25% are Medicaid beneficiaries. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations.
Category 1 or 2 expected patient benefits:	New program faculty will increase access to targeted specialty care with annual counts of 200 half-day clinic/procedure sessions in DY3, 400 in DY 4, and 600 in DY5. After the residency program is accredited in 2014, residents will be recruited to begin training and providing care to patients in 2015. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, patient registries, and quality improvement.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Project Option 1.9.1 - Establish General Surgery Residency Training Program

Unique Project ID: 160709501.1.4
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

PROJECT DESCRIPTION:
Doctors Hospital at Renaissance proposes to expand specialty care capacity by establishing a General Surgery residency training program.

This project is designed to improve patient access to specialty care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new General Surgery residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, resident trainees, and graduates of the training program will expand the physician workforce in a high-impact specialty area. Allaying the shortage of specialty care providers will increase access to care in the appropriate time and place, reduce inappropriate and costly emergency department utilization, increase patient satisfaction, and improve the health of the community.

When fully implemented in 2019, the new General Surgery residency will have the capacity to train as many as 20 residents – 4 residents in each of five classes. The DHR General Surgery residency training program will complement other new residency programs at DHR in Internal Medicine, Family Medicine, and Obstetrics & Gynecology to fulfill DHR's goal to become a teaching hospital for the region. DHR's new General Surgery residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:
This project has the following goals**:**

- To create an General Surgery Residency program with faculty, residents, and graduates who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates integration of primary care and specialty care and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a continuity clinic for the residency program to focus on transitions of care, reduce hospital readmissions and integrate with the patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and
- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combining the resources of DHR as a major safety net hospital and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to specialty care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The General Surgery Residency Review Committee (GS-RRC) meets to review proposals only a few times each year. Residency programs must accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the General Surgery Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including integrate primary and specialty care in the patient-centered medical home model and chronic care disease management to address the unique needs of RHP 5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of three to four General Surgery residents will have joined the initial cohort of three to four residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2020. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-75% of their time to clinical care. Specialty care capacity and patients' access to specialty care will increase as the program matures to full, maximum build-out of 20 General Surgery residents in RHP 5 (4 PGY1, 4 PGY2, 4 PGY3, 4 PGY4, and 4 PGY5).
Because some of the faculty for the new training program will be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are

limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we project in the metrics that an additional/incremental 200 half-day clinic/procedure sessions will be provided by new faculty physicians each year DY3 through DY5, for an annual total of 600 half-day clinic/procedure sessions by the end of DY 5. Because the residency program will be brand new, we project that we will fill six of the maximum eight first-year training slots each year in DY4 and DY5. By the end of DY5, we expect 6 PGY1 and 6 PGY2 residents in training at DHR. The residents will provide patient care in half-day clinic sessions as required by RRC standards. The number of sessions will increase from DY4 to DY 5 as the number of residents increase along with the maturity of their experience.

STARTING POINT/BASELINE

DHR currently hosts no residency programs. In all of RHP 5, existing UTHSCSA residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center. Valley Baptist also sponsors directly a separate family medicine program with 15 residents.

DHR is a 506-bed general acute care hospital located in South Texas. Our hospital was founded to serve over 1.2 million residents and improve healthcare access in a region that lacked any public or county hospitals. Today, we are working to forge a new integrated health care delivery model that incorporates patient navigation, electronic medical records, population-based care, and superior quality and efficiency to meet every patient's health needs. DHR offers some of the most comprehensive medical care on the U.S. Southern Border. We are located in a community that Forbes Magazine recently listed as one of the poorest areas in the United States. Despite these challenges, DHR has excelled in the delivery of care and was recently recognized, for the third straight year, by Thompson Reuters as one of the Top 100 Hospitals in the nation.

RATIONALE

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 220 and 91, respectively.) From 2001 to 2011, the Texas physician workforce grew 32%, exceeding the population growth of 25%. Primary care physician workforce, however, grew only 25% in the same period, barely keeping pace with population growth. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges (AAMC) to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates in Texas. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

Hidalgo County has a population of 842,000 and 26 practicing general surgeons compared to El Paso County with a population of 791,000 and 43 practicing general surgeons.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the AAMC Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:
This project has several components:

- (a) Identify high impact services and gaps in care, coordination, and ambulatory capacity
- (c) Recruit General Surgery Program Directors and core faculty in calendar years 2013-2014
    - Program Director and Associate Program Director will have 75% academic time for program development/accreditation activities and 25% patient care/clinical time
    - Core faculty will have 25% academic time and 75% clinical time
- Create innovative curriculum including patient registries, team-based community care, integrated primary and specialty care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- (d) Provide Clinical Safety & Effectiveness (rapid cycle improvement) training to faculty and DHR staff
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for General Surgery at DHR
- Complete and submit the Program Information Form (PIF) to the RRC by May 2014
- Attain ACGME approval for the program via RRC meeting in November 2014
- Recruit prospective General Surgery residents in the fall of 2014
- (b) Enroll the first class of residents in July 2015
- Enroll the second class of residents in July 2016

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, RHP 5 has very few residency programs and no residency training programs exist at DHR. The faculty for the General Surgery residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs in RHP 5.

Data Driving this Project:

The need for enhanced health care in this health disparity population is extensively documented. Data published by the United States Census Bureau in 2012 show that 88% (Cameron County) and 91% (Hidalgo County) of the population is Mexican American or Latino in origin and that 35% live below the poverty line compared with 17% for Texas and 14% nationally (http://quickfacts.census.gov/qfd/states/00000.html). Currently about 65% of RHP 5 residents have health insurance of some kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from UT's locally recruited, randomized community cohort show that the prevalence of obesity is 48% and that 8% are morbidly obese. The prevalence of diabetes is an alarming 31% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55%) and hypertension (50%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):
OD-14 Physician Workforce

Stand-alone:
IT - 14.1 Number of practicing General Surgery physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone: Bundle of 3: (for internal tracking only)
IT - 14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice.

Because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-75% of their time to clinical care, they will have an impact on the number of practicing specialty care physicians per 100,000 individuals in RHP 5.

Relationship to other Projects:
This project is related to the following DHR projects:

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/Family Medicine Training Program; and
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program.

Relationship to Other Performing Providers' Projects in the RHP:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for DHR physicians and staff to participate in the CS&E course and projects.

Project Valuation:
This project's impact on the Medicaid and indigent population will be profound. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. Creating residency training programs in RHP 5 that will attract graduates of the growing local medical school who are highly likely to remain the area post-residency will positively impact the long-term number of practicing primary care physicians per 100,000.

DHR has chosen to dedicate the majority of Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region in Hidalgo County. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

Unique Identifier: 160709501.1.4	***Reference number: 1.9.1***	***Component(s):1.9.1 (a-d)***	***Establish specialty care Training Program***
Performing Provider Name: Doctors Hospital at Renaissance			TPI: 160709501
Category 3 Outcome Measure(s):	160709501.3.4	IT-14.1	Number of practicing specialty care physicians per 100,000

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Goal: Produce a comprehensive report documenting existing and needed specialty care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment: $1,193,867 **Milestone 2** [P-14]: Expand targeted specialty care (TSC) training. Metric 1 [P-14.2]: Hire TSC faculty members. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire three faculty physicians including the Program Director, Associate Program Director, and one Core Faculty member by 9/30/2013. Data Source: HR documents. Milestone 2 Estimated Incentive Payment: $1,193,867	**Milestone 3** [P-14]: Expand targeted specialty care (TSC) training. Metric 1 [P-14.1]: Expand the TSC residency training program. Baseline: Program does not exist at beginning of DY 2. Goal: Submit the application, the Program Information Form (PIF), no later than 5/2014 for Residency Review Committee (RRC) 11/2014 meeting Data Source: Training program documentation. Metric 2 [P-14.2.]: Hire additional precepting TSC faculty members. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Hire an additional 2 core faculty members as compared to DY 2. Five cumulative faculty additions from baseline of 0 in DY2. Data Source: HR documents. Milestone 3 Estimated Incentive Payment: $787,228 **Milestone 4** [P-X]: Develop/disseminate clinical teaching tools for TSC training program. Metric 1 [P-X.1]: Clinical teaching tools. Baseline: No clinical teaching tools exist at the beginning of DY2.	**Milestone 7** [P-16]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents. Metric 1 [P-16.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline: No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $801,163 **Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Metric 1 [I-22.1] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Baseline: No faculty in place in DY2. Goal: Increase clinic/procedure hours available for General Surgery attributable to new faculty physicians to 400 half-day clinic/procedure sessions per year; an increase of 200 sessions over DY3.	**Milestone 11** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.4]: Increase the number of TSC residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2, DY3. Goal: Enroll second cohort of 3 residents as of 7/15/2016. Total residents in Cohorts 1 and 2 = 6 at end of DY5. Data Source: Program enrollment records. Metric 2 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: 3 PGY1 trainees in rotation at DHR. Total residents in Cohorts 1 and 2 = 6 at end of DY5. Data Source: Resident training schedule. Milestone 11 Estimated Incentive Payment: $527,555 **Milestone 12** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits.

Unique Identifier: 160709501.1.4	***Reference number: 1.9.1***	***Component(s):1.9.1 (a-d)***	***Establish specialty care Training Program***	
Performing Provider Name: Doctors Hospital at Renaissance				TPI: 160709501
Category 3 Outcome Measure(s):	160709501.3.4	IT-14.1	Number of practicing specialty care physicians per 100,000	
Year 2 (10/1/2012 – 9/30/2013)	**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: Documentation and dissemination of clinical teaching tools. Data source: Clinical teaching tools documents/ materials. Milestone 4 Estimated Incentive Payment: $787,228 **Milestone 5** [P-12] Implement a specialty care access plan to include such components as statement of problem, background and methods, findings, implication of findings in short and long term, conclusions. Metric 1 [P-12.1] Documentation of specialty care access plan. Baseline: No baseline data exists currently. Goal: Implement the specialty care access plan. Data Source: Plan documents. Milestone 5 Estimated Incentive Payment: $787,228 **Milestone 6** [I-22] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Metric 1 [I-22.1] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Baseline: No faculty in place in DY2; zero clinic sessions.		Data Source: Program records. Milestone 8 Estimated Incentive Payment: $801,163 **Milestone 9** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.4]: Increase the number of TSC residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll first cohort of 3 residents as of 7/15/2015. Data Source: Program enrollment records. Metric 2 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2, DY3. Goal: 3 PGY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $801,163 **Milestone 10** [P-21] Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around share or similar projects.	Demonstrate improvement over prior reporting period (baseline for DY2). Baseline: No trainees to provide visits in DY2. Goal: Increase clinic sessions for residents from 2 half-day sessions per month for 2 months for 3 trainees in Cohort 1 in DY4 TO 2 half-day sessions per month for 12 months for Cohort 1 and 2 half-day sessions per month for 2 months for Cohort 2 in DY5. Data Source: Number of resident half-day clinic sessions from clinical schedule. Milestone 12 Estimated Incentive Payment: $527,556 **Milestone 13** [P-X] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Metric 1 [P-X.1] Quality assessment and improvement curriculum and practicum for residents. Baseline: No curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology based on CS&E course. Data Source: Curriculum and

Unique Identifier: 160709501.1.4	***Reference number: 1.9.1***	***Component(s):1.9.1 (a-d)***	***Establish specialty care Training Program***
Performing Provider Name: Doctors Hospital at Renaissance			TPI: 160709501
Category 3 Outcome Measure(s):	160709501.3.4	IT-14.1	Number of practicing specialty care physicians per 100,000

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Goal: Increase clinic/procedure hours available for General Surgery attributable to new faculty physicians by 200 half-day clinic/procedure sessions for the year. Data Source: Program records. Milestone 6 Estimated Incentive Payment: $787,229	Metric 1 [PI-21.1] Participate in semi-annual face-to-face meetings organized by the RHP (may be CS&E training sessions and/or project discussions). Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two face-to-face meetings per year. Data Source: Documentation of meetings including meeting agendas, slides from presentations, etc. Milestone 10 Estimated Incentive Payment: $801,162	practicum documentation. Milestone 13 Estimated Incentive Payment: $527,555 **Milestone 14** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Metric 1 [I-22.1] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Baseline: No faculty in place in DY2. Goal: Increase clinic/procedure hours available for General Surgery attributable to new faculty physicians by 200 more half-day sessions per year over DY4; annual count of 600 half-day clinic/procedure sessions. Data Source: Program records. Milestone 8 Estimated Incentive Payment: $527,556
Year 2 Estimated Milestone Bundle Amount: $2,387,734	Year 3 Estimated Milestone Bundle Amount: $3,148,913	Year 4 Estimated Milestone Bundle Amount: $3,204,651	Year 5 Estimated Milestone Bundle Amount: $2,110,222
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,851,520			

Expand Physician Assistant Studies Program [1.2.4]

Doctors Hospital at Renaissance [160709501.1.5]

Project Description:
Description: RHP5, as of 2010, has a population of 1.26 million, and is expected to grow by another 400,000 by 2020[46]. As the region continues to grow, so does its historical circumstance of being medically underserved. As the demand for physicians increases, so does the demand for mid-level staffing such as physician assistants (PA). According to the Bureau of Labor Statistics, demand for physician's assistants is expectedto grow by 30% by the year 2020.
In response to the increase indemand, the University of Texas Pan American (UTPA) will be in the process of expanding its Physician Assistant Studies Program (PASP). Currently, each entering PASP class is capped at 50 students. In order to achieve accreditation for an increased number of physician assistant students, UTPA must ensure that there is adequate space, faculty, staff, and equipment. Once these elements are secured, an additional 30 students can begin the program in DY2 (an increase in class size from 50 to 80). By DY3, the program will reach its goal of 100 accepted PA students and will be well on its way toward graduating an increased number of physician assistants that can serve a community that has been considered a medically underserved area since the 1980's.
To ensure that the PA students receive adequate exposure in their clinical rounds, Doctors Hospital at Renaissance will help accommodate the expansion of PA's who will need to fulfill their clinical requirements. In collaboration with Doctors Hospital at Renaissance, Hidalgo County Health and Human Services Department has clinic sites that will help absorb the number of PA students that will need to do their clinical rotations. DHR is one of the largest physician owned partnerships in the nation, as this program matures DHR will be able to encourage physician collaboration with UTPA to increase the availability of clinical rounds for the PA students. This will translate into more providers throughout the healthcare system, specifically within the clinics and within the hospital as the students accompany the physician.
Goals and Relationship to Regional Goals: The overarching goal of this project aligns itself with community need 5 (CN5) which is increasing the amount of primary care providers throughout RHP5. Through each demonstration year, UTPA is focusing on increasing matriculation of students eventually reaching its goal of accepting 100 PA students per year resulting in 100% growth over the current class size limit of 50 students. Historically, approximately 65% of the graduates enter employment in the primary care sector, so this will act as the continued goal for the project.Of the 216 students who graduated from the PA program from 2002 to 2009 (the last time period from which long-term tracking data is available), 83.8% of the graduates remained working as PAs in the RHP 5 while 13.89% worked as PAs in other areas of Texas. The baseline will be set as the current 50 PA slots of the program, as this project expands the program resulting in greater availability of healthcare services to the community as the increased number of yearly graduates enter into the job market to serve the community at large.

[46] RHP5 Community Needs Assessment

Patient Impact:
By the end of the project, 180 additional students will have been matriculated into the program. Of the 180 students, 80 additional PAs (30 in DY 5 and 50 within 2 ½ months of DY 5) will have had enough time (27 months) to complete the program and graduate.The additional 30 students who enter the program in DY2 will graduate in DY 5. The additional 50 studentswho enter the program in DY3 will graduate within 2 ½ months of DY5.
According to Health Resources and Services Administration (HRSA), each midlevel primary health care provider will provide on average 2,700 patient encounters per year. Each of the PA graduates in the first cohort of 30 will have nine months of private practice and will provide approximately 2,000 patient encounters during the remaining time of DY 5. For the cohort, this will result in an estimated 60,750 patient encounters during DY 5.
Starting in August 2014, PA students in the first cohort of 30 will begin their clinical rotations during a 16-month period. In all, the PA students will spend 48 weeks in clinical rotations. During each of the weeks, each PA students sees approximately 80 patients a week. During that time, each PA student will average about 3,840 (80 x 48) patient visits. This will result in 115,200 patient encounters (30 students x 3,840 patient encounters) for the first cohort. Cohort #2 will have 14 months (42 clinical weeks) of clinical rotations during DY 4 and DY 5. Cohort #3 will be in clinical rotations during the last two months (8clinical weeks) of DY 5. In all, PA students will provide approximately 300,000+ patient encounters during DY 3 through DY 5.
During their estimated 25-year professional careers, the 80 additional PAs graduating during the project term (DY2-DY5) will result in services to approximately 1.5 million patient consultations This is a long-term project that can vastly increase the amount of accessibility to a medically underserved area. This project will continue to increase accessibility of midlevel primary and specialty healthcare as the program continues to introduce PAs into healthcare care system throughout RHP5. DHR will plan on incorporating these PA into the participating facilities as well with the upcoming residency programs to harbor collaborative skills to increase the quality of healthcare throughout the region as these programs continue to mature.

Challenges/Issues: For the region, the challenge revolves around increasing access to healthcare as a whole. As demand increases, it will be up to the major healthcare providers and medical school systems to introduce physicians and mid-level staffing into the system where they are needed the most. Demand for physician assistant services will continue to rise due to their cost effectiveness. PAs increase the level of preventative care, reduce medical errors, are key players in the new interdisciplinary team model of health care delivery, and will continue to be in demand as the population outgrows the supply of physicians and accessibility to healthcare
Issue Resolution: This PA program expansion addresses the shortage ofhealth care services in the region by doubling the amount of PAs in the RHP5 healthcare system. The PASP historically has a 95% rate of graduation with a regional retention rate of 74%[47]. Once the program is fully matured, it will have the capability of graduating at least 95 PAs annually, approximately 70 of which will practice in RHP5. Not only will these PAs be trained locally, many of them are from the region, so they will be acclimated to its culture and aware of its strengths and challenges,

[47] UTPA Proprietary Information

including educationaldeficiencies. This cultural awareness can result in potentially much more effective and higher qualityhealthcare.

Expected Outcomes: With such a fast turnaround from acceptance to graduation for PA students, the expected outcomes for this project will be an increased number of midlevel, primary care provider availability for RHP5 by DY 5.The expansion of the PA program will be a phased process in which the first expansion of the PA training program will be demonstrated as soon as DY2. With the inherent overlap of resources, as Doctors Hospital is a performing provider for these projects, collaboration with the medical residency program will be an added component of this project. This expected collaboration will enable the soon to be physicians and PAs to work together in the participating facilities as a team and develop collaborative skills that will be necessary as they enter the healthcare system throughout the region.

Rationale:

The rationale for this project being included within the RHP5 plan is Community Need 5 (CN5), access to healthcare services and preventive healthcare[48]. In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 per 100,000 statewide[3].This project was selected to join the list of pass 2 projects to address the short and long-term goals of increasing accessibility to healthcare by increasing the availability of primary health care services.

As the majority of RHP5 is listed as an MUA[49], the physician assistant serves as a cost effective alternative to the healthcare system in providing comparable primary care medicine which is capable of providingcongruent patient satisfaction as that of a physician when services arenot available otherwise[50]. UTPA realizes the potential value of PAs to the community and is seeking to meet a growing demand.

As the demand for physicians continues to increase with the population growth of RHP5, demand for mid-level staffing such as PA's will also increase. To meet the community demands and increase the availability of primary care services, UTPA has decided to double their Physician Assistant Studies Program (PASP). DHR, in partnership with the UTPA PA department, is developing the curriculum for inpatient clinical rotations. This is the hospitalist 3-month clinical capstone.

UTPA has designed the project so that it vastly increases the availability of healthcare that PAs are able to deliver by expanding its number of slots by 100%. Each of the following outcome measures, which are displayed in the next section, is geared towards serving medically underserved areas (MUA) and the Medicaid populationso that preventive healthcare will be available in quantities that it wasn't before.

Related Category 3 Outcome Measures:

<u>Stand-alone:</u>

[48] RHP5 Community Needs Assessment

[49] HHSC: http://muafind.hrsa.gov/

[50] Stanford: http://www.stanford.edu/class/e297c/poverty_prejudice/citypoverty/physician.htm

IT-14.2 Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs

Related non-stand-alone:

- T-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs base on a systematic survey
- IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey.

The rationale behind choosing these outcome measures is the lack of the providers throughout the region as a whole. These outcome measures revolve around increasing the numbers of PA's in a market that caters to Medicaid and indigent populations; thereby increasing the numbers of providers in an area that has been long considered a MUA.

Relationship to Other Projects:

The relationship to other projects will be a long-term development. As residency programs in south Texas develop, midlevel practitioner demand will continue to be stimulated and met by UTPA. This project will enhance the following:
160709501.1.1 Establish Primary Care/Internal Medicine Training Program (Doctors Hospital at Renaissance);
160709501.1.2 Establish Primary Care/Family Medicine Training Program(Doctors Hospital at Renaissance);
160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program (Doctors Hospital at Renaissance);
160709501.1.4 Establish Surgery Residency Training Program (Doctors Hospital at Renaissance)
Each of these projectswork in conjunction with each other and are in response to the shortage of providers compared to the growing population[51]. As community need 5, access to healthcare services and preventive healthcare, is improved upon, and healthcare availability increases, community need 1 (Diabetes & Obesity) will also see improvement. Support for this predicted improvement is that diabetes & obesity more often than not are caused by a lack of knowledge and follow up healthcare, challenges that will be met by an enhanced workforce of physicians and physician assistants.

Project Valuation:
The project valuation was derived from its overall impact on the community. The PA program is focused on creating interdisciplinary teams in which the PA is an integral part of team efforts working with physicians and residents to deliver better outcomes, reduce the number of medical errors, and promote the reduction of readmissions.As this project works in conjunction with the upcoming medical residency programs, the community will benefit greatly from

[51] RHP5 Community needs assessment

health care providers from the mid to top level being trained within the region that understand the overall demographics and circumstances of the area as a whole.
As the increased number of PA's are ready to enter the market, the program will keep track of which stay within the area, and which are seeking to serve in the primary care segment of healthcare. As these numbers increase, creating greater access to healthcare services, preventative and follow up care will be more accessible helping to create a healthier population. As a resultof a healthier population, preventable conditions and readmissions will be decreased in the long-term.
It is predictable that with the large population increase and steady growth in RHP5[4], if initiatives are not taken to increase the provider to population ratios, there will be a vast majority that will seek services from the local emergency departments or go without services until it becomes a dire emergency. Because the majority of the population that will be in these circumstances will be those that are on Medicaid or are indigent, the hospitals will end bearing the costs of these services, which are unsustainable in the long term.
The true value of the project cannot be seen until DY5 when the PA students graduate in a greater number as a result of the initial DY2 expansion. On average, each PA is capable of seeing 80 patients a week, which equals potentially over 4000 patient consultations a year. Once the project has reached complete maturity, within two months after DY5 the PA program will be graduating 50 additional students creating a potential for over 200,000 patient consultations in a calendar year (400,000+ when the entire class of 100 PA's is taken into consideration).
UTPA hires PASP faculty from across the country and does not specifically target hiring from the local physician assistant pool and will not create any decrease in the overall regional pool of physician assistants.Faculty will be hired that will include retiring physicians and some practicing PAs.

160709501.1.5	1.2.4	P-1; P-2; I-11	Increase the number of primary care providers (physician assistants)
Doctors Hospital at Renaissance			160709501
Category 3 Outcome: OD14	IT-14.2 IT-14.7 IT-14.8	160709501.3.5 160709501.3.6 160709501.3.7	• Number of practicing NPs and Physician Assistants per 1000 individuals in a MUA (*stand-alone measure*) • Percent of trainees who report that they plan to practice in HSPAs or a MUA based on a systematic survey • Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-1) Conduct a primary gap analysis to determine workforce needs **Metric (P-1.1)**Gap assessment of workforce shortages **Data Source:** Assessment results *Milestone 1 Estimated Incentive Payment:* ***$895,310.00*** **Milestone 2: (P-2):** Expand primary care training for primary care providers, including physicians, PAs, NPs, RNs, pharmacists, dentists. *-UTPA will be making additions to their core*	**Milestone 4: (P-2):**Expand primary care training for primary care providers, including physicians, PAs, NPs, RNs, pharmacists, dentists. *-UTPA will be making additions to their core faculty as necessary to accommodate the expansion of the PA program for an additional 20 slots.* **Metric P-2.2:**Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (DY2) **Documentation:** Increased number of additional training	**Milestone 6 (I-11):** Increase primary care and/or rotations **Metric I.11.2:** Increase the number of primary care trainees rotating at the Performing Provider's facilities. **Goal:** 80 PA students will have started their clinical rotations at the end of DY3 *(50 original slots*	**Milestone 7 (I-11):** Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline **Metric I.11.2:** Increase the number of primary care trainees rotating at the Performing Provider's facilities.

faculty as necessary to accommodate the expansion of the PA program *-In DY2 UTPA will expand the program by 30 slots for a total of 80.* **Metric P-2.1:** Expand the primary care residency, mid-level provider, and/or other clinician staff training programs and/or rotations. **Goal:** Documentation of applications and agreements to expand training programs **Data Source:** Training program documentation **Metric P-2.2:**Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (FY11) **Documentation:** Increased number of additional training faculty/staff members **Data Source:** HR documents, faculty lists, or other documents. *Milestone 2 Estimated Incentive Payment: $895,310.00* **Milestone 3 (I-11):**Increase primary care training and/or rotations **Metric I-11.1:**Increase the number of primary care trainees (PA's), as measured by percent change of class size over baseline. **Documentation:**Demonstrate improvement over prior reporting	faculty/staff members **Data Source:** HR documents, faculty lists, or other documents *Milestone 4 Estimated Incentive Payment:* ***$1,373,535.00*** **Milestone 5 (I-11):** Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline. – *In DY3 UTPA will expand the PA program by 20 more slots allowing for a total of 100 slots.* **Metric I-11.1:** Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline. Trainees may include physician assistants and nurse practitioners. **Documentation:** Number of trainees enrolled in primary care training program(s) **Goal:** Increase the number of slots in the PA program by 20 which is a 25% increase over DY2 resulting in 100 total slots. (initial 30 slot expansion in combination with the second cohort of the 20 slot expansion) **Data Source:** Documented enrollment by class by year by primary care training program. **Metric I.11.2:** Increase the number or primary care trainees rotating at the Performing Provider's facilities -The cohort of 30 that was accepted in DY2 will be able to start their clinical rotations in August of 2014 (end of DY2) **Documentation:** Number of primary care	*combined with the additional 30)* and will continue through the entirety of DY4 ending in December of DY5. In August of DY4, the second cohort of an additional 20 *(making a total of an extra 50 for that class)* will begin their clinical rotations. Total of 80 additional PA's rotating over the original 50 PA slot allotment. **Data Source:** Student/trainee rotation schedule *Milestone 6 Estimated Incentive Payment:* ***$ 3,388,280.00***	**Goal:** Initial class of 80 PA students will have finished their clinical rotations in Nov. of DY5, the second cohort of a 100 total PA's (50 original slots, 50 expanded slots) will continue their rounding for the entirety of DY5 finishing two months after the end of the fiscal year. In August of DY5 the third cohort of 100 PA's will begin their clinical rounding. Total of 130 additional trainees participating in clinical rounds over the original 50 PA slot allotment. **Data Source:** Student/trainee rotation schedule. **Metric I-11.7:** Improvement in number of primary care

period. - *In this case the turnover from planning the expansion and actually creating more slots in the program will be fast, so the baseline will be created by created by how many PA students were admitted over the prior class year (50 slots).* **Goal:** Increasing the PA program by 30 slots which is a 60% increase resulting in 80 total slots in the PA program. Baseline: FY11 class of 50 PA students; capable of approximately 100,000+ patient consultations a year. **Data Source:** enrollment by class by year *Milestone 3 Estimated Incentive Payment:* ***$895,311.00***	trainees in rotation at Performing Provider's facilities – total of 30 additional PA's will begin their clinical rotations over the original 50 PA slot allotment at the end of DY3. **Data Source:** Student/trainee rotation schedule *Milestone 5 Estimated Incentive Payment:* ***$1,373,534.00***		practitioners that went to practice primary care after graduating. -The first cohort of 30 (total class of 80 PAs) will be graduating Dec. of DY5. The exit survey will demonstrate the improvement over the baseline over the 2012 graduating PA class. **Data Source:** Exit Survey or other follow-up survey *Milestone 7 Estimated Incentive Payment: $ 2,865,155.00*
Year 2 Estimated Milestone Bundle Amount: ***$2,685,931***	Year 3 Estimated Milestone Bundle Amount: ***$2,747,069***	Year 4 Estimated Milestone Bundle Amount: ***$3,388,280***	Year 5 Estimated Milestone Bundle Amount: ***$2,865,155***
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $11,686,435.00			

Driscoll Children's Hospital – Category 1 Infrastructure Development

- Driscoll Children's Hospital
- 132812205.1.1
- 1.8.12 –Increase, Expand, and Enhance Oral Health Services

Provider: Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30k square mile area.

Intervention(s): This project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider's (PCP's) office. More children will gain access to crucial preventative oral health care services, thereby reducing the incidence of oral health disease.

Need for the project: In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%.

Target population: Medicaid patients account for more than 70 percent of Driscoll's patient base. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child & dentist.

Category 1 expected patient benefits: By the end of year 5, the oral health project will accomplish the following: Increase, expand, and enhance oral health services performed by PCPs in the Driscoll's delivery service area by 20 percent over the baseline (State Fiscal Year 2012).

- The project is estimated to serve 210 additional patients in DY2 (5% increase); 420 patients in DY 3 (10% increase); 630 patients in DY 4 (15% increase) and 840 patients in DY 5 (20% increase).
- Train 15 additional providers to perform dental education and fluoride varnish treatments in a PCP office over the baseline (SFY12), which represents an increase of more than 16 percent.

Category 3 outcomes: Driscoll Children's Hospital has selected an Oral Health outcome improvement target (IT-7.10) to prevent severe dental caries that result in operative interventions in the Driscoll Service area by 5%.

Collaboration: This project will be performed in collaboration with three other local providers; Doctors Hospital at Renaissance, Valley Baptist Health System, and South Texas Health Systems. Each provider entered into the collaboration agreement freely and with the intention of benefiting RHP 5 through local healthcare delivery transformation. Each collaborator will be responsible for supporting the performing provider in efforts to fully implement a robust and transformative project. As the local community provider, the collaborators will assist Driscoll by participating in the planning, design, and execution of the oral health project. This will include but is not limited to participating in the multidisciplinary Oral Health Service Task Force and the region-wide learning collaborative. These efforts will provide Driscoll with invaluable information regarding project impact and "lessons learned", opportunities to adjust project target patient populations, identifying special considerations needed for safety-net populations, and reviewing challenges. The supply of dentists in RHP 5 is second in deficit only to mental health professionals. There are only 21 dentists per 100,000 people—less than half the rate for Texas. The oral health project is designed to address this community need by expanding the pediatric primary care oral health services, thus improving overall health care delivery and health outcomes in the region. Driscoll appreciates the willingness of local providers to

collaborate on such a project and we acknowledge that this collaboration is necessary to achieve the project goals and ensure a complete and successful transformation in RHP 5.

Project Option: 1.8.12 –Increase, Expand, and Enhance Oral Health Services
Unique Project ID: 132812205.1.1
Performing Provider Name/TPI: Driscoll Children's Hospital / 132812205

Project Description:
Driscoll Children's Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children's Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children's hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children's Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children's Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)'s comprised of pediatric subspecialists), The Driscoll Children's Hospital Auxiliary, and the Driscoll Children's Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

The DSRIP project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider's (PCP's) office. In the U.S., millions of children are predisposed to dental disease because of dietary, behavioral, and socio-environmental factors that overwhelm preventive interventions available to them. For children with extreme dental disease, dental caries frequently contribute to distracted behavior and associated poor educational performance. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

Today, Driscoll Children's Hospital collaborates with Driscoll Children's Health Plan and Primary Care Provider (PCP) to offer dental fluoride varnish treatments to Medicaid-enrolled children in the office of their PCP. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child, dentist, and dental program.

To further enhance the Oral Health Program, Driscoll Health System will form an Oral Health Services Task Force that will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Oral Health services milestones and

metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and "lessons learned", reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Oral Health Services Project.

Project Goals and Challenges:
Expanding access to education and preventive dental care to children in a PCP's office will improve and promote better oral health care for low-income children and help to prevent severe dental caries that often result in loss of teeth and surgical interventions.

By the end of year 5, the Oral Health project will accomplish the following:

- Increase, expand, and enhance oral health services performed by PCPs in the Driscoll's delivery service area by 20 percent over the baseline (State Fiscal Year 2012)
- Train 15 additional providers to perform dental education and fluoride varnish treatments in a PCP office over the baseline (SFY12), which represents an increase of more than 16 percent.
- Prevent number of children requiring surgical intervention to treat severe dental caries.

This project advances Region 5 goals identified in the RHP Plan and in the Community Needs Assessment of expanding access to oral health services and reducing preventable health care complications that result from poor oral health, such as severe dental caries that often must be treated with surgery. The project also promotes care coordination between PCPs and traditional oral health care providers.

Driscoll faces several challenges and barriers to implement the fluoride varnish program; including the high rate of early childhood dental caries in our target population, a need to reach underserved populations to deliver preventative services; the need to educate PCPs in appropriate evaluation and preventive oral health.

Starting Point/Baseline:
For Project option 1.8.12, Driscoll provided 4,200 dental education and fluoride varnish treatments for State Fiscal year 2012 baseline metric. Today, ninety-three trained medical providers of our target provider population in the Driscoll service area are qualified to perform Driscoll oral health services today.

Rationale:
The United States Surgeon General identified tooth decay as the most common chronic childhood disease in a 2000 report, "Oral Health in America." Tooth decay is five times more common than asthma. In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%. Many parents and even physicians do not understand the importance of healthy primary teeth. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

Data suggest a high utilization of dental procedures in the operating room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expansion of pediatric primary care oral health services is one key to improving overall health care delivery and health outcomes in the region. The project goal is to increase access to dental fluoride varnish treatments in our service delivery area. Driscoll Children's Hospital does not include any project components or receive any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

Based on the Community Needs Assessment (CNA) for Region 5 of the State of Texas 1115 Waiver, only 48% of those in RHP 5 had seen a dentist or dental clinic during the past year, well under the proportion of Texas (62%) or the US (67%). Since only 35% of RHP5 (ranging from 17% to 38% in counties) have dental insurance compared to 61% in the US it is commonplace for individuals with dental problems to visit the hospital emergency room or seek care in Mexico for dental care. RHP 5 Plan and Community Needs Assessment expressed a strong need for primary care and specialist physicians, nurses and physician assistants. The supply of dentists in RHP 5 is second in deficit only to mental health professionals. There are only 21 dentists per 100,000 populations—less than half the rate for Texas. Consistent with this assessment this project addresses CN.1 (Shortage of primary and specialty care providers and inadequate access to primary or preventive care).

Related Category 3 Outcome Measure(s):
OD-7 Oral Health –IT-7.10 Other Outcome Improvement Target **– Reduce incidence of severe dental caries that result in operative interventions in the Driscoll service area**

Driscoll Children's Hospital has selected an Oral Health outcome improvement target (IT-7.10) to prevent severe dental caries that result in operative interventions in the Driscoll Service area by 5% in DY 4 and 10 % in DY 5.

The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in preventing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30% of all cases performed in the operating room for Calendar Year 2011 in other markets. Application of dental education and fluoride varnish treatments will prevent dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

Relationship to other Projects:
Project 1328122051.1, Expand Access to Oral Health Services, complements other projects that expand access to services for children, including 132812205.2.1, Implement Evidence-based Health Promotion Programs, and 132812205.2.2 – pass 2, Implement Evidence-based Disease Prevention Programs. The Oral Health project does not have a corresponding Category 4 Population-focused measure.

Relationship to Other Performing Providers' Projects in the RHP:
This is the only project in the RHP addressing oral health needs in the community targeted to children.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative, as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
We believe the Oral Health project is a highly valuable initiative in the RHP 5 Region in terms of cost avoidance, population served, and community benefit and need. In 2011, Medicaid spent $4.6 million at Driscoll Hospital on operating room (OR) and related follow up services to treat children with severe dental caries. Dental cases account for 30 percent of all OR cases at Driscoll hospital. A large share of these surgical procedures and costs could have been avoided if the patients had access to appropriate preventive dental care. Over the demonstration period, the proposed DSRIP project will expand Driscoll's oral health program by 20 percent, serve more children, and reduce even further surgical interventions and cost to treat severe dental caries. In addition, the project will significantly expand qualified providers in the Driscoll area to perform dental education and fluoride varnish treatments in a PCP's office by more than 30 percent. These improvements will have a significant impact on improving health status of under-served, low-income children in our region. Based on these reasons, the value of the Oral Health project is $6,000,000 (inclusive of Categories 3 and 4).

Unique Project ID: 132812205.1.1	***RHP PP Reference number:*** 1.8.12	***Project Components:*** ***N/A***	**Expand and Improve Pediatric Oral Health**	
Performing Provider Name: Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s):	*132812205.3.1*	*IT-7.10*	*Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing pediatric oral health services performed by a primary care provider **Metric 1** [P-X.1]: Documentation of Task Force establishment **Data Source:** Hospital/health plan record **Milestone 1**: Estimated Incentive Payment *(maximum amount):* $ 318,750 **Milestone 2:** [P- X1]: Develop plan to increase training of PCP providers on how to administer dental education and fluoride varnish treatments for pediatric patients. **Metric 2** [**P-X1.1**]: Copy of the plan. **Data Source:** Roster/ attendance sheets for grand rounds and training **Milestone 2**: Estimated Incentive Payment *(maximum amount):* $318,750 **Milestone 3:** [P-X2]: Conduct an initial assessment to expand, increase, and enhance pediatric	**Milestone 5** [P-X3]: Task Force leads quality improvement initiative for oral health care project. **Metric 5a** [P-X3.1]: Documentation of Quality Improvement meetings held twice per year **Metric 5b**: [P- X3.2] Documentation of Task Force report, findings and/or action plan to further enhance oral health project. **Data Source:** Hospital/health plan record **Milestone 5**: Estimated Incentive Payment *(maximum amount):* $ 400,000 **Milestone 6** [I-11]: Increase dental care training **Metric 6** [I-11.3]: Train an additional 5 providers to perform dental education and fluoride varnish treatments in a PCP office above the SFY 2012 baseline. **Data Source:** Enrollment/ attendance at training **Milestone 6**: Estimated Incentive Payment *(maximum amount):* $ 400,000		**Milestone 8** [P- X3]: Task Force leads quality improvement initiative for oral health care project **Metric 8a** [P- X3.1]: Documentation of Quality Improvement meetings held twice per year **Metric 8.b** [P- X3.2]: Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project **Data Source:** Hospital/health plan record **Milestone 8**: Estimated Incentive Payment *(maximum amount): $ 375,000* **Milestone 9** [I-11]: Increase dental care training **Metric 9** [I-11.3]: Train an additional 10 providers to perform dental education and fluoride varnish treatments in a PCP office above SFY 2012 baseline. **Data Source:** Enrollment/ attendance at training **Milestone 11**: Estimated Incentive Payment *(maximum amount):* $ 375,000	**Milestone 11** [P- X3]: Task Force leads quality improvement initiative for oral health care project **Metric 11a** [P- X3.1]: Documentation of Quality Improvement meetings held twice per year **Metric 11b** [P- X3.2]**:** Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project **Data Source:** Hospital/health plan record **Milestone 11**: Estimated Incentive Payment *(maximum amount): $ 285,000* **Milestone 12** [I-11]: Increase dental care training **Metric 12** [I-11.3]: Train an additional 15 providers to perform dental education and fluoride varnish treatments in a PCP office above the SFY 2012 baseline. **Data Source:** Enrollment/ attendance at training **Milestone 12**: Estimated Incentive Payment *(maximum amount):* $ 285,000

UNIQUE PROJECT ID: 132812205.1.1	***RHP PP REFERENCE NUMBER:*** 1.8.12	***PROJECT COMPONENTS:*** ***N/A***	**Expand and Improve Pediatric Oral Health**	
Performing Provider Name: Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s):	*132812205.3.1*	*IT-7.10*	*Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
oral health services performed by a primary care provider. **Metric 3:** [P- X2.1]: Documentation of plan assessment **Data Source**: Hospital/health plan records **Milestone 3**: Estimated Incentive Payment *(maximum amount):* $318,750 **Milestone 4:** [I-X]: Expand Preventive Dental services by PCP. **Metric 4:** [I- X.1]: Goal: Increase the number of education and dental fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 5% above the SFY 2012 baseline of 4,200 patients to include an additional 210 treatments. **Data Source**: Hospital/health plan records **Milestone 4**: Estimated Incentive Payment: $ 318,750	**Milestone 7:** [I-X]: Expand Preventive Dental services performed by PCP office. **Metric 7:** [I- X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 10% above the SFY 2012 baseline of 4,200 patients to include an additional 420 treatments **Data Source**: Hospital/health plan records **Milestone 7**: Estimated Incentive Payment: $ 400,000		**Milestone 10:** [I- X]: Expand Preventive Dental services performed by PCP office. **Metric 10:** [I- X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 15% above the SFY 2012 baseline of 4,200 patients to include an additional 630 treatments **Data Source**: Hospital/health plan records **Milestone 10:** Estimated Incentive Payment: $ 375,000	**Milestone 13:** [I- X]: Expand Preventive Dental services performed by PCP office. **Metric 13:** [I- X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 20% above the SFY 2012 baseline of 4,200 patients to include an additional 840 treatments **Data Source**: Hospital/health plan records **Milestone 13**: Estimated Incentive Payment: $ 285,000
Year 2 Estimated Milestone Bundle Amount: $ 1,275,000	Year 3 Estimated Milestone Bundle Amount: $ 1,200,000		Year 4 Estimated Milestone Bundle Amount: $ 1,125,000	Year 5 Estimated Milestone Bundle Amount: $ 855,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 4,455,000				

Starr County Memorial Hospital
Increasing OB Primary Care
136332705.1.1

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Starr County Memorial Hospital (SCMH) is a major healthcare provider in Starr County serving as a critical access hospital for the region. The nearest acute care hospital is over 50 minutes away, so the community turns to SCMH for a high percentage of their medical needs.
Intervention(s): Clearly state the intervention(s).	This project will allow SCMH to obtain a family practice physician that is has OB background to provide these types of services as well. The physician will provide services in the Starr County Rural Health Clinic as well as complete rounds at SCMH to increase availability to those who are in need.
Need for the project: A brief description of the need for the project including data as appropriate.	SCMH Rural Clinic currently only has one full time physician. As a result, the majority of the patients are left receiving services from a nurse practitioner. Additionally, the recruitment of this family practice physician will have OB background so that SCMH can have this specialty available fulltime at the hospital which it currently does not.
Target population:	The target population is the indigent care and Medicaid population that often seek services either at the rural health clinic or through the emergency department at SCMH. There are approximately ten thousand visits to the rural clinic, of which 70% are seen by a nurse practitioner.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks increase unique patient encounters by the end of DY3 through DY5. These patient encounters will be consults by the physician versus the nurse practitioner. The proportions of patients seeing a physician will be misrepresented since there will now be increased availability as a whole, so the nurse practitioners can see more people as well. For this reason, the baseline will have to be set in DY2.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-1.10: HbA1c Poor Control. – Starr County has a high percentage of population that is diabetic. As this population seeks services from the rural health clinic where the family practice physician will be primarily located, diabetes education will be provided to help the patients stabilize and improve their condition once they leave the clinic.

Increase OB Primary Care [1.1]

Starr County Memorial Hospital [136332705]

RHP Performing Provider Unique Number 136332705.1.1

Project Description:

Description: The Rio Grande City Rural Health Clinic in Starr County serves approximately 10,000 patient consultations per year[52]. Due to a lack of physician availability and a growing patient population, many patients at the Rio Grande City Rural Clinic are often cared for primarily by advanced nurse practitioners (NP). While NPs are quality providers, they are not trained to offer in-depth specialized care that only a family medicine or obstetrical (OB) physician can offer. This project aims to recruit a family practice physician that is also able to render OB services increasing the availability of healthcare within surrounding community.

Additionally, evidence-based diabetic education will be incorporated within the clinic in a group setting according to class scheduling that will be convenient for the patients. There will be a set schedule of classes and topics regarding diabetes. Materials will be developed in such a way that anyone can understand and take home to share amongst their own support group. Sign-In sheets will be provided as well as a CPT code to be bundled in with the visit. Patient satisfaction surveys will be conducted with focus on the education outreach and newly added physician services. With the new family practitioner also practicing OB, diabetic woman will be documented in a registry and their HbA1c scores will be documented with each visit. It is important to have these improve as signs of blood glucose stabilization to promote a healthy development of the fetus and prevent labor complications[53] that typically would have to be turned away to another facility.

With 70% of the 10,000 average patient consultations presently being cared for by an NP, this project will improve care for approximately 2,000 and 3,000 lives each demonstration year by bringing much needed Family Practice and Obstetric services[1]. Additionally, over 3,500 patients will have new access to diabetic education that will help reduce present and long-term complications.

Goals and Relationship to Regional Goals: The goal of the project will be to increase the volume of family medicine services currently available to our community. Additionally, this projects goal is also to increase the OB care that is available for woman at this rural health clinic and at the Starr County Memorial Hospital. Far too many patients are left without physician rendered services and either seeks services elsewhere or simply goes without them.

The goals of the project are:

- Adding the services of an additional physician within the rural health clinic that is associated with Starr County Memorial Hospital. This physician will be a family practice practitioner with OB capabilities.

[52] Starr County Proprietary Information

[53] http://www.hopkinsmedicine.org/healthlibrary/conditions/adult/pregnancy_and_childbirth/medical_conditions_and_pregnancy_85,P01200/

- Increase the availability of OB services within Starr County Memorial Hospital.
- Integrate diabetes education in a group setting and optional one-on-one for diabetic, pregnant women, in an effort to promote a healthy pregnancy and decrease complications.

The project meets the following regional goals:
This project aligns itself with the regional goal of increasing healthcare availability to the indigent and Medicaid population. The Rio Grande Rural Health Clinic services primarily Medicaid, Medicare and indigent patients. This project will also help expanded services for the indigent who seek care through the emergency department at Starr County Memorial Hospital (SCMH). The Rio Grande Rural Health Clinic is the primary facility that SCMH refers to for transitional and follow-up care if the patient does not already have a PCP. The addition of a physician at the clinic will double the amount of people that are able to receive physician consults which also directly supports community need 5 (CN5), "Access to healthcare service/preventive healthcare".
Patient Impact: This project's primary objective is creating more accessibility to a physician in an underserved rural health community clinic setting. On average, the Rio Grande Rural Health Clinic services approximately 10,000 patient visits per year. With, on average, 20 working days in any given month; that divides out to 41 patients that are able to be seen per day[1] by the NPs and physician combined. With a large amount of individuals who are unable to access the clinic due to physician shortage. With the addition of another physician with OB capabilities, it is estimated that another 3000 current or new patient encounters will be serviced through a physician at this clinic.
A more specific patient impact will be that of the services being rendered to the female population that will be possible with the OB capabilities that this physician brings to the clinic. Additionally, the project will provide all patients with access to evidence-based diabetic classes. Broad concepts of living with diabetes will be covered such as medications, nutrition, checking areas for wounds (such as foot ulcers). Several studies show, such that of the Centers of Disease Control and Prevention[54] (CDC) that while pregnant, and living with diabetes, there must be blood glucose control and a plan in place to help ensure the development of a healthy baby. For those patients seen by the physician that are diabetic and pregnant, a class will be created just for that patient demographic to encourage a healthy pregnancy and improve on potential preventable conditions that are associated with premature deliveries.
Challenges/Issues: Due to the limited availability of Ob/Gyn services in Starr county, patient demand quickly exceeds physician resources. The present ability to remedy this situation is challenging given the regions socioeconomic condition and payer mix. These factors translate to the following statistic: Of the 10,000 patients (on average) seen in Rio Grande Valley City Rural Clinic, approximately 70% were serviced by advanced nurse practitioners[55].
Issue Resolution: Increasing the number of physicians where they are severely lacking, with adequate mid-level staffing, can dramatically increase the volume percentage of patients that are able to be seen. Where patients are seeking services elsewhere, a greater amount will now be able to receive the quality health care they deserve in their local community.
5 year expected outcome for provider and patients: With the community and provider population relatively small in relation to the rest of RHP5, outcome measures will eventually stabilize as the

[54] http://www.cdc.gov/features/diabetespregnancy/
[55] Starr County Proprietary Information

increased number of providers continue to meet their own caps of patient care to ensure safety and quality. Over the five years of this project, Improvements should increase by DY3 all the way through DY5. *The addition of a family practitioner will increase the clinics "physician encounter" numbers increase by 5%, 10%, and 15% in each consecutive year starting in DY3 (over the DY2 baseline).*
Rational: Expansion of primary care with an increase in physicians is crucial to the healthcare foundation in the surrounding community. When an area's key deterrent to a lack of services is the amount actually available, then no matter how innovative processes are a physician simply has a threshold, and the only way to improve is the employment of an additional physician.

Although funding is limited, the value of a Diabetes educator will be greater than the cost if implemented correctly in the rural clinic. Milestone 1 & 2 are both "P-5" so that there is time allowed to recruit both a physician and a qualified educator in DY2. Because of the difficulty in recruiting Diabetes educators, there will be additional time required in the pursuit of recruitment and establishment in Starr County. It may seem unorthodox to have two of the same milestones in the same year, but there is simply no other way to list them [P-5] unless one of them is drafted as a custom milestone [P-X].
Due to the nature of this project, improvement milestones can be implemented rather quickly identifying patient satisfaction/value as a cornerstone of this project (I-2). As satisfaction increases, it will serve as a good indicator that the project planning was done correctly and we can continue to evolve and progress in the right direction. Once in operation and processes have been streamlined in the clinic with the addition of the physician and educator, improvement milestone I-3 (Increase primary care clinic volume of visits and evidence of improved access for patients seeking services) can be documented to demonstrate the increase in volume and quality of care.
Improvement milestone I-3 was also added in the project once more in DY5 with a focus on the diabetic population (this is accomplished with diabetic educator and increase in primary care). Special attention will be provided to diabetic pregnant woman as they are automatically deemed "high-risk". The over-all goal of the provider addition will be to increase volume of patients, but also provide education, prevention, and maintenance of diabetic conditions to a community where this wasn't readily available before. This will be geared towards helping those at high-risk control their HbA1c levels, and help ensure others don't become "high-risk" to begin with.
The project option as a whole has set core project components: expand primary care clinic space, expand primary care clinic hours, and expand primary care clinic staffing. As a rural health clinic, funding and space is already at a maximum. The only options left are to expand the primary care hours, and to expand the primary care clinic staffing. Hours will be expanded upon according to necessity once the staffing has been increased with the family practice practitioner to enhance availability.

Related Category 3 Outcome Measures:
The recruitment of a family physician, in an area where services are denied due to the sheer volume of necessity, plays to the outcome measure of OD-1 (Primary Care and Chronic Disease Management). Of course access to quality care caters to OD-2 with PPAs being a concern when there is a large number of uninsured and Medicaid patients being provided for in this rural clinic. The fact remains that prior to the addition of this physician, 70% of patient services were rendered by a NP, so even with the addition

of an MD, the NP service percentage will still be relatively high. For this reason, **OD-1.IT-1.10 (HbA1c control)** will be a perfect for this type of clinic.
IT-1.10, which focuses on getting HbA1c levels under control, will be a suitable improvement target with the incorporation of the diabetes educator reaching out to the groups of patients helping them understand the basics of nutrition and importance of medication. This will be a team effort where the MD and NPs will play a vital role in further educating the patient on basic necessities during the one-on-one visit time.
Starr County is one of a handful of areas where diabetes rates are exceptionally high. A full 50% of adults over the age of 35 in Starr County either have diabetes themselves or have a first degree relative with the disease.[56] This improvement target (IT: 1.10) will focus on decreasing HbA1c levels, decreasing the risk for diabetic complications, helping to bring the disease under control, and creating a high value to the community. To accomplish this goal, clinic measure's will include: group classes for diabetic literacy, segmented one-on-ones with NP's and/or MD for diabetic women, a follow-up plan, and pregnancy monitoring to encourage improvement in HbA1c levels increasing the percentage for healthy fetus development. Not only will this measure capture the lives of high risk diabetics, it will also create an environment of prevention for a generation that is yet to come.

Relationship to other projects: Being that this county is relatively isolated with the next major hospital 51 minutes away57, the projects associated with this participating provider, Starr County Memorial Hospital, all tie into each other by increasing availability over all with increased staffing capacity.
Project 136332705.1.2, increasing surgery capacity, has a goal of preventing conditions and timely access to general surgery services. It also includes a diabetic foot exam component it in as well to help prevent conditions from developing. These two projects will support each other in such a way that follow ups and referrals will be sent to-and-from one another each with the same goal in mind.
This project directly supports the emergency department throughput project, 136332705.2.1, by increasing access to services, employing continuous quality improvement, and increasing the overall quality of life for the patients that utilize the rural health clinic's services enabling them to keep healthy and out of the emergency room.
Project Valuation: This project is valued around prevention of costly complications, admissions, and readmissions that come with a lack of family care specialty access for the community. Diabetic education for the community is another value creating initiative by supplying the diabetic community with an opportunity to self-manage their condition which reduces probabilities of advancing conditions and overall admissions. This expansion of services will focus on diabetic and Ob care, with a goal of decreasing pregnancy complications such as premature birth.
The nation as a whole spends on average $13,000 on each person with diabetes, compared to $2,500 for those who don't, and incur 2.4 times higher medical expenses.[58] Starr County is one of a handful of areas where diabetes rates are exceptionally high. A full 50% (30,000+ people, 36% of which are uninsured) of adults over the age of 35 in Starr County either have diabetes themselves or have a first degree relative with the disease.

[56] http://txtell.lib.utexas.edu/stories/d0006-full.html
[57] http://maps.google.com/maps?q=south%20texas%20uninsured&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a&um=1&ie=UTF-8&hl=en&sa=N&tab=wl
[58] http://www.foh.dhhs.gov/NYCU/diabetescost.asp

Studies show that HbA1c levels over 7% (diabetic) have been associated with preterm delivery.[59] The value output created by helping to decrease these numbers becomes evident when the cost of just one premature baby averages $49,000[60] in the first year of life. When there is prevalence of poor diabetes control, prematurity rates can range from 30-50 percent. Prematurity may contribute to problems such as cerebral palsy, vision problems, learning disabilities, and developmental delays. To decrease these numbers means to save on long-term costs and provide an increased quality of life for the mother and child[61]. In 2009, Starr County birthed 150 low birth weight babies, each of which are at greater odds of having birth defects such as respiratory distress syndrome, bleeding in the brain, necrotizing enterocolitis, and an increased chance of developing diabetes and heart disease later in life[62]. If even half of these babies fall into the $49,000 per first year of life demographic, that will result in a $3.67 million dollar strain on the healthcare system. An increase in access to OB care and Family Practice through the establishment of a new additional physician at the rural health clinic and the hospital will help reduce those numbers and provide a normal life for these newborns.

This project is pushing for a cultural change with the educational component being offered to the community. With an increase in Ob/Gyn availability, over a 1000 (approximate average number of births from Starr County) women a year will have increased access to more adequate follow-up care. When combined with the category 3 initiative of lowering the HbA1c levels, possibility preventable conditions such as birth complications can be reduced. A combination of Ob follow-up access, a diabetic stabilizing initiative, and an education component, the potential of the project becomes invaluable to the community at large.

[59] http://care.diabetesjournals.org/content/27/12/2824.full

[60] http://www.cnn.com/2009/HEALTH/03/17/premature.babies/index.html

[61] http://www.ncbi.nlm.nih.gov/pubmed/11398596

[62] March of Dimes. http://www.marchofdimes.com/baby/premature_lowbirthweight.html

136332705.1.1	1.1.2	1.1.2	Increase Obstetrical and Family Medicine Access
Starr County Memorial Hospital			136332705
Related Category 3 Outcome: OD1	136332705.3.1	IT-1.10	Diabetes Care: Poor Hba1c Control (>9%)

Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-5) Hire additional primary care provider **Metric 1 (P-5.1)** Documentation of increased number of providers and staff and/or clinic sites. **Baseline/Goal:** Addition of 1 extra physician; 5% unique patient consultation at end of DY3 over baseline of patients consulted by a physician in FY11. **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. *Approximate incentive payment of Milestone 1:*	**Milestone 3 [I-27]:** Patient satisfaction with primary care services **Metric [I-27.1]:** Patient Satisfaction scores, specific ranges and items to be determined by assessment tool scores. **Baseline/Goal:** Create baseline at the end of DY2 for DY3 comparison: goal will be an average increase of satisfaction to start with and adjust percentage improvement or maintenance from new baseline. **Data Source:** CG-CAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. *Approximate incentive payment of Milestone 3:*	**Milestone 5 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. -With the availability of a diabetic educator, the patient demographic that will be focused on by the additional physician will be those that are diabetic. With this physician also having OB capabilities, further emphasis will be granted to those seeking these specific services to maximize the availability of the specific services that this physician is capable of. **Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline) **Goal:** 10% increase of consultations over the DY2 baseline	**Milestone 6 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. -With the availability of a diabetic educator, the patient demographic that will be focused on by the additional physician will be those that are diabetic. With this physician also having OB capabilities, further emphasis will be granted to those seeking these specific services to maximize the availability of the specific services that this physician is capable of. **Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline) **Goal:** 15% increase of consultations over the DY2 baseline **Data Source:** Claims history for reporting period; EMR registry (if

$164,052.50 **Milestone 2: (P-5):** Hire additional primary care staff (educator) **Metric 1:** (P-5.1): • Documentation of increased number of providers and staff and/or clinic sites. • Contractual documentation of diabetes educator **Baseline/Goal:** Recruit a diabetic educator by mid-fiscal year allowing adequate time to create a baseline of average number of patients attending class per month at the end of DY2 **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	***$185,027.00*** **Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. -With the availability of a diabetic educator, the patient demographic that will be focused on by the additional physician will be those that are diabetic. With this physician also having OB capabilities, further emphasis will be granted to those seeking these specific services to maximize the availability of the specific services that this physician is capable of. **Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline) **Goal:** 5% increase of consultations over the DY2 baseline **Data Source:** Claims history for reporting period; EMR	**Data Source:** Claims history for reporting period; EMR registry (if applicable) *Approximate incentive payment of Milestone 5:* ***$369,720.00***	applicable) *Approximate incentive payment of Milestone 6:* ***$285,670.00***

documentation. (Sign-in Documentation and/or billing code on consultation) *Approximate incentive payment of Milestone 2:* ***$164,052.50***	registry (if applicable) *Approximate incentive payment of Milestone 4:* ***$185,027.00***		
Year 2 Estimated Outcome Amount: $328,105.00	***Year 3 Estimated Outcome Amount: $370,055.00***	***Year 4 Estimated Outcome Amount: $369,720.00***	***Year 5 Estimated Outcome Amount: $285,670.00***
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $1,353,550.00			

Starr County Memorial Hospital

Increasing Surgery Availability

136332705.1.2

Provider:	Starr County Memorial Hospital (SCMH) is a major healthcare provider in Starr County serving as a critical access hospital for the region. The nearest acute care hospital is over 50 minutes away, so the community turns to SCMH for a high percentage of their medical needs.
Intervention(s): Clearly state the intervention(s).	SCMH will contract with a full time surgeon and two operating room (OR) technicians so that they can fully utilize their current facilities and expand availability of this service line to the Starr County population when it's needed.
Need for the project: A brief description of the need for the project including data as appropriate.	Currently SCMH can only offer general surgery two days out of the week. With the nearest capable facility being 50 minutes away, minor emergencies can escalate into more serious conditions. Being able to increase capacities for general surgery will be in response to a need for healthcare in the right place at the right time.
Target population:	The target population will be all of Starr County since SCMH is a critical access hospital, and the only facility capable of general surgery. The baseline will be collected from FY2011 to see how many have been turned away, and how many were able to receive services, and move forward from there once adequate staffing is in place. With SCMH servicing as a critical access hospital, both Medicaid patients and the indigent will be taken care of as they come seeking services through the emergency department.
Category 1 or 2 expected patient benefits:	Expected benefits for the patients will be an increased access to a critical service line to any large population. With the nearest availability being at such an inconvenient distance, general surgery access will increase patient satisfaction with the hospital, and held decrease possible conditions that come with conditions needing surgery.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	Each improvement target (IT) seeks constant quality improvement. IT-1.13: Patient foot exam – Starr County has a high percentage of diabetic population. For this reason a simple foot exam can help prevent many long-term conditions and possible amputations. IT-4.4: Surgical Site Infections (SSI): IT-4.4 will be in place to help ensure that patients receiving the services will not come out with new conditions as a result of a SSI. Reduction of SSI will be crucial in SCMH efforts of constant quality improvement.

Expand Surgery Service Capacity [1.9.3]

Starr County Memorial Hospital [136332705]

Unique RHP Project ID Number: 136332705.1.2

Project Description:
Description: Starr County Memorial Hospital wants to contract with a general surgeon in an effort to provide full-time surgical services in their facility for the community. Starr County currently has two operating rooms (OR) and would like to maximize their utilization. As this service becomes readily available, processes and protocols regarding full-time general surgery will be streamlined to increase efficiency. To create increased utilization of current resources such as the two operating rooms, two more OR techs will need to be staffed as well as a CRNA. The addition of these support staff positions will allow surgical services to be rendered simultaneously in both operating rooms creating further utilization and turnover while maintaining quality.
Goals and Relationship to Regional Goals:
Currently, surgical services availability is limited to two days out of the week within Starr County Memorial Hospital. With the addition of a full-time general surgeon and support staff this service line will be available to the community five days out of the week.
The goals of the project are:

- Increasing surgery availability from 2 days a week to 5 days a week
- Increasing patient satisfaction regarding surgical accessibility.
- Improving on PPCs and PPRs by providing foot exams for all diabetic patients that receives services in the surgery department.

This project meets the following regional goals:
This project aligns itself with the regional goal of increasing healthcare availability to the indigent and Medicaid population. The emergency department serves as the primary access point for those seeking emergency primary and specialty type care for those that cannot receive it in a traditional outpatient setting. With an increase in general surgery coverage at Starr County Memorial Hospital patients will have to access to surgical services locally thereby reducing unnecessary transport costs to other higher level of care settings and leading to a reduction in preventable conditions and readmissions through right time, right place, and right manner healthcare services.
Community needs that are met:
CN5 – Access to Healthcare Services/Preventive healthcare
Challenges/Issues: Specialty care such as general surgery is seen as generally out of reach in this community. This is a well known circumstance by the physician community and by the Starr County population. For this reason many elective surgeries are automatically referred and sought after out of the county. As of right now Starr County Memorial Hospital is able to provide this service only two days out of the week. Due to the lack of services, the emergency department is forced into transferring, on average, 6 patients per week to other facilities[63] that can handle the procedure due to there being surgeon availability (Nearest hospital is 51 minutes away[64]). This results in a facility that is capable of providing services if only it had the proper staffing to do so. Due to these circumstances, capacity is going to waist, the patients aren't able to be seen in a timely manner, quality is strained, and patient satisfaction decreases.

[63] Starr County Proprietary Information

[64] http://maps.google.com/maps?q=south%20texas%20uninsured&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a&um=1&ie=UTF-8&hl=en&sa=N&tab=wl

Issue Resolution: As stated before, the general surgery service has only been available for two days out of any given week. This project will recruit the necessary staff to increase that accessibility to five days allowing more patients to be seen more often. This vast improvement of access will enhance goals towards PPAs, PPCs, and patient satisfaction with the right care being given at the right time.

Patient Impact:

Currently, the Starr County community knows that SCMH does not offer a full time surgeon in house, so they go out of the county to obtain elective surgical procedures. On average, SCMH transfers six emergency patients per week for surgical services elsewhere. The closest acute-care facility that can accommodate the majority of these transfers is 46 and 51 miles away.

With the current surgical availability, SCMH is able to provide three (3) cases a week with a part time surgeon that is typically available one day out of the week. The community as a whole generally does not turn to SCMH for their surgical needs, and the physician community typically doesn't refer to the hospital as well. For that reason, this project will have to ramp up over each year until adequate referral patterns are established and more patients receive their surgical care within Starr County and not elsewhere.

With the additional staffing through this project, the hospital will be able to vastly increase its capacity of possible surgical cases. Referral patterns will have to be established within the physician community, the rural health clinics, and patient awareness will need to be stimulated to increase the volumes of services provided through SCMH. Once awareness and physician confidence increases with time, so will the volumes for surgical care within SCMH.

Through the project implementation process described above, SCMH aims to increase patient surgical encounters to 5 cases per week in DY3, 6 cases per week in DY4, and 8 cases a week in DY5. With these goals in place the targeted impact on the community will be approximately **900+** cases from DY3-DY5, or over a 100% increase in surgical services rendered within Starr County (not including the follow up care that will now be available for the community). The major impact on the community this project represents is a vast increase in access to needed surgical services and reducing related PPAs, PPRs, and PPCs.

Expected Outcomes:

This project will build and fortify the long-term surgical care capacity of a growing, but underserved community with grave health disparities. Through the establishment of surgical services at SCMH five days out of the week, fewer patients will be transferred out of the community for care services reducing preventable conditions. As the entire hospital focuses on continuous quality improvement and increased patient throughput, the surgical department will continue to improve its processes geared towards quality, safety, and overall patient satisfaction. Once the baseline has been set in DY2, there will be a measurable increase incare accessibility in each coinciding year. These goals will ensure constant improvement in healthcare access through the practice of effective, safe, and quality surgical healthcare for the Starr County community.

Rational:

Starr County Regional Hospital chose this project as a necessity due to the deficiency of a full-time, general surgeon servicing their facility. As the sole community provider in the county, the lack of full-time surgery capacity is unsustainable and costly. In prior years these services were only offered two days out of the week, and as of recent they had to be scaled back to only day a week on average. Due to these circumstances an average of 6 cases per week are being referred out to other facilities[65]. The community as a whole generally

[65] Starr County Proprietary Information

does not turn to SCMH for their surgical needs, and the physician community typically doesn't refer to the hospital as well.

To adequately portray the implementation of this project in accordance to the category 1 project guidelines, the necessary milestones and improvement targets were selected. From the specialty care access plan in DY2, to ensuring there is a volume increase of this service line (DY3-DY5), each component has been assigned properly. Through the opportunities presented by increasing the surgical line's resources and availability community need 5 will be improved on by improving specialty care accessibility. It will be a good of SCMH to have the physician and patient community eventually start to turn to SCMH as their primary source for inpatient surgical needs.

Milestones:

- P-12: Implement a specialty care access plan – This is a crucial element to the project where all the stakeholders are able to see the importance of the project and derive its true value.
- P-3: Collect baseline data for waiting times, backlog, and/or return appointments – Baseline data will be essential for creating goals that demonstrate an increase of availability to the community.
- I-22: Hire additional surgeon & support staff – Obtaining the best human resources possible will be paramount to the entire project regarding patient satisfaction and quality outcomes.
- I-23: Increase volume of visits and evidence of improved access for services. – This milestone represents the primary focus of the entire project. Increasing the availability of the surgical service line which will be demonstrated by the increase service volume.
- I-27: Patient satisfaction with primary care services. – Although the primary objective is increasing the accessibility of specialty care for the community, delivering patient satisfaction with safe practices and quality outcomes will still be very important. The insight gathered by the assessment tools will be key in how SCMH approaches any continuous quality improvement.

Project Components:

A.) *Increase service availability with extended hours:* The purpose of this project will be to create a full-time availability to our surgical service line within the hospital. Currently the availability is only two (2) days out of the week. With implementation of this expansion, we are projecting to have an availability of five (5) or more days a week.

B.) *Increase number of specialty clinic locations:* Starr County Memorial Hospital is considered a sole community provider (due to isolation, SCMH is the sole source of inpatient hospital services[66]). As such, we serve as the primary health care provider for many indigent and Medicaid patients. Project 136332705.2.1, Improving ED processes, is also in implementation in parallel to the surgery expansion efforts, so there will be a greater need for our facilities to have increased surgery capacity with the expected increase of patient flow within our own emergency department.

C.) *Implement transparent, standardized referrals across the system:* We are in a unique position where our hospital is also affiliated with the rural health clinic (there is another project being implemented, 136332705.1.1, which expands its capacity). As patients are being seen in our surgery facilities and require follow-up services, a referral pattern will be created with the rural health clinic as needed. These patterns will be monitored through claims history and EMR availability.

[66] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/solecommhospfctsht508-09.pdf

D.) *Conduct quality improvement for project using methods such as rapid cycle improvement:* Although this aspect will not be reflected within the milestones of the project, SCMH will be going through continuous quality improvement through the ED process improvement program. This program will be looked at to be applied across multiple functions of the hospital according to necessity. With surgery services moving from part-time to full-time, methods of implementation for "rapid cycle improvement" is still to be determined. Documentation of the expansion plan will detail the methods used to help ensure an efficient use of the newly added staffing recourses.

Related Category 3 Outcome Measures:

With such an integral part of the health care system having such limited availability in Starr County Memorial Hospital, frustrations throughout the community arise when minor surgical procedures have to be referred out to another facility that is over 45 minutes away[2]. It can be understood why patient satisfaction would be low without timely care, appointments, and information. With suppressed patient satisfaction, disenfranchised patients stop coming in for the service unless it's an emergency and we are able to service their needs. The category 3 outcome measures that are being implemented through this project are the following:

- IT-4.4 Surgical site infections (SSI) rates: With the increase of surgical availability by an additional three days out of the week, chances of SSIs may increase due to an increase in surgical services. This measure was put into place to focus on continuous quality improvement, creating feedback of appropriate data to surgeons, in an effort to keep the SSI percentage low. This will support an overarching goal of reducing PPCs and PPRs.
- IT-1.13 Diabete care Foot exam – NQF 0056: Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. In Starr County 50% of the population is affected by diabetes which can lead to serious and potentially fatal health complications. With that in mind, and with the addition of a full-time surgeon, it would benefit the patients to implement **IT-1.13** into the mix of the Category 3 outcomes. A simple foot exam will incorporated into the consultation due to its potential for reducing complications. Catching a wound in its early stages for a diabetic can help prevent some serious complications that can lead to further hospital readmissions.

Relationship to Other Projects:

The expansion of surgical services is tied into the ED throughput project [136332705.2.1] for Starr County Memorial Hospital. This project's relationship to project 136332705.2.1 is such that efficiencies of throughput time throughout the hospital and emergency department will help build overall hospital capacity for surgical service expansion while allowing for continuous quality improvement.

Due to the geographic isolation of Starr County, the projects that Starr County Memorial Hospital has selected leave limited opportunities for learning collaborative. These projects do increase the availability of healthcare overall for the region, specifically Starr County's population. This will help decrease the amount of patients that have to seek services elsewhere in Hidalgo County harboring a "health care at the right time, at the right place" focus.

Project Valuation:

As a sole community provider in Starr County, Starr County Memorial Hospital (SCMH) serves as the primary care for a large majority of the indigent and Medicaid population. In a population of 60,000+, 36% is uninsured, roughly 50% have Medicaid[67], and SCMH is

[67] Texas Department of State Health Services (2009)

often the only place to turn to for any primary and emergency care. This projects valuation revolves around all the potential cost prevention and that comes with accessible, preventative care. With the increased availability of this service by more than double fewer patients have to be transferred out in case of emergencies and follow up care. As this service line becomes more effectively utilized, patients will have surgical care at the right time in the right setting helping prevent costly conditions that are associated with surgical complications such as infections and readmission. Additionally, transportation costs are reduced as well, where a patient has to be transferred out for a procedure that could have been handled at the outpatient clinic or hospital. Another valuation factor that must be taken into consideration is that Starr County has a 50% rate of individuals older than 35 years that are directly affected by diabetes either by having the disease or by being a first-degree relative of a diabetic[68]. When this circumstance is combined with a lack of surgical availability and decreased wound healing capabilities that plague uncontrolled diabetics[69], ulcers, and minor wounds in general can lead to costly conditions and possible hospital admissions. High value to cost is placed on the category 3 improvement target 1.13, diabetic foot exams as well. With surgical capacities increased, and the high cost potential for the diabetic population, any minor wounds can be addressed on the spot preventing potentially costly condition.

[68] US National Library of Medicicine National Institutes of Health - http://www.ncbi.nlm.nih.gov/pubmed/6637993

[69] http://www.internurse.com/cgi-bin/go.pl/library/abstract.html?uid=9598

136332705.1.2	1.9.3	1.9.3	Increase Surgical Care Availability
Starr County Memorial Hospital			136332705
Related Category 3 Outcome: OD1, OD4, OD6	• 136332705.3.2 • 136332705.3.3	• IT-1.13 • IT-4.4	• Increased access to quality surgical services • Surgical Site Infections Rates (SSI)

Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-12) Implement a specialty care access pan to include such components as state of problem, background and methods, findings, implication of findings in short and long term, conclusions **Metric (P-12.1)** Documentation of specialty care access plan **Baseline/Goal:** Assess complications and value lost of not adding an additional surgeon. **Data Source:** Documentation of provider plan. ***Milestone 1 Estimated Incentive Payment: $214,422.67*** **Milestone 2: (P-3)** Collect baseline data for wait times, backlog, and/or return appointments **Metric (P-3.1)** Establish baseline for performance indicators **Data Source:** Average wait time and patient transfer numbers for FY2011 (baseline) ***Milestone 2 Estimated Incentive***	**Milestone 4 [I-23]** - Increase volume of visits and evidence of improved access for services. **Metric [I-23.1]** documentation of increased number of visits. Demonstrate improvement over DY2. (total number of visits for reporting period) **Goal:** 5 general surgical cases per week – 260/year **Data Source:** Registry, HER, Claims ***Milestone 4 Estimated Incentive Payment : $370,055*** **Milestone 5 [I-27]:** Patient satisfaction with primary care services **Metric [I-27.1]:** Patient satisfaction scores: Ave. reported patient satisfaction scores. Specific ranges and items to be determined by assessment tool scores.	**Milestone 6 [I-23]** Increase volume of visits and evidence of improved access for services over DY3 *(Continuous Improvement)* **Metric [I-23.1]** documentation of increased number of visits. Demonstrate improvement over DY3 if thresholds haven't been met. (total number of visits for reporting period) **Goal:** 6 general surgical cases per week – 312/year **Data Source:** Registry, HER, Claims ***Milestone 6 Estimated Incentive Payment: $385,253.50*** **Milestone 7 [I-27]:** Patient satisfaction with primary care services – Improvement over DY3 **Metric [I-27.1]:** Patient satisfaction scores: Ave. reported patient satisfaction scores. Specific ranges and items to be determined by assessment tool scores.	**Milestone 8 [I-23]** Increase volume of visits and evidence of improved access for services over DY4 *(Continuous Improvement)* **Metric [I-23.1]** documentation of increased number of visits. Demonstrate improvement over DY4 if thresholds haven't been met. (total number of visits for reporting period) **Goal:** 8 general surgical cases per week – 416/year **Data Source:** Registry, HER, Claims ***Milestone 8 Estimated Incentive Payment: $309,476.50*** **Milestone 9 [I-27]:** Patient satisfaction with primary care services – Improvement over DY4 **Metric [I-27.1]:** Patient satisfaction scores: Ave. reported patient satisfaction scores. Specific ranges and items to be determined by assessment tool scores. ***Numerator:*** sum of all survey scores

Payment: $214,422.67 **Milestone 3: (I-22):** Hire additional surgeon & support staff for Starr County Memorial Hospital **Metric 1:** (P-22.1): Increase in number of providers and availability of surgical specialty in Starr County Memorial Hospital. **Numerator:** Increase of number of specialist providers in targeted specialty **Denominator:** Number of providers in specialty at the baseline. **Baseline/Goal:** Baseline will be created by how many patients were turned away on average per month in FY11 **Data Source:** Documentation of services rendered & staff contractual documentation ***Milestone 3 Estimated Incentive Payment: $214,422.66***	***Numerator:*** sum of all survey scores ***Denominator:*** Number of surveys completed **Data Source:** CG-CAHPS41 or other developed evidence based tool, available in formats and language to meeting patient population. ***Milestone 5 Estimated Incentive Payment: $370,055***	***Numerator:*** sum of all survey scores ***Denominator:*** Number of surveys completed **Data Source:** CG-CAHPS41 or other developed evidence based tool, available in formats and language to meeting patient population. ***Milestone 7 Estimated Incentive Payment: $385,253.50***	***Denominator:*** Number of surveys completed **Data Source:** CG-CAHPS41 or other developed evidence based tool, available in formats and language to meeting patient population. ***Milestone 9 Estimated Incentive Payment: $309,476.50***
Year 2 Estimated Milestone Bundle Amount: **$643,268.00**	Year 3 Estimated Milestone Bundle Amount: **$740,110.00**	Year 4 Estimated Milestone Bundle Amount: **$770,507**	Year 5 Estimated Milestone Bundle Amount: **$618,953**
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $2,772,838.00			

Tropical Texas Behavioral Health (TTBH) - Category 1:

- ***Tropical Texas Behavioral Health***
- ***Expand Primary Care Capacity***
- ***138708601.1.1***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will increase behavioral heath care infrastructure and capacity through the expansion of clinic space, staffing and transportation services at three TTBH clinics serving communities throughout the Rio Grande Valley, and serve at least 900 new individuals including persons who meet the state's clinical eligibility criteria to receive ongoing behavioral health services but who are on waiting lists due to existing resource limitations.
Need for the project: A brief description of the need for the project including data as appropriate.	In FY 2012, an average of 820 individuals in the TTBH catchment area (adults and youth combined) who were eligible for ongoing routine behavioral health services were on waiting lists each month due to resource limitations.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is adults and youth in our local service area who meet clinical and state eligibility criteria to receive ongoing routine behavioral services but who are on waiting lists due to their uninsured status. At least 900 new individuals will be served by DY5. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to provide necessary routine behavioral health services to at least 100 new individuals in DY2, 250 additional new individuals in DY3, 275 additional new individuals in DY4 and 275 additional new individuals in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
1.1 Expand Primary Care Capacity
Unique RHP Project identification number: 138708601.1.1
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 1.1.2 Will expand behavioral health service capacity at all TTBH clinic locations to provide services to individuals currently on TTBH waiting lists.

Project Description:
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. TTBH will expand capacity to deliver additional services primary to our mission as the Local Mental Health Authority (LMHA) for the Rio Grande Valley, namely community-based services addressing the behavioral health needs of individuals who meet criteria for a diagnosis of severe mental illness, to 900 new individuals by the end of the waiver period. The project's specific focus is to expand capacity for the delivery of psychiatry, counseling, case management and rehabilitative services to people with mental health diagnoses that meet the state's eligibility criteria to receive routine behavioral health care, but who are not being treated due to resource limitations. TTBH will also expand access to transportation services with this project.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):
Project goals:

- Expanded behavioral health service capacity at TTBH clinics across the Valley through the expansion of clinic space and staffing.
- Expanded availability of transportation to appropriate levels of care, in particular, for indigent persons in need of routine behavioral health services.
- Provision of behavioral health services to at least 900 new individuals including those meeting the state's clinical eligibility criteria to receive ongoing behavioral health services but who are currently on waiting lists due to resource limitations.

- Increased access to the right care at the right time in the right setting.
- Increased utilization of routine behavioral health services.
- Improved health outcomes and experience of care.
- Decreased need for costly emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

This project meets the following regional goals:

- Improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services, including behavioral health services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access to and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and inappropriate emergency department utilization, help prevent admission/readmission to inpatient psychiatric care and improve patient satisfaction.

Challenges and How Addressed:

Challenges:

- Appropriate space for additional behavioral health staff and persons served.
- Recruitment and retention of behavioral health providers.
- Equipment necessary for expansion of services at all clinic locations, including vehicles for expanded transportation.

Addressed by:

- Continued progress on the planned expansion of three outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Marketing strategies for recruitment.
- Recruitment incentives through the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.
- Tuition reimbursement opportunities.
- Re-location reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5-Year Expected Outcome for Provider and Patients:

TTBH will expand behavioral health service capacity to enhance access to the right care at the right time in the right setting and improve behavioral health outcomes and the experience of care for

those served. By Waiver Demonstration Year (DY) 5, TTBH will expand behavioral health service capacity at our three largest clinic locations across the Valley through the expansion of clinic space and staffing, and provide services to at least 900 new individuals, including those meeting the state's clinical eligibility criteria to receive ongoing behavioral health services but are on waiting lists due to resource limitations. TTBH will admit 100 new individuals from the waitlists in DY2, 250 additional individuals in DY3, 275 additional individuals in DY4 and 275 additional individuals in DY5. Over the term of the waiver, TTBH will significantly reduce the number of people waiting to access comprehensive and culturally sensitive preventative behavioral health services, resulting in increased utilization of routine behavioral health services, improved health outcomes and experience of care, and decreased need for more costly emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

Starting Point/Baseline:
In FY 2012, an average of 820 individuals in the TTBH catchment area (adults and youth combined) who were eligible for ongoing routine behavioral health services were on waiting lists each month due to resource limitations.

Rationale:
In 2003, Texas began rationing state-provided mental health services in order to address budget shortfalls. Ongoing mental health services were targeted primarily to people with schizophrenia, bipolar disorder and major depression. Those with other illnesses, such as anxiety and post-traumatic stress disorder, and the uninsured, were placed on waiting lists for months, or longer, awaiting access to essential services including medication, therapy and substance abuse care. As a result, according to the Department of State Health Services (DSHS), more than 6,800 adults and children with schizophrenia, bipolar disorder and major depression were on waiting lists for community mental services statewide in 2009. This number peaked at 10,354 in 2010, and has hovered at a quarterly average of over 9,400 people waiting for necessary services since then.

TTBH has expanded our array of services and service capacity since 2007 through state and alternative funding sources, and consistently exceeded our state-mandated monthly targets for the number of adults and children served by an average of 115% and 475%, respectively, during the same period. In spite of this, similar to statewide trends, TTBH's waiting lists for adults and children have risen steadily since 2005, peaking at approximately 850 combined individuals in 2010, and have remained relatively constant in the years since.

Delays in the ability to access appropriate behavioral health care have been linked to disproportionately high rates of a range of negative and expensive consequences for people diagnosed with mental illness including disability, unemployment, homelessness, substance abuse, incarceration, hospital emergency department visits, psychiatric and medical inpatient hospitalization, preventable complications of co-morbid medical illnesses and suicide. From a financial perspective, evidence suggests that delays in accessing community-based mental health services can translate to significantly greater costs to intervene with an individual with mental illness in other, often less appropriate, settings. In their 2011 study of proposed budget cuts to community-based mental health services, Health Management Associates found the average per day cost of community-based services is $12 for adults and $13 for children, as compared to $401 for a State

Hospital bed, $137 for a jail bed for an inmate with mental illness, and $986 for an emergency room visit.

TTBH's planned expansion of service capacity will also address longstanding transportation barriers to service access. Many residents of the Rio Grande Valley, in particular those seeking behavioral health services, experience significant barriers to reliable transportation due to the disabling effects of poverty and the complications associated with using public transit systems including service coverage areas and schedules that limit users' ability to get where they need to go when they choose. Individuals with mental illness often don't know about available transportation opportunities or how to use them, and uninsured residents with mental illness aren't eligible to participate in transportation programs that are limited to people with Medicaid or other insurance. Among the areas of unmet public transportation needs identified by the Lower Rio Grande Valley Development Council in its 2011 Human Service-Public Transit Coordination Plan were insufficient fixed-route public transportation vehicles for the more than 600,000 residents of the Mission, McAllen, Edinburg, Pharr area; difficulty using the existing transit systems to travel from one city to another; lack of regularly scheduled transit services for those residing in the many low-income colonias throughout the Valley; the extra burden on existing transit systems from the growing number of Mexican nationals using the systems and inadequate availability of transit from rural areas like Willacy County to cities like Harlingen.

In July 2012, 2150 adults served by TTBH responded to survey questions concerning patterns of health care use and ability to access care. Forty three percent (43%) reported that they lacked health insurance; more than 25% indicated their home was 10 or more miles from the nearest medical facility; 30% reported that they had only occasionally reliable transportation or none at all; only 3% reported using public transportation to get to their appointments; and although a majority of respondents said they relied on personal vehicles or the support of family or friends to get to their appointments, nearly half (48%) indicated they did not access routine checkups or preventative care on a regular basis.

Project Components:
We propose to meet the required project components a) Expand primary care clinic space and c) Expand primary care clinic staffing. TTBH will increase behavioral heath service infrastructure and capacity through the expansion of clinic space and staffing at our 3 largest clinics in the Rio Grande Valley. Insofar as TTBH stakeholder input does not support extended operating hours at our behavioral health clinics and doing so would require a more comprehensive and expensive expansion of staffing than is currently planned, TTBH will not extend our clinic hours at this time. Through the expansion of our behavioral health service capacity including expanded clinic space and staffing and the implementation of contracted services to increase transportation to appropriate care for low-income and uninsured persons, TTBH will significantly reduce our waiting lists, increase access to and utilization of evidence-based preventative health care services, increase opportunities for recovery and wellness, and decrease avoidable costs associated with delays in accessing care.

Milestones and Metrics:
The following milestones and metrics were chosen for TTBH's project to Expand Primary Care Capacity based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-X (P-X.1)
- Improvement Milestones and Metrics: I-12 (I-12.1)

Unique Community Needs Identification Number:
This project addresses community need CN. 2, related to shortage of behavioral health professionals and inadequate access to behavioral health care.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
By increasing service capacity at our clinics across the Lower Rio Grande Valley, this project will expand on the accomplishments of our existing behavioral health care delivery system including maximizing the use of best practices. In so doing, it will better ensure that the system is adequately developed to address the routine behavioral health care needs of our rapidly growing, yet historically underserved service area and reduce the unnecessary use of costly emergency psychiatric interventions.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to Other Projects:
Expanding behavioral health care capacity is fundamental to the success of related projects to expand and enhance TTBH's behavioral health services including projects to provide necessary behavioral health services to an increasing number of individuals diverted from the criminal justice system (Project 138708601.2.2), to persons with co-occurring substance use disorders (Project

138708601.1.2) and/or to persons with co-occurring Intellectual and Developmental Disabilities (IDD) (Project 138708601.1.3).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, to develop and participate in a learning collaborative related to our respective projects to expand behavioral health care services.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY5 is calculated to be $7,352,230.
- Homelessness: Of our current mental health population served, 5% were identified as at risk or homeless by either our PATH (Projects for Assistance in Transition from Homelessness) or Supported Housing programs. According to a two-year University of Texas survey of homeless individuals, each homeless person costs taxpayers $14,480 per year. The overall value is calculated to be $1,214,191.
- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678. The overall value is calculated to be $1,047,854.
- Emergency Room: Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of $986 per visit and a total emergency room valuation of $287,522.
- Transportation: With transportation readily accessible to our high use clients we anticipate of seeing a reduction not only in hospital and emergency room visits, but homelessness and jail diversion as well. The overall value is calculated to be $3,864,117
- Overall Project Valuation: The total project valuation is $13,765,914.

Project	***Project Option***	***Project Component(s)***	***Expand Primary Care Capacity***
138708601.1.1	***1.1.2***	***1.1.2.a, 1.1.2.c***	
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: 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 is 0. Goal is to develop a plan for the expansion of service capacity including building construction and renovation, purchase of necessary equipment and recruitment, hiring and training of staff. • Data Source: Documentation of work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,708,275.66 **Milestone 2** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to	**Milestone 4** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Add 250 new individuals (above DY2) from waiting lists into services. • Data Source: MBOW Waiting List reports. Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,517,080 **Milestone 5** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 5 Estimated Incentive Payment *(maximum amount):*	**Milestone 6** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Add 275 new individuals (above DY3) from waiting lists into services. • Data Source: MBOW Waiting List reports. Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,599,830 **Milestone 7** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 7 Estimated Incentive Payment *(maximum amount):*	**Milestone 8** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Add 275 new individuals (above DY4) from waiting lists into services. • Data Source: MBOW Waiting List reports. Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,203,633.50 **Milestone 9** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 9 Estimated Incentive Payment *(maximum amount):*

Project	***Project Option***	***Project Component(s)***	***Expand Primary Care Capacity***	
138708601.1.1	***1.1.2***	***1.1.2.a, 1.1.2.c***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,708,275.67 **Milestone 3** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. • Baseline/Goal: In FY 2012, an average of 820 individuals in the TTBH catchment area were eligible for ongoing routine behavioral health services, but were on waiting lists each month due to resource limitations. The goal is to add 100 new individuals from waiting lists into services. • Data Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) Waiting List reports. Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,708,275.67	$1,517,080		$1,599,830	$1,203,633.50

Project	***Project Option***	***Project Component(s)***	***Expand Primary Care Capacity***
138708601.1.1	***1.1.2***	***1.1.2.a, 1.1.2.c***	
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $5,124,827	Year 3 Estimated Milestone Bundle Amount: $3,034,160	Year 4 Estimated Milestone Bundle Amount: $3,199,660	Year 5 Estimated Milestone Bundle Amount: $2,407,267
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $13,765,914			

- ***Tropical Texas Behavioral Health***
- ***Expand Primary Care Capacity***
- ***138708601.1.2***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will increase access to Co-Occurring Psychiatric and Substance Use Disorder (COPSD) services for persons with co-occurring mental health and substance use diagnoses through the addition of twelve (12) COPSD Specialists across our three clinics serving communities throughout the Rio Grande Valley. The project will increase the volume of COPSD service encounters by 45% over our FY 2011 baseline to 1,995 encounters by DY5.
Need for the project: A brief description of the need for the project including data as appropriate.	The prevalence of co-occurring substance abuse and dependence among people with severe mental illness is estimated to be from 30% to as high as 50% depending on psychiatric diagnosis. Our current capacity to serve individuals with co-occurring disorders, in terms of clinic space and specially trained staff, is insufficient to meet the existing COPSD needs of our service population, and this service gap will widen given the high rate of population increase in our service area.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is adults and youth in our local service area assessed with co-occurring substance use and mental health disorders, and in particular, uninsured individuals. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	This project seeks to increase the delivery of COPSD services to at least 1,580 service encounters in DY3, 1,786 encounters in DY4 and 1,995 encounters in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
1.1 Expand Primary Care Capacity
Unique RHP Project identification number: 138708601.1.2
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 1.1.2 Will increase access to Co-Occurring Psychiatric and Substance Use Disorder (COPSD) services for persons with co-occurring mental health and substance use diagnoses through the addition of 12 COPSD Specialists across TTBH's main clinic locations.

Project Description:
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. TTBH will expand behavioral health service capacity at three of our clinic locations across the Valley. The added clinic space will allow us to hire additional staff to include 12 trained Co-occurring Psychiatric and Substance Use Disorder (COPSD) Specialists at TTBH clinics across the Rio Grande Valley: 6 in Edinburg, 3 in Harlingen and 3 in Brownsville, to support the delivery of integrated substance use-related treatment services to increasing numbers of individuals in our target population who struggle with co-occurring substance use disorders. Previously, we have been limited in our capacity to deliver the specialized, evidence-based services to treat the growing numbers of individuals in our target population assessed to have a co-existing substance use issue in addition to persistent mental illness, and have had to prioritize the delivery of COPSD services to those determined to be at highest risk of a poor outcome. This project will increase the availability of specially trained staff to deliver evidenced-based services shown to offer the best hope for improved outcomes to persons with substance use issues that complicate and compound the effects of their mental illness. The project's specific focus is to increase the availability of specialized services limited to individuals with co-occurring mental health and substance use disorders who are not currently receiving the clinically indicated services due to resource limitations, and who cannot be served in an integrated manner unless this specialty service is expanded.

Substance use-related treatment will be tailored to the individual's stage of change and treatment readiness as identified by standardized substance use screening and assessment instruments. The person's assessed motivation for change and treatment readiness will inform the clinician's selection of the evidence-based treatment approach shown to be most effective in helping the individual with co-occurring disorders to engage in, initiate or maintain recovery from substance use/abuse. Treatment modalities will include motivational interviewing, cognitive behavioral therapy, skills training and elements of twelve-step facilitation and peer support. Substance use-related services will be delivered in concert with services to support recovery from mental illness, and will be provided according to an integrated and collaboratively developed person-centered plan. The expansion of COPSD services will result in increased utilization of routine behavioral health services, improved health outcomes and experience of care, and a decrease in the utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees

including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Expanded behavioral health service capacity at TTBH clinics across the Valley through the expansion of clinic space and staffing.
- Expanded capacity and staffing to support the delivery of integrated substance use-related treatment services to increasing numbers of individuals in our region with co-occurring substance use disorders.
- Increased access to the right care at the right time in the right setting.
- Increased utilization of routine behavioral health services.
- Improved health outcomes and experience of care.
- Decreased need for costly emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

This project meets the following regional goals:

- Improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services, including behavioral health services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access to and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and inappropriate emergency department utilization, help prevent admission/readmission to inpatient psychiatric and medical care and improve patient satisfaction.

Challenges and How Addressed:

Challenges:

- Appropriate space for additional behavioral health staff and persons served.

- Recruitment, retention and training of staff competent in the delivery of integrated services for individuals with co-occurring substance use disorders.

Addressed by:

- Continued progress on the planned expansion of three outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Marketing strategies for recruitment.
- Recruitment incentives through the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.
- Tuition reimbursement opportunities.
- Re-location reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5-Year Expected Outcome for Provider and Patients:
We expect to increase the volume of COPSD service encounters by 45% over baseline to 1,995 encounters by Waiver DY5.

Starting Point/Baseline:
In FY 2011, TTBH delivered 1374 COPSD service encounters.

Rationale:
Substance abuse is a common disorder among individuals with severe mental illness. Individuals with mood or anxiety disorders are reported to be twice as likely to have a substance use disorder, and vice versa, in comparison to the general population. Other estimates place the prevalence of substance abuse and dependence among those with severe mental illness from 30% to as high as 50% depending on the psychiatric diagnosis, compared to only 8% in those without mental illness. Establishing a clear causal relationship between the co-occurrence of mental and substance use disorders is difficult, but three scenarios have been offered to explain the connection: use of a particular drug results in symptoms of a mental illness; individuals suffering from a mental illness "self-medicate" with illicit drugs in an attempt to reduce symptoms of their illness; or both disorders are the result of underlying genetic and/or environmental factors. The prognosis for individuals with co-occurring mental and substance use disorders is significantly worse than for those with a mental illness or substance use disorder alone, including increased rates of relapse, medical illness, violence, hospitalization, work and school problems, incarceration, suicide and early death. While the treatment of the mental illness or the substance abuse disorder separately may reduce the risk, lessen the severity or increase a person's amenability to treatment of the co-occurring disorder, navigating separate and complex systems of care can result in barriers to treatment access and recovery. A growing body of evidence has demonstrated that integrated and concurrent treatment of both disorders results in the best possible outcomes for those with co-occurring disorders.

Project Components:

We propose to meet the required project components a) Expand primary care clinic space and c) Expand primary care clinic staffing. TTBH will increase behavioral heath service infrastructure and capacity through the expansion of clinic space and staffing at three of our clinics serving communities across the Rio Grande Valley. In doing so, we will increase access to and utilization of preventative evidence-based integrated COPSD services for low-income and uninsured persons, increase opportunities for recovery from co-occurring mental health and substance use disorders and decrease avoidable costs associated with emergency behavioral health interventions. Insofar as TTBH stakeholder input does not support extended operating hours at our behavioral health clinics and doing so would require a more comprehensive and expensive expansion of staffing than is currently planned, TTBH will not extend our clinic hours at this time.

Milestones and Metrics:
The following milestones and metrics were chosen for TTBH's project to Expand Primary Care Capacity for the delivery of co-occurring substance use/abuse services based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-X (P-X.1)
- Improvement Milestones and Metrics: I-12 (I-12.1)

Unique community need identification numbers:
This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health care.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
By increasing our capacity to deliver services integrating the treatment of co-occurring psychiatric and substance use-related disorders, this project will expand on the accomplishments of our existing behavioral health care delivery system including maximizing the use of best practices. In so doing, it will better ensure that the system is adequately developed to address the routine behavioral health care needs of our rapidly growing, yet historically underserved service area and reduce the unnecessary use of costly emergency psychiatric interventions.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient,

continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Expanded COPSD services may lead to the identification of medical issues appropriate for referral to TTBH's planned co-located primary care clinics and care management services (Projects 138708601.2.1 and 138708601.2.4). Evidence suggests it is likely that many of the individuals we serve who come into contact with law enforcement and are identified for diversion to treatment by Mental Health Officers (Project 138708601.2.2) will have COPSD related needs.

Relationship to Other Performing Providers' Projects in the RHP:
This project is unique to the region in expanding access to care for people with co-occurring mental health and substance use diagnoses.

Plan for Learning Collaborative:
As applicable, TTBH will host bi-weekly conference calls with regional partners engaged in similar delivery system reform projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will also request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY2, TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY5 is calculated to be $4,220,391.
- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678. The overall value is calculated to be $601,498.
- Emergency Room: Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of $986 per visit and a total emergency room valuation of $165,046.

- Overall Project Valuation: The total project valuation is $4,986,935.

Project	***Project Option***	***Project Component(s)***	***Expand Primary Care Capacity***	
138708601.1.2	***1.1.2***	***1.1.2.a, 1.1.2.c***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.2*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: 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 is 0. Goal is to develop a plan for the expansion of service capacity including building construction and renovation, purchase of necessary equipment and recruitment, hiring and training of new COPSD staff. • Data Source: Documentation of work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $697,680 **Milestone 2** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.	**Milestone 3** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Baseline/Goal: In FY 2011, TTBH delivered 1374 COPSD service encounters. Goal is to increase COPSD services by 15% over baseline to 1,580 encounters. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment *(maximum amount):* $630,558 **Milestone 4** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive		**Milestone 5** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Increase COPSD services by 30% over baseline to 1,786 encounters. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment *(maximum amount):* $664,952 **Milestone 6** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $664,952	**Milestone 7** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Increase COPSD services by 45% over baseline to 1,995 encounters. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment *(maximum amount):* $500,277.50 **Milestone 8** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $500,277.50

Project ***138708601.1.2***	***Project Option*** ***1.1.2***	***Project Component(s)*** ***1.1.2.a, 1.1.2.c***	***Expand Primary Care Capacity***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.2*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment *(maximum amount):* $697,680	Payment *(maximum amount):* $630,558			
Year 2 Estimated Milestone Bundle Amount: $1,395,360	Year 3 Estimated Milestone Bundle Amount: $1,261,116		Year 4 Estimated Milestone Bundle Amount: $1,329,904	Year 5 Estimated Milestone Bundle Amount: $1,000,555
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $4,986,935				

- ***Tropical Texas Behavioral Health***
- ***Development of behavioral health crisis stabilization services as alternatives to hospitalization.***
- ***138708601.1.3***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will add two Mobile Crisis Outreach Team (MCOT) staff at three TTBH clinics serving communities throughout the Rio Grande Valley, specially trained in the delivery of crisis services to individuals with co-occurring Intellectual and Developmental Disability (IDD) and mental health needs.
Need for the project: A brief description of the need for the project including data as appropriate.	A fundamental barrier to appropriate care for people with co-occurring mental health disorders and IDD is a lack of adequately trained clinicians, competent to respond most effectively to behavioral health crises with this particular population. The lack of available clinicians skilled in addressing the behavioral health needs of these individuals results in poor outcomes.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is adults and youth in our local service area assessed with co-occurring mental health and IDD needs. It is unclear at this time how many clients will be served, baseline data pertaining to this need are currently being gathered by the Department of Aging and Disability Services. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	This project seeks to annually increase the number of crisis encounters that appropriately address the needs of individuals with co-occurring MI and IDD by at least 10% over the baseline of 1,373 to 1,510 encounters in DY3, by 20% over baseline to 1,648 encounters in DY4 and by 30% over baseline to 1,785 encounters by DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization.
Unique RHP Project identification number: 138708601.1.3
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 1.13.2 Will add 2 Mobile Crisis Outreach Team (MCOT) staff at each of TTBH's main clinics trained in the delivery of crisis services to individuals with co-occurring IDD and behavioral health needs and improve access to respite, emergency crisis respite and behavior management services for individuals with co-occurring behavioral health and IDD needs to prevent admission/readmission to inpatient psychiatric care.

Project Description:
Develop crisis stabilization alternatives to more expensive and preventable crisis resolution mechanisms. TTBH will add two Mobile Crisis Outreach Team (MCOT) staff at each of our three main clinics trained in the delivery of crisis services to individuals with co-occurring mental health needs and Intellectual and Developmental Disabilities (IDD), and increase the volume of crisis encounters to individuals with co-occurring behavioral health needs and IDD by 30% over baseline. Additionally, TTBH staff will collaborate with the Rio Grande State Center and the Wood Group to make respite and crisis respite services, respectively, available to this targeted population, and to implement behavior management plans when clinically indicated to prevent admission/readmission to inpatient psychiatric care. By enhancing our MCOTs through the addition of specially trained staff, TTBH will ensure more consistent identification of co-occurring mental illness in individuals with IDD who experience behavioral health crises. Based on their training and experience, these staff will have the knowledge and skills needed to comprehensively address the co-occurring disorders and recommend and coordinate levels of care appropriate to stabilize behavioral health crises in the community. This will prevent or reduce repeat cycles of higher-cost, restrictive institutional alternatives, increase utilization of routine behavioral health services, and improve health outcomes and the experience of care for the person served.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goals and Relationship to Regional Goals:

Project goals:

- TTBH will add two Mobile Crisis Outreach Team (MCOT) staff at each of our three main clinics trained in the delivery of crisis services to individuals with co-occurring mental health needs and Intellectual and Developmental Disabilities (IDD).
- Increase the number of crisis encounters that appropriately address the needs of individuals with co-occurring MI and IDD by at least 10% over the baseline of 1,373 to 1,510 encounters in DY3, by 20% over baseline to 1,648 encounters in DY4 and by 30% over baseline to 1,785 encounters by DY5.
- Collaborate with the Rio Grande State Center and the Wood Group for the availability of respite and crisis respite services, respectively.
- Increase utilization of routine behavioral health services.
- Reduce the use of higher-cost, restrictive institutional alternatives.
- Improve health outcomes and the experience of care for the person served.

This project meets the following regional goals:

- Improve on existing programs to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services, including behavioral health services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access to and timely utilization of appropriate care, including behavioral health services.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and inappropriate emergency department utilization, help prevent admission/readmission to inpatient psychiatric and improve patient satisfaction.

Challenges and How Addressed:

Challenges:

- Appropriate space for additional behavioral health staff and persons served.
- Recruitment, retention and training of behavioral health care providers.

Addressed by:

- Continued progress on the planned expansion of three outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Marketing strategies for recruitment.
- Recruitment incentives through the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.

- Tuition reimbursement opportunities.
- Re-location reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5 Year Expected Outcome:
We expect to see an increase in utilization of appropriate crisis alternatives and plan to increase the number of crisis encounters that appropriately address the needs of individuals with co-occurring MI and IDD by 30% over baseline to 1,785 encounters annually by DY5.

Starting Point/Baseline:
In FY 2011 TTBH reported 1,373 crisis encounters involving individuals with co-occurring behavioral health and IDD needs.

Rationale:
While the existence of co-occurring mental illness in persons with IDD has been acknowledged within the field of behavioral health, as has their increased risk of developing mental illness compared to people without IDD, the realization of successful mental health treatment outcomes for this population has not kept pace with this knowledge. A study commissioned by the Texas Legislature determined that a fundamental barrier to appropriate care for people with co-occurring mental health disorders and IDD is a lack of adequately trained clinicians who are competent to respond to behavioral health crises with this population. The lack of available clinicians skilled in addressing the behavioral health needs of this population results in undiagnosed, untreated or undertreated mental illness and an increased risk of behavioral health crisis. This problem is compounded by the cognitive and intellectual limitations experienced by this population. The resulting poor outcomes for persons with co-occurring mental illness and IDD include more frequent and longer psychiatric hospitalizations with little improvement in behavioral functioning. The alternatives to competent community-based treatment are repeated and extended stays in psychiatric hospitals and institutionalization in State Supported Living Centers; expensive and often ineffective intervention options. Through the development of crisis stabilization alternatives we avoid costly inpatient and emergency services and allow for a better opportunity for improved patient outcomes.

Project Components:
Project option 1.13.2 does not have additional core components.

Milestones and Metrics:
The following milestones and metrics were chosen for the TTBH Crisis Stabilization project based on the project option and the needs of the target population:
- Process Milestones and Metrics: P-4 (P-4.1); P-6 (P-6.1)
- Improvement Milestones and Metrics: I-12 (I-12.1)

Unique community needs identification numbers:
This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health care.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
Currently, TTBH MCOTs are not staffed by individuals with specialized training to intervene on behalf of individuals with co-occurring mental health and IDD needs. Ensuring the delivery of the most appropriate and timely care for these especially vulnerable members of our treatment population in the event of and to prevent psychiatric emergencies requires communication between already overburdened mental health and IDD service providers, often resulting in unnecessary delays in access to appropriate care. The addition of crisis team staff skilled in addressing issues unique to the delivery of crisis intervention and prevention services to individuals with these co-occurring disorders will reduce unnecessary inpatient psychiatric admissions/readmissions and improve outcomes and the experience of care for those we serve and their families.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Enhancement of behavioral health services to those with co-occurring mental illness and IDD is linked to and supports the Center's goal for the overall expansion of behavioral healthcare capacity (Project 138708601.1.1). Persons receiving integrated MH/IDD crisis stabilization services may be assessed as having physical health needs that would benefit from the planned integration of primary care within TTBH clinics (Projects 138708601.2.1 and Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:

This project is unique to the region as we will develop behavioral health crisis stabilization services as alternatives to hospitalization. We will coordinate our service capacity to support this community.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY5 is calculated to be $2,069,024.
- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678. The overall value is calculated at $294,881.
- Emergency Room: Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of $986 per visit and a total emergency room valuation of $80,913.
- Overall Project Valuation: The total project valuation is $2,444,818.

PROJECT ***138708601.1.3***	***PROJECT OPTION*** ***1.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.3*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric 1 [P-4.1]: Number of staff hired and trained. • Baseline/Goal: Baseline, NA. Goal is to develop a plan to expand service capacity at TTBH's 3 main clinics for the delivery of crisis services to persons with co-occurring IDD and behavioral health needs, including building construction and renovation, purchase of necessary equipment, revision to applicable policies and procedures and recruitment, hiring and training of staff. • Data Source: Documentation of work plan and time frames including building construction and renovation, purchase of necessary equipment, development of necessary policies and procedures and recruitment, hiring and training of staff. Milestone 1 Estimated Incentive Payment *(maximum amount):* $143,020	**Milestone 3** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives. • Baseline/Goal: In FY2011 TTBH delivered 1,373 crisis intervention services to individuals with co-occurring behavioral health and IDD needs. Goal is to increase the number of crisis encounters that appropriately address the needs of individuals with co-occurring MI and IDD by 10% over baseline to 1,510. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $379,007.50 **Milestone 4** [P-6]: Evaluate and continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to	**Milestone 5** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives. • Goal: Increase the number of crisis encounters that appropriately address the needs of individuals with co-occurring MI and IDD by 20% over baseline to 1,648. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $399,681 **Milestone 6** [P-6]: Evaluate and continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):*	**Milestone 7** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives. • Goal: Increase the number of crisis encounters that appropriately address the needs of individuals with co-occurring MI and IDD by 30% over baseline to 1,785. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $300,700 **Milestone 8** [P-6]: Evaluate and continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):*

PROJECT ***138708601.1.3***	***PROJECT OPTION*** ***1.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.3*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-6]: Evaluate and continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $143,020	guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $379,007.50		$399,681	$300,700
Year 2 Estimated Milestone Bundle Amount: $286,040	Year 3 Estimated Milestone Bundle Amount: $758,015		Year 4 Estimated Milestone Bundle Amount: $799,362	Year 5 Estimated Milestone Bundle Amount: $601,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,444,817				

- ***Tropical Texas Behavioral Health***
- ***Introduce, Expand or Enhance Telemedicine/Telehealth***
- ***138708601.1.4 (Pass 2)***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will add equipment to connect all TTBH community-based and Mobile Crisis Outreach Team (MCOT) staff to the telemedicine/telehealth system and provide necessary training to increase the volume of electronic psychiatric consultations.
Need for the project: A brief description of the need for the project including data as appropriate.	The Lower Rio Grande Valley has been, and continues to be, a Health Care Professional Shortage Areas (HPSAs) for primary and mental health care. Telemedicine services are critical to TTBH's efforts to meet the increasing demand for timely access to medically necessary professional behavioral health care. Of our approximately 250 community-based direct-care staff providing services across a 3,100 square mile catchment area, only half currently have the ability to access the center's telemedicine system remotely to facilitate electronic consultations with a psychiatrist.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is the behavioral health population served by TTBH. In FY 2011 we served over 23,000 unduplicated individuals. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the number of staff with the equipment and required training to facilitate the delivery of telemedicine/telehealth services in the community and increase the number of remote electronic patient consultations by 5% over baseline to 3,490 encounters in DY3, by 10% over baseline to 3,656 encounters in DY4, and by 15% over baseline to 3,822 encounters by DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:

1.7 Introduce, Expand or Enhance Telemedicine/Telehealth
Unique RHP Project Identification Number: 138708601.1.4

Performing Provider/TPI: Tropical Texas Behavioral Health/138708601

Project Option 1.7.1 Will add equipment to connect all TTBH community-based and Mobile Crisis Outreach Team (MCOT) staff to the telemedicine/telehealth system and provide necessary training to increase the volume of electronic psychiatric consultations.

Project Description:

Provide electronic health care services to increase patient access to health care. TTBH will maximize the effectiveness of our telemedicine and telehealth services and increase access to timely psychiatric consultations with persons served, by expanding remote connectivity to the system to 100% of our community-based staff over the term of the waiver and increasing the volume of electronic psychiatric patient consultations by 15% over baseline to 3,822 encounters. Expanding remote access to the telemedicine/telehealth system to most or all of TTBH's community-based staff will improve the timeliness of clinically indicated psychiatric consultations, reduce the number of people waiting to access routine behavioral healthcare services, improve health outcomes and the experience of care and reduce the utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process

milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Add equipment to connect all community-based and Mobile Crisis Outreach Team (MCOT) staff to the Telemedicine system and Electronic Health Record (EHR).
- Expand the provision of telemedicine/telehealth services including patient consultations by psychiatrists, and the completion of concurrent documentation remotely in the EHR.
- Increase the number of electronic patient consultations by 15% over baseline to 3,822 encounters by DY5.
- Improve access to and the timely delivery of routine behavioral health services.
- Improve health outcomes and the experience of care.
- Reduce utilization of more expensive emergency behavioral health interventions.

This meets the following regional goals:

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services, including behavioral health services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best practices, improves access to and timely utilization of appropriate care including behavioral health services, particularly in our rural communities, and helps prevent admission/readmission to inpatient psychiatric care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.

Challenges and How Addressed:

Challenges:

- Equipment and training necessary for expansion of behavioral health services at all clinic locations.
- Recruitment and retention of behavioral health providers.

Addressed by:

- Continued progress on the planned expansion of our outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Implementing marketing strategies for recruitment.
- Enhanced recruitment through maintenance of the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.
- Opportunities for tuition reimbursement.
- Opportunities for re-location reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5 Year Expected Outcome for Provider and Patients:

TTBH will expand behavioral health service capacity to enhance access to the right care at the right time in the right setting and improve behavioral health outcomes and the experience of care for those served. We will increase the number of staff with the equipment and required training to facilitate the delivery of telemedicine/telehealth services in the community and increase the number of remote electronic patient consultations by 15% over baseline to 3,822 encounters by DY5. In doing so, TTBH will reduce the number of people waiting to access culturally competent routine behavioral health services, increase utilization of preventative behavioral health care, improve health outcomes and the experience of care and decrease the need for more costly emergency behavioral health interventions.

Starting Point/Baseline:

In FY 2011, 125 community-based staff had the remote access and training to facilitate telemedicine/telehealth services, and 3,324 electronic consultations were completed.

Rationale:

Telemedicine services improve access to and the delivery of health by bringing services to underserved communities and individuals and helping to attract and retain health professionals in rural areas through facilitated training and collaboration with other health professionals. Telemedicine is an accepted and effective health care delivery system with emerging standards and best practices and demonstrated client satisfaction with it as a substitute for face to face interventions. It has stable costs after initial investments in equipment, can increase revenues through the delivery of services to more people than would have been served without its availability and can improve the coordination of care by facilitating communication among members of a treatment team and between physical health and behavioral health service providers.

TTBH currently has one of the most advanced telemedicine systems in use among the state's Local Mental Health Authorities (LMHAs). The Center has contractual agreements for telemedicine services with psychiatrists located throughout the state and in other parts of the country allowing the system to provide prompt access to telepsychiatric consultations 24 hours per day, 7 days per week. In 2008, The Commission on Accreditation of Rehabilitation Facilities (CARF) commended TTBH for "exemplary conformance to standards" for its use of telemedicine to supplement on-site services, and in 2011 reported the Center "continues to lead service delivery by expanding the use of telemedicine into mobile devices, such as tablets, [allowing] services to be provided to patients who are incarcerated, who are in rural areas, or who have mobility restrictions."

The counties of the Lower Rio Grande Valley have long been, and continue to be, Health Care Professional Shortage Areas (HPSAs) for primary and mental health care. Given the shortage of available health care professionals and the longstanding barrier to service access due to a lack of reliable transportation for the Valley's largely poor and rural population, expanded telemedicine services are critical to TTBH's efforts to meet the increasing demand for access to medically necessary professional behavioral health care in as timely a manner as possible. Of our roughly 250 direct-care staff providing community-based services across a 3,100 square mile catchment area, only half currently have the ability to access the Center's telemedicine system remotely to facilitate electronic consultations with a psychiatrist. TTBH proposes to maximize the effectiveness of our telemedicine and telehealth services and increase access to timely patient consultations by psychiatrists, by expanding remote connectivity to the system to 100% of our community-based staff and increasing the volume of services delivered using telemedicine technology over the term of the waiver.

TTBH will apply for funding through the Health Information Technology for Economic and Clinical Health (HITECH) Act in January 2013, however, previous expenditures to ensure our Electronic Health

Record (EHR) is in compliance with HITECH standards already exceed the amount of funding we anticipate receiving should our application for HITECH funding be approved.

Project Components:

Through our project to expand telemedicine/telehealth services we propose to meet the required components of project option 1.7.1 as follows:

a) *Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications*. TTBH direct-care staff will facilitate electronic consultations between persons served and psychiatrists from remote locations in the communities served using telemedicine equipment and training in the delivery of telemedicine services.
b) *Conduct quality improvement for project using methods such as rapid cycle improvement*. This will be accomplished through our existing Quality Management/Utilization Management structures as described in the project description, through the planned learning collaborative activities with Border Region Behavioral Health Center and other regional partners as appropriate and through the activities of the various Community Mental Health Center consortia sponsored by the Texas Council of Community Centers.

Milestones and Metrics:

The following milestones and metrics were chosen for the TTBH Expand Telemedicine/Telehealth project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-3 (P-3.1); P-X (P-X.1)
- Improvement Milestones and Metrics: I-12 (I-12.1)

Unique Community Needs Identification Number:

This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health care.

How the Project represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:

By increasing telemedicine/telehealth service capacity throughout our catchment area, this project will expand on the accomplishments of our existing telemedicine delivery system including

maximizing the use of best practices. In so doing, it will better ensure that the system is adequately developed to address the routine behavioral health care needs of our rapidly growing, yet historically underserved service area and reduce the unnecessary use of costly emergency psychiatric interventions.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:

TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to Other Projects:

Expanding telepsychiatry consultations is linked to the overall expansion of TTBH's behavioral healthcare capacity (Project 138708601.1.1) and supports the Center's goals to successfully divert more individuals from the criminal justice system into treatment as clinically indicated (Project 138708601.2.2), and expand the delivery of comprehensive behavioral health services to more

people with co-occurring substance use disorders (Project 138708601.1.3) and co-occurring Intellectual and Developmental Disabilities (Project 138708601.1.4).

Relationship to Other Performing Providers' Projects in the RHP:

TTBH will coordinate with Border Region Behavioral Health Center and Valley Baptist Health Systems to develop and participate in a learning collaborative related to our respective projects to implement or expand telemedicine/telehealth services.

Plan for Learning Collaborative:

TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings between LMHAs involved in healthcare transformation projects.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to research by University of Texas Austin Center for Social Work, the monetary value per life-year gained due to the interventions is $50,000.
- Overall Project Valuation: The total project valuation is $2,035,950.

Project	***Project Option***	***Project Component(s)***	***Introduce, Expand, or Enhance Telemedicine/Telehealth***	
138708601.1.4	***1.7.1***	***1.7.1.a – 1.7.1.b***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.8*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. • Baseline/Goal: Currently only 50% of community-based staff have the training and equipment to access the telemedicine system. The goal is to expand telemedicine access to 100% of community-based staff, including the purchase of necessary equipment and completion of staff training. • Data Source: Program materials evidencing the purchase of necessary equipment and staff training. Milestone 1 Estimated Incentive Payment *(maximum amount):* $669,842.50 **Milestone 2** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and	**Milestone 3** [I-12]: Increase number of telemedicine visits for each specialty identified as high need. Metric 1 [I-12.1]: Number of telemedicine visits. • Baseline/Goal: In FY 2011, 3324 electronic consultations were completed. The goal is to increase the number of electronic consultations by 5% over baseline, to 3,490. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $45,479.50 **Milestone 4** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $45,479.50		**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 the number of electronic consultations by 10% over baseline, to 3,656. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $106,015.50 **Milestone 6** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $106,015.50	**Milestone 7** [I-12]: Increase number of telemedicine visits for each specialty identified as high need. Metric 1 [I-12.1]: Number of telemedicine visits. • Goal: Increase the number of electronic consultations by 15% over baseline, to 3,822. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $196,637.50 **Milestone 8** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $196,637.50

Project	***Project Option***	***Project Component(s)***	***Introduce, Expand, or Enhance Telemedicine/Telehealth***	
138708601.1.4	***1.7.1***	***1.7.1.a – 1.7.1.b***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.8*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $669,842.50				
Year 2 Estimated Milestone Bundle Amount: $1,339,685	Year 3 Estimated Milestone Bundle Amount: $90,959		Year 4 Estimated Milestone Bundle Amount: $212,031	Year 5 Estimated Milestone Bundle Amount: $393,275
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,035,950				

- ***Performing Provider: UT Health Science Center at San Antonio***
- ***Project Name: Expand primary care/Internal Medicine residency training program at Valley Baptist Hospital –Harlingen.***
- ***Project Identifier: 085144601.1.1***

Provider:.	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.
Intervention(s):	This project will expand the existing internal medicine program at Valley Baptist Medical center increasing the pipeline for more primary care physicians in RHP 5.
Need for the project:	RHP 5 has 55 primary care physicians per 100K population compared to 70 in Texas. Furthermore there is a large pool of undiagnosed and untreated people with chronic conditions, e.g. diabetes, in RHP 5 requiring more primary care physicians to manage this rapidly growing problem. This project will greatly increase the pipeline for new primary care physicians.
Target population:	The target population is the entire RHP 5 where about 45% of people live in poverty and more than 25% are Medicaid beneficiaries. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. In FY 2012, 33% of VBMC-H's 20,000 admissions were of persons either covered by Medicaid or indigent and uninsured. 24% of VBMC-H's 54,000 emergency visits were for Medicaid patients; another 22% were indigent uninsured. Reducing the use of these high cost services through increased primary care is the focus of this project.
Category 1 or 2 expected patient benefits:	The project seeks to greatly increase the number of primary care physicians practicing in RHP5 over the next decade. There will be 10 residents graduating per year starting in 2018, an increase of 100% over the current maximum of 5 graduates per year. In addition, by the end of DY5, faculty physicians new to RHP5 will add 6,000 primary care patient visit slots annually and residents will provide 40 continuity clinic sessions per month.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA and RHP5.

Project Option 1.2.4 - Expand Primary Care/Internal Medicine Residency Training Program at Valley Baptist – Harlingen

Unique Project ID: 085144601.1.1
Performing Provider/TPI: University of Texas Health Science Center San Antonio / 085144601

PROJECT DESCRIPTION

The primary goal of this DSRIP project is to increase the number of primary care providers (i.e., physicians, residents) in RHP 5 by expanding and strengthening the existing internal medicine residency program sponsored by the Regional Academic Health Center of The University of Texas Health Science Center San Antonio (UTHSCSA-RAHC). The project will build on the partnership among UTHSCSA-RAHC, Valley Baptist Medical Center – Harlingen (VBMC-H), Su Clinica Familiar (Su Clinica), and the Veterans Administration Coastal Bend Health System (VA) to expand the training program from its current 15 residents (5 in each year of the 3-year program) to a capacity of up to 30 (10 per year), and will expand the full time faculty leadership and staff in the program commensurately. It will build on the success of the program in training clinicians who locate their practices in RHP 5, helping to alleviate the area's substantial primary care workforce shortage and will update the training program to include more organized care delivery models and related research and scholarly work. The new faculty (over the near term), and new resident trainees (over the medium term), and graduates (over the longer term) will expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction. It will complement the other existing and new residency programs of UTHSCSA-RAHC and be a foundational element for development of the UTHSCSA-RAHC into a full four-year medical school in RHP 5 as envisioned by the Texas legislature and planned by the Regents. The Texas 1115 Medicaid waiver provides an important opportunity to increase access to primary care through increasing the number of primary care physicians and expanding the pipeline of well trained and culturally aware physicians for the underserved RHP5.

Additional Project Goals: Beyond the goal of expanding the RHP5 primary care workforce to increase access and capacity, this expansion is designed to strengthen an integrated health care system and to play a key role in implementing disease management programs, through:

- implementing an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- conducting quality improvement projects to continuously improve clinical outcomes and efficiency; and
- collaborating with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

A greater focus on primary care will be crucial to the success of an improved, reformed and more integrated health services delivery system in which patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Relationship to Regional Goals:

This project will advance achievement of regional goals identified in RHP 5:

- By combining the resources of a major safety net hospital, VBMC-H; safety net ambulatory care provider, Su Clinica; the VA; and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term also with resident trainees, and in the long-term also with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the existing health care system.

Challenges or Issues faced:
At the dawn of the implementation of health care reform, Texas is experiencing a dramatic shortage of primary care workforce including physicians and a dearth of medical students choosing careers in primary care. South Texas has long been a medically underserved region, and is particularly underserved for primary care with 55 physicians per 100,000 population compared to 70 per 100,000 in Texas (80% of Texas average). Similarly, there are 103 direct care physicians per 100,000 in RHP 5 compared to 165 per 100,000 in Texas. The need for enhanced primary care resources in Region 5 is challenging.

Designing interventions to meet the need also is challenging. Doubling the size of the existing internal medicine residency will require approval by the Internal Medicine Residency Review Committee (RRC), which meets only three times each year to review well documented requests that must be submitted at least two months prior to the meeting. Approval for expanding the program must be obtained before the program can recruit more than 5 residents to enter the next year's class. Over the past several years, the RRC's requirements for program accreditation have become increasingly specific on requirements for protected academic time for core faculty members, scholarly activity by faculty and residents, and limitations on the work hours and schedules for residents. Meeting these requirements in an expanded program will require the hiring and development of a cadre of full-time UTHSCSA-RAHC faculty who will become the faculty core for the program, taking over a range of duties formerly performed by community volunteer faculty.

How the Project addresses these Challenges
Expanding the faculty physicians who will provide patient care services and expanding the pipeline of primary care physicians through this project is an important part of the solution to the constellation of health problems documented in the RHP 5 Health Needs Assessment. To meet the challenges of accrediting the expanded program, UTHSCSA-RAHC will draw on its strong and successful history of

relationships with VBMC-H, Su Clinica and the VA; its ability to recruit faculty nationally; and the extensive experience of UTHSCSA faculty and staff with accreditation processes.

Five-year expected outcomes:
By the end of the Demonstration Period in September 2016, increase the number of internal medicine residents from 15 to 25 (toward 30 in full development), increase the faculty by a total of 6 including an Associate program Director and 5 core faculty, and increase access to primary care through expansion of the continuity clinic now in operation and new ambulatory care established by the new full time faculty.
Because some of the new faculty for the expanded training program may be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we project in the metrics that an additional/incremental 2,000 primary care visit slots will be provided by new faculty physicians each year DY3 through DY5, for an annual count of 6,000 visit slots annually by the end of DY 5. The residency program will be expanding from 5 residents in each class/cohort to 10 residents in each class/cohort. By the end of DY5, we expect the additional 5 PGY1 and 5 PGY2 residents to provide patient care in half-day clinic sessions as required by RRC standards. The number of sessions will increase from DY4 to DY 5 as the number of residents increases along with the maturity of their experience.

STARTING POINT/BASELINE

As of December 2011, the benchmark for internal medicine residents is 15 (5 per year in a three-year training program). The other UTHSCSA-RAHC primary care residency in RHP 5 is the family medicine program in Hidalgo County, which provides training for 18 residents (6 per year in a three-year training program).

RATIONALE
Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians—especially in South Texas.

The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population -- a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 220 and 91, respectively.) From 2001 to 2011, the Texas physician workforce grew 32, exceeding the population growth of 25%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry level

GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 primary care physicians per 100,000 population statewide.

Project components:

- Identify high impact services and gaps in care, coordination, and ambulatory capacity
- Recruit Internal Medicine Associate Program Director and full-time core faculty in DY 2 and 3
    - Associate Program Director: 75% academic time for program development/accreditation activities and 25% patient care/clinical time
    - Core faculty: 35% academic time and 65% clinical time
- Implement innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- Provide Clinical Safety & Effectiveness (CS&E) training to faculty and VBMC staff
- Integrate inpatient and ambulatory clinical training/patient care opportunities for Internal Medicine at VBMC
- Attain ACGME approval for expansion of the program in fall of 2014
- Recruit additional prospective Internal Medicine residents in the fall of 2014
- Enroll the first expanded class of residents in July 2015 (incremental increase of 5)
- Enroll the second expanded class of residents in July 2016 (additional incremental increase of 5)

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

The Internal Medicine residency training program has had good success in producing graduates who have remained in RHP 5 to provide primary care services. Expansion of the program seeks to expand on that success. It also will expand the ability of the residents and faculty to provide primary care services through the continuity clinic organized at Su Clinica as well as providing comprehensive follow-up care for previously undiagnosed patients admitted to VBMC. The faculty for the Internal Medicine residency program will collaborate with the faculty for the new and existing training programs throughout RHP 5. Expansion of the program faculty also will allow enhancement of the program through greater scholarly activity focused on the clinical conditions especially prominent in RHP 5 and greater involvement of faculty and residents in quality improvement efforts at VBMC.

Data Driving this Project:
The need for enhanced primary care in this health disparity population is extensively documented. Data published by the United States Census Bureau in 2012 show that 88% (Cameron County) and 91% (Hidalgo County) of the population is Mexican American or Latino in origin and that 35% live below the poverty line, compared with 17% for Texas and 14% nationally (http://quickfacts.census.gov/qfd/states/00000.html). Currently about 65% of RHP 5 residents have health insurance of some kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from UT's locally recruited, randomized community cohort show that the prevalence of obesity is 48% and that 8% are morbidly obese. The prevalence of diabetes is an alarming 31% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55%) and hypertension (50%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s): OD-14 Primary Care Workforce
Stand-alone:
IT - 14.1 Number of practicing primary care practitioners per 1,000 individuals in HPSA/MUA

Non-stand-alone but related: (for internal tracking only)
IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the expansion of the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinical practice. The Associate Program Director and core faculty will be recruited and in place even before the expansion is fully accredited. Because they will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing primary care practitioners per 100,000 individuals in RHP 5.
The bundle of three non-standalone measures above, in the program's experience to date, is a set of strong predictors of the future decisions of residents in the program to enter practice in RHP5 or elsewhere in South Texas.

Relationship to other Projects:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support an updated Family Medicine residency program at McAllen Medical Center.

Relationship to Other Performing Providers' Projects in the RHP:
This project is related to the following projects by other performing providers in RHP5 (all at Doctors Hospital at Renaissance):

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/Family Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for VBMC physicians and staff to participate in the CS&E course and projects.

Project Valuation:
This project's impact on RHP 5's large Medicaid and indigent population will be profound. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. As documented above RHP 5 has a very large pool of undiagnosed chronic disease that leads to high rates of emergency visits and admissions that could be avoided through primary care. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. This residency expansion project, along with the other new and expanding residency projects in RHP 5, can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospital quality improvement efforts.

Unique Identifier	*Reference number*	*Project Component(s):*	
085144601.1.1	*1.2.4*		Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen
Performing Provider: UT Health Science Center San Antonio			TPI: 085144601
Related Category 3 Outcome Measure(s):	085144601.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA/MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment*:* $1,367,593 **Milestone 2 [P-2]:** Expand primary care training for primary care internal medicine providers: Metric 1 [P-2.2]. Hire additional precepting primary care faculty members. Baseline: At the beginning of DY	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1: [P-2.1]: Expand the primary care training program. Baseline: Program limited to 15 residents in DY2. Goal: Submit the application for increase from 15 to 30 residents by 2/2014 for Residency Review Committee (RRC) 9/14 meeting. Data Source: Training program records Metric 2 [P-2.2] Hire additional primary care faculty members. Baseline: At the beginning of DY 2, the program has no Associate Program Director or Core full-time faculty Goal: Hire 2 more Core faculty members in addition to those	**Milestone 7** [P-10]. Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents to 30. Metric 1 [P-10.1] Documentation of ACGME approval for residency position expansion Baseline: Program limited to 15 residents at the beginning of DY2. Goal: receive GME approval for expansion to 30 total residents Data Source: Training program records Milestone 7 Estimated Incentive Payment*:* $606,923 **Milestone 8 [P-2**]. Expand primary care training for primary care internal medicine. Metric 1 [P-2.2]. Hire additional precepting primary care faculty members. Baseline: At the beginning of DY 2, the program has no Associate	**Milestone 12 [I-11]:** Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents. Baseline: Program limited to 15 residents at the beginning of DY2 Goal: Enroll 10 residents into the PGY1 class beginning 7/2016; as compared to 5 PGY1 residents in DY2, DY3. Total residents in program increases from 15 to 25; 10 PGY1, 10 PGY2, 5 PGY3. Data Source: Program enrollment records. Milestone 12 Estimated Incentive Payment*:* $776,116 **Milestone 13 [I-15]:** Increase primary care training in Continuity Clinics. Metric 1 [I-15.1]: Increase number

Unique Identifier	*Reference number*	*Project Component(s):*	
085144601.1.1	*1.2.4*		Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen
Performing Provider: UT Health Science Center San Antonio			TPI: 085144601
Related Category 3 Outcome Measure(s):	085144601.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA/MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
2, the program has no Associate Program Director or Core full-time faculty Goal: Hire three faculty including an Associate Program Director and 2 Core full-time faculty members. Data Source: HR documents Milestone 2 Estimated Incentive Payment*:* $1,367,592	hired in DY2. Cumulative hiring for DY2 - DY3 = 5 including Associate Program Director, 4 Core faculty physicians. Data Source: HR documents. Milestone 3 Estimated Incentive Payment: $750,892 **Milestone 4** [P-3]: Expand positive primary care exposure for residents. <u>Metric 1</u> [P-3.3] Include residents in quality improvement projects. Baseline: No specific training experience incorporated with the hospital exists currently. Goal: Five residents will participate in QI projects with behavioral health/research director. Data source: Curriculum or QI project documentation.	Program Director or Core full-time faculty Goal: Hire 1 more Core faculty member in addition to those hired in DY2 and DY3. Cumulative hiring for DY2 – DY4 = 6 including Associate Program Director, 5 Core faculty physicians. Data Source: HR documents. Milestone 8 Estimated Incentive Payment*:* $606,923 **<u>Milestone 9 [</u>**I-11]. Increase primary care training and/or rotations. <u>Metric 1</u> [I-11.4]. Increase the number of primary care residents Baseline: Program limited to 15 residents (5 per cohort) at the beginning of DY2. Goal: Enroll 10 residents into the PGY1 class beginning 7/2015; as compared to 5 PGY1 residents in DY2, DY3. Total residents in program increases from 15 to 20. Data source: Program records Milestone 9 Estimated Incentive	of Continuity Clinic sessions available for primary care residents. Baseline: 4 half-day clinic sessions per month for 12 months for 15 residents enrolled in DY2. Goal: Add incremental Clinic sessions for additional PGY1 and PGY2 residents as compared to DY2. Add 4 sessions per month for 2 months for 5 additional PGY1s and 4 sessions per month for 12 months for 5 additional PGY2s. Data Source: Number of resident continuity clinic sessions from program records Milestone 13 Estimated Incentive Payment*:* $776,117 **Milestone 14 [P-4]** Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement.

Unique Identifier	*Reference number*	*Project Component(s):*	
085144601.1.1	*1.2.4*		Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen
Performing Provider: UT Health Science Center San Antonio			TPI: 085144601
Related Category 3 Outcome Measure(s):	085144601.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA/MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 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: $750,893 **Milestone 5** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty trained in CS&E in DY2. Goal: Two faculty members complete the CS&E training. Data Source: Certificates of completion. Milestone 5 Estimated Incentive Payment: $750,893 **Milestone 6** [I-X] Increase primary care access provided by new faculty physicians	Payment: $606,923 **Milestone 10 [I-14]** Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty trained in CS&E in DY2. Goal: Two additional faculty members complete the CS&E training. Cumulative total for DY3 and DY4 = 4. Data Source: Certificates of completion. Milestone 10 Estimated Incentive Payment: $606,923 **Milestone 11** [I-X] Increase primary care access provided by new faculty physicians	Metric 1 [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Baseline: No curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology based on CS&E course and including data analytics and population management. Data Source: Curriculum and practicum documentation. Milestone 14 Estimated Incentive Payment: $776,116 **Milestone 15** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2 for faculty recruited in DY2.

Unique Identifier	*Reference number*	*Project Component(s):*	
085144601.1.1	*1.2.4*		Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen
Performing Provider: UT Health Science Center San Antonio			TPI: 085144601
Related Category 3 Outcome Measure(s):	085144601.3.1	IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA/MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2 for faculty recruited in DY2. Goal: Annual count of 2,000 additional primary care patient visit slots attributable to new faculty physicians. Data Source: Clinical faculty schedules. Milestone 6 Estimated Incentive Payment: $750,893	Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2 for faculty recruited in DY2. Goal: Annual count of 4,000 additional primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY3. Data Source: Clinical faculty schedules. Milestone 11 Estimated Incentive Payment: $606,923	Goal: Annual count of 6,000 additional primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY4. Data Source: Clinical faculty schedules. Milestone 15 Estimated Incentive Payment: $776,117
Year 2 Estimated Milestone Bundle Amount: $2,735,185	Year 3 Estimated Milestone Bundle Amount: $3,003,571	Year 4 Estimated Milestone Bundle Amount: $3,034,615	Year 5 Estimated Milestone Bundle Amount: $3,104,466

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,877,837

- ***Performing Provider: UT Health Science Center at San Antonio***
- ***Project Name: Expand high impact specialty care capacity in Behavioral Health: Establish Psychiatry Residency Training Program at Valley Baptist Hospital –Brownsville.***
- ***Project Identifier: 085144601.1.2***

Provider:	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.
Intervention(s):	This project will create a new residency program in adult and child psychiatry that does not currently exist in RHP5. Targeted specialty care capacity in behavioral health will be increased by the addition of faculty in the short term, and residents in the medium term, and graduates staying in the area to practice in the long term.
Need for the project:	There are 2.8 psychiatrists per 100,000 population in RHP 5 compared to 6.8 per 100,000 in Texas. There is a high burden of undiagnosed and untreated behavioral health conditions often co-occurring with physical health problems. This project will create a pipeline for new behavioral health professionals.
Target population:	The target population is the entire RHP5, a region with a high concentration of Medicaid and indigent patients. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. All of the population will stand to benefit from more trained psychiatrists. In FY2012, 47% of VBMC-B's 12,000 admissions were of persons either covered by Medicaid or indigent and uninsured. 26% of VBMC-B's 31,000 emergency visits were for Medicaid patients; another 30% were indigent uninsured. Reducing the use of these high cost services is a focus of this project.
Category 1 or 2 expected patient benefits:	The project seeks to greatly increase the number of psychiatrists practicing in RHP 5 over the next decade. New program faculty will increase access to care with annual counts of 2,000 visit slots in DY3, 4,000 in DY 4, and 6,000 in DY5. There will be 4-5 adult residents and 1-2 child &adolescent psychiatrists graduating per year starting in 2019.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing behavioral health physicians per 100,000 people in HPSA and RHP5.

Project Option 1.9.1 - Expand high impact specialty care capacity in Behavioral Health: Establish Psychiatry Residency Training Program at Valley Baptist – Brownsville

Unique Project ID: 085144601.1.2

Performing Provider/TPI: UT Health Science Center San Antonio /085144601

PROJECT DESCRIPTION

The primary goal of this DSRIP project (1.9.1) will be to expand specialty care in behavioral health by establishing a new psychiatry residency program (including child and adolescent psychiatry) that will address the severe shortage of behavioral health professionals in RHP5. The program will be sponsored by the Regional Academic Health Center of The University of Texas Health Science Center San Antonio (UTHSCSA-RAHC) and located primarily at Baptist Medical Center – Brownsville (VBMC-B). The Veterans Administration Coastal Bend Health System (VA) and the Rio Grande State Center (RGSC) also will provide sites for clinical training in the program.

New full-time UT faculty (to be recruited over the near term), and new resident trainees (over the medium term), and graduates (over the longer term) will expand the behavioral health workforce, allaying the extreme shortage of behavioral health providers in RHP5 thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction. It will complement the other existing and new residency programs of UTHSCSA-RAHC and be a foundational element for development of the UTHSCSA-RAHC into a full four-year medical school in RHP 5 as envisioned by the Texas legislature and planned by the Regents. As the program matures and the number of faculty and local psychiatrists grow, opportunities for multidisciplinary training and clinical programs will expand. The Texas 1115 Medicaid waiver provides an important opportunity to increase access to behavioral health care through increasing the number of psychiatrists and expanding the pipeline of well trained and culturally aware mental health providers for the underserved RHP5.

Additional Project Goals: Beyond the goal of expanding the RHP5 behavioral health workforce to increase access and capacity, this project is designed to strengthen an integrated health care system, through:

- conducting quality improvement projects to continuously improve clinical outcomes and efficiency; and
- collaborating with other new and expanding residency training programs in the region to transform the delivery system to better meet the physical and mental health needs of the South Texas community.

The program will be crucial to the success of an improved, reformed and more integrated health services delivery system in which patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Relationship to Regional Goals:

A major regional goal is to increase the number of behavioral health professionals and to create a pipeline for continuing to develop and supply behavioral health professionals. This program achieves that goal.

In addition, this project will advance achievement of other regional goals identified in RHP 5:

- By combining the resources of a major safety net hospital, VBMC-B; the VA; Rio Grande State Center (RGSC); and The University of Texas, ensure that the behavioral health delivery system will be adequately developed to meet the needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access behavioral health services in the short-term with new faculty, in the intermediate term also with resident trainees, and in the long-term also with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and improves the existing health care system.

Challenges or Issues faced:
Texas is experiencing a dramatic shortage of behavioral health workforce including psychiatrists. South Texas has long been a medically underserved region, and is particularly underserved for behavioral health with 2.8 psychiatrists per 100,000 population and virtually no child psychiatrists compared to the entire state of Texas that has 6.8 psychiatrists per 100,000 population. Similarly there are 9.2 psychologists per 100,000 in RHP 5 compared to 25.8 per 100,000 in Texas.

In Region 5, one out of every five adults reports that their mental health is fair or poor, which is much worse than the national average. Given that the region is among the poorest in the US, and that the burdens of chronic disease and poverty are high, it is not surprising that mental health is an issue. National data show that when mental illness co-occurs with general medical illnesses such as diabetes, cardiovascular disease, rheumatoid arthritis, or cancer, morbidity and mortality is greater. In studies carried out in the region, the level of measurable depression and anxiety is 29% and 30% of the adult population, respectively, (CCHC unpublished data). The self-reported low ratings of mental health are particularly significant among women (overall), people over age 40 (often associated with a chronic illness such as diabetes or heart disease), and the poorer Hispanic population (Needs Assessment of RHP5). Depression and anxiety were significantly associated with greater BMI and waist circumference, and less physical activity. Depression was positively associated with fasting glucose. Similarly, anxiety was positively associated with elevated HbA1c. Consistent with the lack of access to health services, particularly behavioral health services, only about half of people who report behavioral health problems have sought any help. Because of the lack of mental health services, the last resort is usually a hospital emergency room, when the problem becomes overwhelming, and as a result also increases cost and resource utilization.

Establishing a psychiatry residency and child & adolescent psychiatry training will require approval by the Psychiatry Residency Review Committee (RRC), which meets only twice each year to review well

documented requests that must be submitted at least two months prior to the meeting. Approval for expanding the program must be obtained before the program can recruit residents through the National Residency Match Program (NRMP), which itself has a cycle requiring posting of residency program positions in the fall of the year before the candidates are matched to programs (announced in March) and before they begin the program (July 1). There is a total dearth of local information on child mental health, particularly on autism spectrum disorders and the ADHD complex of conditions. Thus, in addition to the accreditation challenges facing development of an adult psychiatry program, development of a child & adolescent psychiatry program will require work to further define the problem as well as on developing interventions. Meeting these requirements in new psychiatry and child & adolescent psychiatry programs will require the hiring and development of a cadre of UTHSCSA-RAHC faculty to design the program and related clinical activity, apply for accreditation, recruit residents, and become the core faculty for the programs.

How the Project addresses these Challenges Creation and expansion of residency programs for psychiatry residents will not only increase the available service to the population, but those who complete the training have a high likelihood of practicing in the region. Expanding the faculty physicians will provide patient care services and expanding the pipeline of behavioral health physicians. To meet the challenges of accrediting the programs, UTHSCSA-RAHC will draw on its strong and successful history of relationships with VBMC, the VA and other area providers; its depth in research; its ability to recruit faculty nationally; and the extensive experience of UTHSCSA faculty and staff with accreditation processes.

Baseline: Currently there are no psychiatry residents, few child psychiatrists, and only 2.8 psychiatrists per 100,000 population in RHP 5.

Five-year expected outcomes:
The target goals include:
1) Recruitment of an Adult Psychiatry Program Director, Child and Adolescent Psychiatry Program Director, four adult psychiatry faculty members, and two child and adolescent psychiatry faculty members.
2) Submission of a proposal (Program Information Form (PIF)) for the residency program to the national accrediting body, the Accreditation Council for Graduate Medical Education (ACGME) and obtaining approval for the first and only such training programs in the region.
3) Recruiting and training psychiatry residents in both the adult and child and adolescent programs.

Program approval by the ACGME and matriculation of the first cohort of five adult psychiatry residents is planned for July 2015. As a four year program, the first cohort of adult program residents will graduate in 2019. Child & adolescent training includes two years of training and candidates must have completed two years of adult psychiatry training before matriculating into a child and adolescent program. Candidates have the option to count one of the years of child and adolescent training toward the four years required for adult certification, so most psychiatrists who complete training in child and adolescent psychiatry will have had a total of 5 years of training (3 adult + 2 child). Most often, residents within a program will transfer from the adult program to the child and adolescent program, doing so in either the Post Graduate Year–3 (PGY-3) or PGY-4 year.

Matriculation into the child and adolescent program will begin in July 2015 with 2 residents recruited directly into the program. The first cohort of child and adolescent residents will complete their training in 2017. By the time both programs reach maturity, they will be graduating 4-5 adult and 1-2 child and adolescent psychiatrists per year. This will increase the number of psychiatrists per 100,000 population to a level much closer to the average for all of Texas (6.8), providing a much needed increase in behavioral health service capacity.

By the end of the Demonstration Period in September 2016, the project will bring to RHP5:

- Approved Psychiatry and Child & Adolescent Psychiatry residency programs
- 8 new faculty preceptors in the Psychiatry residencies
- 10 psychiatry and 4 child & adolescent psychiatry residents
- Increased access to behavioral health through the clinical services of the faculty and residents

Because some of the faculty for the new training program will be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we project in the metrics that an additional/incremental 2,000 visit slots will be provided by new faculty physicians each year DY3 through DY5, for an annual total of 6,000 visit slots by the end of DY 5. Because the residency program will be brand new, we project that we will fill five of the maximum seven first-year training slots each year in DY4 and DY5. By the end of DY5, we expect 5 PGY1 and 5 PGY2 adult and child psychiatry residents in training at VBMC-Brownsville. The residents will provide patient care in inpatient and outpatient settings as required by RRC standards. The volume of patient care will increase from DY4 to DY 5 as the number of residents increases along with the maturity of their experience.

RATIONALE

Texas, and RHP 5 in particular, has a critical shortage of behavioral health doctors due to a range of factors influencing both supply and community need. Supply has been especially daunting in RHP 5. It is difficult to recruit and hire behavioral health physicians—especially in South Texas. Despite intensive recruitment over many years, as community providers RGSC and VBMC-H continue to struggle to provide sufficient psychiatrists to meet their clinical needs. There is a large actual and identified need by the community of RHP5 for increased availability of behavioral health services. Psychiatrists are the anchors for these services. The poor population in this region has a high level of reported less than good behavioral health, and this is supported by data on depression in this population with high levels of chronic disease and disabilities from the chronic disease. This has a great economic and social impact on the community and affects its ability to improve its levels of education and economic productivity. The shortage of behavioral health providers has contributed to increased wait times in hospitals, community clinics, and other care settings and higher system costs for inpatient care for conditions that more appropriately could be managed in ambulatory settings.

Project components:

- Identify high impact services and gaps in care and coordination
- Recruit Psychiatry and Child & Adolescent Psychiatry Program Directors and full-time core faculty

- Increase in number of residents/trainees choosing psychiatry and child & adolescent psychiatry
- Implement innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System Clinical Safety & Effectiveness (CS&E) course
- Attain ACGME approval for the programs
- Recruit and enroll Psychiatry and Child & Adolescent residents
- Identify project impacts, i.e. "lessons learned," opportunities to scale the project to meet the needs of a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

The UTHSCSA-RAHC's experience in other residency training programs has proven the importance of local residency training opportunities to producing graduates who will remain in RHP 5 when they enter independent practice. This project seeks to expand on that success. The faculty for Psychiatry and Child & Adolescent Psychiatry residency programs will collaborate with the faculty for the other new and existing training programs throughout RHP 5. Recruitment of full-time academic program faculty also will allow enhancement of the programs through greater scholarly activity focused on the clinical conditions especially prominent in RHP 5 and greater involvement of faculty and residents in quality improvement efforts as well.

Data Driving this Project:

The need for enhanced behavioral health services in this health disparity population is extensively documented, as shown above.

Related Category 3 Outcome Measure(s): OD-14 Behavioral Health Workforce

Stand-alone:

IT - 14.1 Number of practicing psychiatrists per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale for selecting the outcome measures:

It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that multiple years of training are required before the first-matriculated residents will begin independent clinical practice. Because the Program Directors and core faculty be recruited and in place even before the programs are accredited and will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing behavioral health practitioners per 100,000 individuals in RHP 5. The bundle of three non-standalone measures above, in the program's experience to date, is a set of strong predictors of the future decisions of residents in the program to enter practice in RHP 5 or elsewhere in South Texas.

Relationship to other Projects:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen; and
- 085144601.1.3 Increase faculty to support an expanded Family Medicine residency program at McAllen Medical Center.

Relationship to Other Performing Providers' Projects in the RHP:
This project is related to the following projects by other performing providers in RHP 5 (all at Doctors Hospital at Renaissance):

- Establish Primary Care Training Programs; 160709501.1.1; 160709501.1.2; 160709501.1.3.
- Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program). 160709501.1.4

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for VBMC physicians and staff to participate in the CS&E course and projects.

Project Valuation:
South Texas has historically been a medically underserved area and as documented above Region 5 has a very large pool of undiagnosed mental health conditions that leads to high rates of emergency

visits and admissions that could be avoided through behavioral health care. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in south Texas if they complete their residency training programs locally. This residency expansion project, along with the other new and expanding residency projects in RHP5, can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT CS&E program in local hospital quality improvement efforts.

PROJECT ID 085144601.1.2	*PROJECT OPTION* 1.9.1	*PROJECT COMPONENT(S)*	Expand Behavioral Health/Establish Psychiatry Residency Training Programs at Valley Baptist - Brownsville
UT Health Science Center San Antonio			TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.2	IT-14.1	Number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]Documentation of gap assessment. (baseline for DY2). Goal: Produce a comprehensive report documenting existing and needed psychiatric care resources Data Source: Needs assessment Milestone 1 Estimated Incentive Payment*:* $1,367,593 **Milestone 2** [P-14]: Expand targeted specialty care (TSC) training in psychiatry: Metric 1 [P-14.2]. Hire TSC faculty members. Baseline: At the beginning of DY 2, no Program Director or faculty are in place for the	**Milestone 3** [P-14]: Expand targeted specialty care (TSC) in psychiatry. Metric 1: [P-14.1]: Expand the TSC residency clinician training programs and/or rotations Baseline: At the beginning of DY2, there is no program Goal: Submit the application for initial accreditation by 2/2014 for Residency Review Committee (RRC) 10/2014 meeting Data Source: Training program records Metric 2 [P-14.2]. Hire additional precepting TSC faculty members. Baseline: At the beginning of DY2, no faculty are present. Goal: Hire two core faculty in addition to those hired in DY3. Cumulative total faculty by end of DY3 = 5. Data Source: HR documents Milestone 3 Estimated Incentive	**Milestone 6 [**P-16]. Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents. Metric 1 [P-16.1] ACGME approval for new residency program Baseline: At the beginning of DY2, there is no approved residency program. Goal: ACGME approval by 10/14 Data Source: Training program records Milestone 6 Estimated Incentive Payment*:* $758,654 **Milestone 7 [**P-14]. Expand targeted specialty care (TSC) in psychiatry. Metric 1 [P-14.2]. Hire additional precepting TSC faculty. Baseline: At the beginning of DY2, no faculty are present. Goal: Hire two core faculty in addition to those hired in DY2 and DY3. Cumulative total faculty by end of DY4 = 7. Data Source: HR documents	**Milestone 10** [I-31]: Increase TSC training and/or rotations Metric 1: [I-31.4]: Increase the number of TSC residents as compared to baseline. Baseline: At the beginning of DY2, no psychiatry residents are present Goal: Recruit second cohort of 5 PGY1 psychiatry residents as of 7/15/2016. Total residents in programs = 10. Data Source: Program enrollment records. Milestone 10 Estimated Incentive Payment*:* $776,116 **Milestone 11** [I-22] Increase the number of specialist providers and clinic hours available for the high impact/most impacted medical specialties Metric I-22.1: Increase number of psychiatry specialist providers and clinic hours

PROJECT ID 085144601.1.2	*PROJECT OPTION* 1.9.1	*PROJECT COMPONENT(S)*	Expand Behavioral Health/Establish Psychiatry Residency Training Programs at Valley Baptist - Brownsville	
UT Health Science Center San Antonio				TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.2	IT-14.1	Number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
residency program. Goal: Hire three faculty physicians including Program Director and 2 Core faculty by 9/30/13. Data Source: HR documents Milestone 2 Estimated Incentive Payment*:* $1,367,592	Payment*:* $1,001,190 **Milestone 4** [I-22] Increase the number of specialist providers and clinic hours available for the high impact/most impacted medical specialties <u>Metric I-22.1</u>: Increase number of psychiatry specialist providers and clinic hours Baseline: No faculty visit slots exist at the beginning of DY2; faculty recruitment begins in DY2. Goal: Add annual count of 2,000 patient visit slots attributable to new faculty physicians Data source: Clinical faculty schedules Milestone 4 Estimated Incentive Payment*:* $1,001,190 **Milestone 5** [I-X] Increase the number of faculty staff completing educational courses.	Milestone 7 Estimated Incentive Payment*:* $758,654 **<u>Milestone 8 [</u>**<u>I-31]</u>. Increase TSC training and/or rotations. <u>Metric 1</u> [I-31.4]. Increase the number of TSC residents as compared to baseline. Baseline: At the beginning of DY2, no psychiatry residents are present Goal: Enroll first cohort of 5 residents beginning 7/1/2015. Data source: Program records Milestone 8 Estimated Incentive Payment*:* $758,654 **Milestone 9** [I-22] Increase the number of specialist providers and clinic hours available for the high impact/most impacted medical specialties <u>Metric I-22.1</u>: Increase number of psychiatry specialist providers and clinic hours Baseline: No faculty visit slots exist at the beginning of DY2; faculty	Baseline: No faculty visit slots exist at the beginning of DY2; faculty recruitment begins in DY2. Goal: Add annual count of 6,000 patient visit slots attributable to new faculty physicians; 2,000 more than in DY4. Data source: Clinical faculty schedules Milestone 11 Estimated Incentive Payment*:* $776,117 **Milestone 12** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline: No trainees to provide visits in DY2. Goal: For each PGY1 resident, complete 45 new inpatient medical management visits from start of 7/15/16 to 9/30/16. For each PGY2

PROJECT ID 085144601.1.2	*PROJECT OPTION* 1.9.1	*PROJECT COMPONENT(S)*	Expand Behavioral Health/Establish Psychiatry Residency Training Programs at Valley Baptist - Brownsville	
UT Health Science Center San Antonio				TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.2	IT-14.1	Number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	Metric 1 [I-X.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty staff complete the CS&E training. Data Source: Certificates of completion. Milestone 5 Estimated Incentive Payment: $1,001,191	recruitment begins in DY2. Goal: Add annual count of 4,000 patient visit slots attributable to new faculty physicians; 2,000 more than in DY3. Data source: Clinical faculty schedules Milestone 9 Estimated Incentive Payment: $758,653	resident, complete 250 new inpatient medical management visits and 750 outpatient visits over the 12 months of DY5. Data Source: Resident clinical schedules. Milestone 12 Estimated Incentive Payment: $776,116 **Milestone 13** [P-X] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Metric 1 [P-X.1] Quality assessment and improvement curriculum and practicum for residents. Baseline: No curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology based on CS&E course and including data analytics and population management. Data Source: Curriculum and practicum documentation. Milestone 13 Estimated Incentive	

PROJECT ID 085144601.1.2	*PROJECT OPTION* 1.9.1	*PROJECT COMPONENT(S)*	Expand Behavioral Health/Establish Psychiatry Residency Training Programs at Valley Baptist - Brownsville
UT Health Science Center San Antonio			TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.2	IT-14.1	Number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA

Year 2 (10/1/2012 – 9/30/2013)	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: $776,117
Year 2 Estimated Milestone Bundle Amount: $2,735,185	Year 3 Estimated Milestone Bundle Amount: $3,003,571	Year 4 Estimated Milestone Bundle Amount: $3,034,615	Year 5 Estimated Milestone Bundle Amount $3,104,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,877,837			

- ***Performing Provider: UT Health Science Center at San Antonio***
- ***Project Name: Increase the Number of Family Medicine faculty to strengthen the residency program at McAllen Medical Center***
- ***Project Identifier: 085144601.1.3***

Provider:	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.
Intervention(s):	This project will expand the existing Family Medicine residency faculty at McAllen Medical Center, providing increased primary care capacity in the program and increase the number of primary care providers in RHP5. The expansion will include some key faculty whose presence will insure the ability to ultimately expand the actual number of residents trained in the near future, and in the near term will increase the quality and breadth of training of the current residents in line with development of a more integrated health system.
Need for the project:	This project will increase the number of primary care providers, and also greatly improve the quality of training of Family Medicine Primary care physicians. RHP 5 has 55 primary care physicians per 100,000 population compared to 70 statewide. Furthermore there is a large pool of undiagnosed and untreated people with chronic conditions, e.g. diabetes, in RHP 5 requiring more primary care physicians to manage this rapidly growing problem.
Target population:	The target population is the entire RHP 5, a region with a high concentration of Medicaid and indigent patients. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. All of the population will stand to benefit from more trained primary care physicians.
Category 1 or 2 expected patient benefits:	The project seeks to greatly increase the quality and number of primary care physicians practicing in RHP 5 over the next decade. We will add 6 Family Medicine faculty and staff specialists in the residency program. New program faculty will increase access to primary care with annual counts of 2,000 visit slots in DY3, 4,000 in DY 4, and 6,000 in DY5. In addition, the program will feature an innovative curriculum incorporating population health analytics, chronic disease management, and quality improvement.
Category 3 outcomes:	IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA RHP 5.

Project Option 1.2.3 – Increase the Number of Family Medicine Faculty to Strengthen the Family Medicine Residency Program at McAllen Medical Center

Unique Project ID: 085144601.1.3
Performing Provider/TPI: UT Health Science Center San Antonio / 085144601

PROJECT DESCRIPTION

The primary goal of this project (1.2.3) is to increase the number of primary care providers in a Health Professions Shortage Area (HPSA) region, thus increasing access and capacity. This will occur by recruiting more faculty to the existing Family Medicine residency training program sponsored by The University of Texas Health Science Center San Antonio (UTHSCSA) at McAllen Medical Center to improve the quality and variety of training of family medicine residents. The new faculty also will increase access to health services through the clinic sessions they conduct in the course of training family medicine residents. This expansion will be an important part of the programs to improve integrated care that will be conducted in parallel to strengthening the family medicine residency.

The project will build on the long-standing and mutually beneficial partnership between UTHSCSA and McAllen Medical Center. It will build on the success of the program in training clinicians who locate their practices in RHP 5, helping to alleviate the area's substantial primary care workforce shortage, and will update the training program to include more organized care delivery models, behavioral health, and related research and scholarly work. It will complement the other existing and new residency programs of UTHSCSA-RAHC and be a foundational element for development of the UTHSCSA-RAHC into a full four-year medical school in RHP 5 as envisioned by the Texas legislature and planned by the Regents. The Texas 1115 Medicaid waiver provides an important opportunity to increase access to primary care through increasing the number of primary care physicians and the pipeline of well trained and culturally aware physicians for the underserved RHP 5.

Additional Project Goals: Beyond the goal of increasing the RHP 5 primary care workforce to increase access and capacity, this expansion is designed to strengthen an integrated health care system and to play a key role in implementing disease management programs, through:

- implementing an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- conducting quality improvement projects to continuously improve clinical outcomes and efficiency; and
- collaborating with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

A greater focus on primary care will be crucial to the success of an improved, reformed and more integrated health services delivery system in which patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Relationship to Regional Goals:
This project will advance achievement of regional goals identified in RHP 5:

- By combining the resources of a major safety net hospital, McAllen Medical Center and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term also with resident trainees, and in the long-term also with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the existing health care system.

Challenges or Issues faced:
Texas is experiencing a dramatic shortage of primary care workforce including physicians and a dearth of medical students choosing careers in primary care. South Texas has long been a medically underserved region, and is particularly underserved for primary care with 55 physicians per 100K population compared to 70 per 100K in Texas (80% of Texas average). Similarly there are 103 direct care physicians per 100K in RHP 5 compared 165 per 100K in Texas. The need for enhanced primary care resources in RHP 5 is challenging.

Designing interventions to meet the need also is challenging. Over the past several years, the essentials for program accreditation by the Family Medicine Residency Review Committee (RRC) have become increasingly specific on requirements for protected academic time for core faculty members, scholarly activity by faculty and residents, training in behavioral health, and limitations on the work hours and schedules for residents. Meeting these requirements will require the hiring and development of an expanded cadre of full-time UTHSCSA-RAHC faculty who will strengthen the elements of the program of most importance for improving the care for pregnant women, children and adults with chronic disease.

How the Project addresses these Challenges
Part of the solution to this constellation of health problems is to increase access to primary care by expanding the primary care faculty who will provide improved training, but will ultimately help increase the pipeline for the future needs. The enlarged faculty will improve the quality of training of family medicine residents and ultimately provide the foundation for increasing the number of physicians in the Family Medicine Residency of the Regional Academic Health Center and begin to reduce the current disparity of primary care physicians in RHP 5.

To meet the challenges of accrediting the expanded program, UTHSCSA-RAHC will draw on its history of local involvement; its ability to recruit faculty nationally; and the extensive experience of UTHSCSA faculty and staff with accreditation processes.

Five-year expected outcomes:
By the end of the Demonstration Period in September 2016,

- Increase the Family Medicine faculty and staff experts in the program by 6;
- Increase access to primary care through the new or expanded clinic sessions by the new faculty; and
- Increase the knowledge base and quality of training of family medicine residents.

Because some of the faculty for the new training program may be recruited from the existing, local supply of culturally competent physicians, the patient access metrics related to faculty practice are limited to incremental access provided by imported faculty physicians new to RHP 5. Accordingly, we project in the metrics that an additional/incremental 2,000 primary care visit slots will be provided by new faculty physicians each year DY3 through DY5, for an annual total of 6,000 visit slots by the end of DY 5.

STARTING POINT/BASELINE

As of December 2011, the benchmark for Family Medicine faculty in the program is 7 including one Program Director and part-time, community preceptors. The overall RHP 5 benchmark of primary care physicians is 55 per 100,000 population compared to 70 statewide.

RATIONALE

Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians—especially in South Texas.

The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population -- a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 220 and 91, respectively.) From 2001 to 2011, the Texas physician workforce grew 32%, exceeding the population growth of 25%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

The pool of undiagnosed and untreated chronic disease in RHP 5 is a social, economic and psychological drain on this population and represents one of the most substantial levels of health disparities in the country. This has a great impact on the community and affects its ability to improve its levels of education and economic productivity. The extremely low level of primary care providers in RHP 5 makes it even more imperative to increase access to primary care for those with undiagnosed and untreated chronic diseases. One of the most cost saving measures that can be taken is to expand primary care to move people with undiagnosed and untreated chronic disease to programs for management and prevention that keep them from costly complications that promote eventual presentation at emergency care facilities and to being hospitalized with advanced disease.

Project components:

- Identify high impact services and gaps in care and coordination
- Recruit 4 additional full-time core faculty with specific expertise and two program specialist staff
- Implement innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System Clinical Safety & Effectiveness (CS&E) course
- Expand clinic sessions and increase patient access and primary care visits

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

The Family Medicine residency training program at McAllen Medical Center has had good success in producing graduates who have remained in RHP 5 to provide primary care services. This project will expand the faculty to provide primary care services through the program's family medicine center (including perinatal and well child care) as well as providing comprehensive follow-up care for previously undiagnosed patients admitted to McAllen Medical Center. The faculty for the Family Medicine residency program will collaborate with the faculty for the new and existing training programs throughout RHP 5. Expansion of the program faculty also will allow enhancement of the program through greater scholarly activity focused on the clinical conditions especially prominent in RHP 5 and greater involvement of faculty and residents in quality improvement efforts at McAllen Medical Center.

Data Driving this Project:

The need for enhanced primary care in this health disparity population is extensively documented. Data published by the United States Census Bureau in 2012 show that 88% (Cameron County) and 91% (Hidalgo County) of the population is Mexican American or Latino in origin and that 35% live

below the poverty line (compared with 17% for Texas and 14% nationally (http://quickfacts.census.gov/qfd/states/00000.html). Currently only about 65% of RHP 5 residents have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48% and that 8% are morbidly obese. The prevalence of diabetes is an alarming 31% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed. Many participants with diabetes (55%) and hypertension (50%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer. The underlying conditions are essentially preventable or treatable. The long term cost of neglect will be huge. Prevention and early intervention are key. These health needs need to be first addressed through primary care, providing diagnosis, preventive care and simple interventions for patients before their disease is advanced. Expansion of the residency program faculty will allow RHP 5 to make significant progress toward this end.

Related Category 3 Outcome Measure(s): OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Rationale for selecting the outcome measure:
Because the additional full-time core faculty will be recruited early in the demonstration period and will dedicate 40-60% of their time to clinical care, they will have an impact on the number of practicing primary care practitioners per 100,000 individuals in RHP-5, as well as strengthening the pipeline for recruitment and training of family medicine residents who will be likely to locate their practices in RHP 5.

Relationship to other Projects:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville and
- 085144601.1.1 Expand Primary Care/Internal Medicine Residency Training Program at Valley Baptist - Harlingen.

Relationship to Other Performing Providers' Projects in the RHP:
This project is related to the following projects by other performing providers in RHP5 (all at Doctors Hospital at Renaissance):

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/Family Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. CS&E is a training course with PDSA (Plan Do Study Act, rapid cycle improvement) at the heart of the curriculum; a strategic improvement project is required as part of the course. Many faculty and staff adopt CS&E into their ongoing activities after graduation from the training. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. All of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, integrating primary and specialty care, the use of patient registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics. UT will provide opportunities for MMC physicians and staff to participate in the CS&E course and projects.

Project Valuation:
This project's impact on RHP 5's large Medicaid and indigent population will be profound. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations. As documented above RHP 5 has a very large pool of undiagnosed chronic disease that leads to high rates of emergency visits and admissions that could be avoided through primary care. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. This residency expansion project, along with the other new and expanding residency projects in RHP 5, can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospital quality improvement efforts.

Unique Project Identifier 085144601.1.3	*Project Option 1.2.3*	*Project Component(s)*	Increase the Number of Family Medicine Faculty to Strengthen the Family Medicine Residency Program at McAllen Medical Center
UT Health Science Center San Antonio			TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.3	IT-14.1	Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment: $1,367,593 **Milestone 2** [P-2]: Expand primary care training for primary care family medicine providers: Metric 1 [P-2.2]. Hire primary care faculty members. Baseline: At the beginning of DY 2, the program has no full-time faculty and staff with the requisite	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1: [P-2.2]. Hire primary care faculty members. Baseline: At the beginning of DY 2, the program has 7 faculty Goal: Hire 2 Core full-time faculty members in addition to those in place at beginning of DY2 and those hired by end of DY2. Cumulative additions = 4 core faculty and 2 staff specialists. Data Source: HR documents Milestone 3 Estimated Incentive Payment: $750,892 **Milestone 4** [P-3]: Expand positive primary care exposure for residents. Metric 1 [P-3.1] Develop mentoring program with new primary care faculty Baseline: At the beginning of DY 2,	**Milestone 7** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in this program have participated in CS&E course. Goal: Two faculty members complete the CS&E training, in addition to the 2 faculty completing CS&E in DY3. Data Source: Certificates of completion Milestone 7 Estimated Incentive Payment: $758,654 **Milestone 8** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.5] Improvement in trainee satisfaction with specific elements of the training program a. Numerator: Sum of trainee	**Milestone 11** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Goal: Two faculty members complete the CS&E training, in addition to the 4 faculty completing CS&E in DY3-DY4. Cumulative total = 6 Data Source: Certificates of completion. Milestone 8 Estimated Incentive Payment: $776,116 **Milestone 12** [1-11] Increase primary care training and/or rotations Metric 1 [I-11.5] Improvement in trainee satisfaction with specific elements of the training program Baseline: DY2 trainee satisfaction scores

Unique Project Identifier 085144601.1.3	*Project Option 1.2.3*	*Project Component(s)*	Increase the Number of Family Medicine Faculty to Strengthen the Family Medicine Residency Program at McAllen Medical Center
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Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
credentials Goal: Hire 2 Core faculty members: pediatrician and behavioral health/ research director; and hire 2 staff specialists in simulation and research in addition to faculty in place at beginning of DY2. Data Source: HR documents Milestone 2 Estimated Incentive Payment: $1,367,592	the program has mentoring program with limited focus areas. Goal: Strengthen the training program by providing new mentoring foci in behavioral health issues, primary care for children and research Data source: Program records <u>Metric 2</u> [P-3.2] Train residents in the medical home model, chronic care model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: No focused training on these topics exists in DY2. Goal: Develop curriculum and implement training per the metric. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. <u>Metric 3</u> [P-3.3] Include residents in	satisfaction scores b. Denominator: total number of trainees Baseline: DY2 trainee satisfaction scores Goal: Increase satisfaction scores by 10% over DY2 baseline. Data Source: Trainee satisfaction assessment tool <u>Metric 2</u>[I-11.6] Improvement in trainee knowledge assessment scores a. Numerator: Sum of differences in pre and post training assessment scores. b. Denominator: Number of graduates from training program. Baseline: DY2 trainee knowledge assessment scores Goal: Increase knowledge assessment scores by 5% over baseline from DY2. Data source: Knowledge assessment tool	Goal: Increase satisfaction scores by 12% over DY2 baseline. Data Source: Trainee satisfaction assessment tool <u>Metric 2</u>[11.6] Improvement in trainee knowledge assessment scores Baseline: DY2 trainee knowledge assessment scores Goal: Increase knowledge assessment scores by 7% over baseline from DY2. Data: Knowledge assessment tool Milestone 12 Estimated Incentive Payment: $776,117 **Milestone 13 [P-4]** Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. <u>Metric 1</u> [P-4.1] Quality assessment and improvement curriculum and practicum for residents.

Unique Project Identifier 085144601.1.3	*Project Option 1.2.3*	*Project Component(s)*	Increase the Number of Family Medicine Faculty to Strengthen the Family Medicine Residency Program at McAllen Medical Center
UT Health Science Center San Antonio			TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.3	IT-14.1	Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	quality improvement projects. Baseline: No specific training experience incorporated with the hospital exists currently. Goal: Five residents will participate in QI efforts with behavioral health/research director. Data source: Curriculum or QI project documentation. Milestone 4 Estimated Incentive Payment: $750,893 **Milestone 5** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in this program have participated in CS&E course. Goal: Two core faculty members complete the CS&E training.	Milestone 8 Estimated Incentive Payment: $758,654 **Milestone 9** [P-3]: Expand positive primary care exposure for residents. Metric 3 [P-3.3] Include residents in quality improvement projects. Baseline: No specific training experience incorporated with the hospital exists currently. Goal: Five residents who have not previously participated will participate in QI efforts with behavioral health/research director. Cumulative total for DY3-DY4 = 10. Data source: Curriculum or QI project documentation. Milestone 9 Estimated Incentive Payment: $758,654 **Milestone 10** [I-X] Increase primary care access provided by new faculty physicians	Baseline: No curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology based on CS&E course and including data analytics and population management. Data Source: Curriculum and practicum documentation. Milestone 13 Estimated Incentive Payment: $776,116 **Milestone 14** [I-X] Increase primary care access provided by new faculty physicians Metric 1 [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: No faculty visit slots exist at the beginning of DY2 for faculty recruited in DY2. Goal: Annual count of 6,000 additional primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY4.

Unique Project Identifier 085144601.1.3	*Project Option 1.2.3*	*Project Component(s)*	Increase the Number of Family Medicine Faculty to Strengthen the Family Medicine Residency Program at McAllen Medical Center
UT Health Science Center San Antonio			TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.3	IT-14.1	Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Year 2 (10/1/2012 – 9/30/2013)	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: Certificates of completion Milestone 5 Estimated Incentive Payment: $750,893 **Milestone 6** [I-X] Increase primary care access provided by new faculty physicians <u>Metric 1</u> [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: New faculty recruitment begins in DY2. Goal: Annual count of 2,000 additional primary care patient visit slots attributable to new faculty physicians. Data Source: Clinical faculty schedules. Milestone 6 Estimated Incentive Payment: $750,893	<u>Metric 1</u> [I-X.1] Increase number of primary care visit slots available to patients attributable to new faculty physicians. Baseline: New faculty recruitment begins in DY2. Goal: Annual count of 4,000 additional primary care patient visit slots attributable to new faculty physicians; 2,000 more than in DY3. Data Source: Clinical faculty schedules. Milestone 10 Estimated Incentive Payment: $758,653	Data Source: Clinical faculty schedules. Milestone 14 Estimated Incentive Payment: $776,117

UNIQUE PROJECT IDENTIFIER 085144601.1.3	*PROJECT OPTION 1.2.3*	*PROJECT COMPONENT(S)*	Increase the Number of Family Medicine Faculty to Strengthen the Family Medicine Residency Program at McAllen Medical Center
UT Health Science Center San Antonio			TPI: 085144601
Category 3 Outcome Measure(s):	085144601.3.3	IT-14.1	Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Year 2 (10/1/2012 – 9/30/2013)	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: $2,735,185	Year 2 Estimated Milestone Bundle Amount: $3,003,571	Year 4 Estimated Milestone Bundle Amount: $3,034,615	Year 5 Estimated Milestone Bundle Amount: $3,104,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,877,837			

D. Category 2: Program Innovation and Redesign

The following narratives describe each Pass 1 Category 2 project of Performing Providers, in alphabetical order of provider.

Border Region Behavioral Health Center – Category 2: Program Innovation and Redesign

Project Summary:

Provider Name/TPI: Border Region Behavioral Health Center/121989102
Project Title: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

Unique Project Identifier: 1219891.02.2.1

Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5. In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 combined adult and child enrolled in approximately 500.
The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other.
Intervention(s): This project initiates integrated primary and behavioral health services. Behavioral health clients identified as co-morbid physical disorder of diabetes, hypertension, obesity or COPD may qualify for the patient panel in this program.
Need for the project (include data as appropriate): This project initiates integrated primary and behavioral health services . Behavioral health clients diagnosed with co-morbid physical disorders of diabetes, hypertension, obesity or COPD may qualify for the patient panel in this program.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): A patient panel consisting of clients with behavioral health issues with co-morbid physical disorders. Initially to consist of 20 Medicaid clients.

Category 1 or 2 expected patient benefits: Clients will be afforded a wider variety of specialized consultations and wait times for services will decrease.

- The project will begin serving clients in DY3, achieving a pool of 20 integrated care clients by the end of that year. 30 will be served by the end of DY4 and 50 by the end of DY5

Category 3 outcomes expected patient benefits: Reduce possibly preventable admission to acute medical surgical hospitals. Patients will experience greater coordination of care for all services.

Unique RHP Project Id Number: 121989102.2.1
Performing Provider/TPI: Border Region Behavioral Health Center TPI: 121989102

Project Option 2.15.1 identify clients with co-morbid conditions and provide integrated primary and behavioral services for residents in Starr County

Project Description:

Develop and implement an integrated Behavioral Health and Primary Care pilot, targeting at risk populations with co-morbid diseases of mental illness and chronic physical disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails.
This project proposes offering a Behavioral Health and Primary Care Integrated treatment model for indigent and Medicaid clients in Starr County. Border Region already provides behavioral health in this service region. A patient panel will be selected from among the client population targeting persons diagnosed with co-morbid physical conditions. The integrated care program/model will offer the following services:

1. Behavioral Health Services
2. Primary care services
3. Health behavior education and training programs
4. Case Management services to help patient navigate the services provided in the community.

Border Region will implement the IMPACT Model of collaborative care.

5. Health screening will be made available to clients interested in integrated care.

Goals and Relationship to Regional Goals:
The Region 5 plan cites the inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions as one of its community needs and states as one of it's goals: Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system. Project 2.15.1 addresses both of these.

Project goals:

Identify a panel of behavioral health clients with co-morbid physical health conditions and provide patient centered treatment and symptoms management under centralized coordination.

Continue management of patient even when some symptoms are in remission.

Improve communication between providers and enhance coordination of care.

Reduce cost and inconvenience of transportation making trips to multiple providers due to colocation.

Challenges:
Finding and employing primary care providers:

- Costs
- Cultural barriers
- Lack of health literacy

These barriers will be addressed by providing competitive salaries. In addition, Border will advertise nationally. Border will hire through federal programs that provide debt relief to physicians for practicing in underserved areas. Recruitment activities are addressed through project 1.14.1

5 year expected outcomes:
We expect to see the following outcomes from implementing this project:

- Increase in access to primary care
- Increase In access to behavioral health care services
- Reduction in inpatient psychiatric hospitalizations
- Increase in patient satisfaction
- Reduction in Emergency Department visits
- Chance to develop and change health behaviors
- Reduction in preventable behavioral health and chronic disease hospitalizations

- The project will begin serving clients in DY3, achieving a pool of 20 integrated care clients by the end of that year. 30 will be served by the end of DY4 and 50 by the end of DY5

Starting Point/Baseline:
No integrated primary care and behavioral health services are currently available in Region 5. Behavioral health services in Starr county include crisis management, medication management, case management, and rehabilitation skills training. Minimal physical health information is available.

Rationale:
Research has shown that patient centered medical homes that use the IMPACT model of collaborative care have had improved outcomes in physical health, which has benefited various populations and resulted in lower costs of care over the long term[70]. Druss and colleagues conducted a randomized trial of patients within the Veterans Administration system in 2001. In the study, individuals living with serious mental illnesses were to receive primary care in an integrated behavioral health-primary care patient focused model of care. The study showed that individuals were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had significantly greater improvement in their health.[71]

[70] http://www.impact-uw.org/about/research.html
[71] Druss, B et al. Integrated medical care for patients with serious psychiatric illness. Archives of General Psychiatry, Vol 58, September 2001

Project Components:

(a)The Border Region Behavioral Health Center clinic in Starr County will be the project location site. Centrally located in Rio Grande City (population 29,000), it will be the most accessible location in this large, rural county. The primary care services will be managed by Border Region and other specialty care services will be provided under contract with Border Region.

(b)Scheduling and client information will reside with the Border Region client information system. It is expected that primary care services will be co-located with the behavioral health services and provider agreements will not be necessary as it is coordinated under Border Region management.

a) (c)Under process standard P3 (milestone 1, DY2), processes and protocols for communication, data sharing and referral will be developed. The number and types of referrals and successful follow through will be measured. Primary and behavioral health providers will both use the Border Region client data, this allowing for data sharing and referral tracking.
b) (d)Specialty providers will be recruited as per Project 1.14.1 and/or contract providers will provide telemedicine services available from project 1.11.2.
c) (e) Provider training will be initiated as per development of protocols and processes for milestone 1, DY2. Milestones 3,6,9 & 13 provide for idea testing to assist providers in developing regular and productive case meetings and review shared treatment planning protocols.
d) (f) Electronic Clinical records are already in use and data reporting systems are in place and used daily.
e) (g)Legal agreements for collaborative practices will be explored as a function of DY2 metric for milestone 2 but the project is initially being planned to operate under Border Region management so collaboration between disparate legal entities may not be an issue..
f) (h) Utilities and building services already exist for selected site. Should new sites become available presenting possibilities for service improvement, this will be addressed under Milestone 2 in DY2 pertaining to identifying sites in the community for clinic co-location.
g) (i) Data systems and reporting mechanisms are in place. New reporting codes will be developed to isolate data pertinent to this project. This will be addressed with Milestone P-9 – review project data weekly and respond with new ideas for practices, tools and solutions.
h) (j) Quality improvement will be addressed under milestones 3 & 4 (DY2), 6 & 7 (DY3), 9 & 11 (DY 4) and 13 & 15 (DY 5).

Milestones & Metrics:

The following milestones and metrics have been chosen for the Border Integrated Primary and Behavioral Health Care project based on the core components and the needs of the target population:

- **Process Milestones and Metrics:** P-2 (P-2.1) to evaluate the best location for the project, ; P-3 (P-3.1) for policy and procedure development related to information sharing and referral handling; P-5 (P-5.2) for tracking the number of non-behavioral providers located in the behavioral health clinic in DY3, P-6 (P-6.1, P-6.2) to track the progress of collaborative co-location from Level 4 colocation to Level 5 in DYs 4&5; P-7 (P-7.1) as a CQI practice in DYs 4&5; P-9 (P-9.1) for weekly project review and idea testing and P-10 (P-10-1) for semi-annual face-to-face learning collaborative with the RHP and other providers. This will be done in collaboration with RHP 5 anchor and performing providers.
- **Improvement Milestones and Metrics:** I-10 (I-10.1) to track No-Shows as an indicator of integrated clinic patient acceptance.

Unique community need identification number the project addresses:

- CN.3 - Inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions

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

Border Region in Starr County has traditionally served only behavioral health needs with no communication or coordination with providers of physical health. This project represents a new initiative and may also be the first experience of regular physical health maintenance for some behavioral health clients.

Related Category 3 Outcome Measure(s):

Outcome Domain 2 – Potentially Preventable Inpatient Admissions. (IT-2.4.) This domain was chosen because research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population[72]. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness.

National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders.

Treating patients in an integrated behavioral health primary care model will reduce preventable inpatient admissions.

[72] Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioral disorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group, May 2006.

Relationship to other Projects:
This project relates to project 1.11.2 in that teleconferencing will permit access to specialty providers on contract and enable participation by qualified panel members in outlying counties. Project 1.14.1 will be necessary to recruit, train and retain addition licensed service providers needed to treat clients involved in this project. Projects 1.14.1 will provide recruitment and training efforts to provide licensed and other primary care workers. Project 1.11.2 will expand telemedicine services to permit inclusion of geographically distant clients and expend the number and type of specialty services that may be offered under this integrated care effort.

Relationship to Other Performing Providers' Projects in the RHP:
This project as other projects in the region supports the regional goals to provide increased access and availability to primary and behavioral health care services. Focusing on integrated care provides the best opportunity for positive patient outcomes and avoids increased costs due to inappropriate inpatient admissions and emergency department usage.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
The project will reduce unnecessary emergency room utilization and inpatient admissions. By creating co-located primary care and behavioral health, patients will experience more years of productive life.

Psychiatric inpatient costs attributed to Starr county are approximately $586, 730 per year and reflect a combination of State Hospital and private psychiatric care. Approximately 70 admissions come from Starr County annually with an average length of stay of 5.7 days. Inpatient cost per day is $595 per based on Center for Medicare Services research (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell_2005_3.pdf). Patient data is not reported by the local medical hospital (48 beds), but if usual regional data is applied for treatment of diabetes, it can be anticipated 25% of this population also suffers from behavioral health issues. Diabetes may complicate and increase the cost of psychiatric inpatient stays as well.

121989102.2.1	2.15.1	2.15.1.A-J	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Border Region Behavioral Health Center			121989102
Related Category 3 Outcome Measure(s):	121989102.3.3	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-3 Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. <u>Metric 1</u> P 3.1 Number and types of referrals that are made between providers at the location **Baseline:** No integrated services or standards exist. Referral system in place in client data system. . No clients served by integrated care model in DY2. **Goal:** Incorporate industry standards as per chosen integration model. No clients served by integrated care	**Milestone 5** P-5 Develop integrated sites reflected in the number of locations and providers participating in the integration project. **Metric 1** P-5.2 Number of primary care health providers newly located in behavioral health clinics. **Data Source:** Human Resources records of employees or contract management records. **Baseline**: Only Behavioral health workers at locations. **Goal:** Begin project operations in DY3. 20 clients receive integrated care. **Milestone 5** Estimated Incentive Payment: $93,252 **Milestone 6** P-9 Review project data and respond to it every week with	**Milestone** 8 P-6 Develop integrated behavioral health and primary care services within co- located sites. <u>Metric 1</u> P-6.1 Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). **Data Source:** Project data **Goal:** Complete first full year of service to clients of integrated clinic. Integrated care provided to 30 clients. Milestone 8 Estimated Incentive Payment: $74,818.50 **Milestone 9** P-7 Evaluate and continuously improve integration of primary and behavioral health	**Milestone** 12P-6 Develop integrated behavioral health and primary care services within co- located sites. <u>Metric 1</u> P-6.2 Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system) **Data Source:** Project data **Goal:** Service delivery indicates full integration. Integrated care provided to 50 clients. Milestone 12 Estimated Incentive Payment: $ 72,288.25 **Milestone 13** P- 7 Evaluate and continuously improve integration of primary and behavioral health services.

121989102.2.1	2.15.1	2.15.1.A-J	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Border Region Behavioral Health Center			121989102
Related Category 3 Outcome Measure(s):	121989102.3.3	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
model in DY2. **Data Sources:** Surveys of providers to determine the degree and quality Of information sharing, Border Region Client data system. Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 66,481 **Milestone 2** P-2 Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.	tests of new ideas, practices, tools or solutions. **Metric 1** P-9.1 Number of new ideas, practices, tools, or solutions tested by each provider. **Baseline**: Idea testing not instituted, data review done monthly, usually related to productivity. **Goal:** Providers introduce 10 new ideas, practices, tools or solutions. **Data Source:** Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly Milestone 6 Estimated Incentive Payment: $ 93,252 **Milestone 7** P-10 Participate in face-	services. Metric 1 P-7.1. Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles **Goal:** Assure system is achieving integration, and moving toward positive outcomes **Data Source:** Client Data system, Documented PDSA sessions. Milestone 9 Estimated Incentive Payment: $74,818.50 **Milestone 10** I-10 No-Show Appointments Metric 1 I-10.1 % decrease the "no shows" for behavioral and physical health appointments.	Metric 1 P 7.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles **Goal:** Assure system is achieving integration, and moving toward positive outcomes **Data Source:** Client Data system, Documented PDSA sessions. Milestone 13 Estimated Incentive Payment: $ 72,288.25 **Milestone 14** I-10 No-Show Appointments Metric 1 I-10.1 % decrease the "no shows" for behavioral and physical health appointments. **Goal:**- Number of No Shows decreased 15%

121989102.2.1	2.15.1	2.15.1.A-J	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Border Region Behavioral Health Center			121989102
Related Category 3 Outcome Measure(s):	121989102.3.3	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Metric 1 P-2.1 Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based organizations **Baseline:** No spaces identified and clinic may be relocating to more accessible section of city. **Goal:** Selected located provides for physical co-location of primary and behavioral health care providers. **Data Source**: Information from participating persons **Milestone 2** Estimated Incentive Payment: $ 66,481	to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric 1** P-10-1 Participate in semi-annual face-to-face meeting or seminars organized by the RHP. **Baseline**: Region 5 RHP hosting meetings, webinars since Waiver project introduction. **Goal:** Share and learn from other providers. **Data Source:** Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes. **Milestone 7** Estimated Incentive Payment: $ 93,252	**Goal:** Number of scheduled appointments for behavioral and physical health services in the project site. Number of No Shows Decreases 10% from DY3 **Data Source**: Project Data; Clinic Registry Data; Claims and Encounter Data Milestone 10 Estimated Incentive Payment $74,818.50 **Milestone 11** P-10 Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric 1** P-10-1 Participate in semi-	from DY4 **Data Source**: Project Data; Clinic Registry Data; Claims and Encounter Data **Milestone 14** Estimated Incentive Payment: $ 72,288.25 **Milestone 15** P-10 Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric 1** P-10-1 Participate in semi-annual face-to-face meeting or seminars organized by the RHP. **Goal:** Share and learn from other

121989102.2.1	2.15.1	2.15.1.A-J	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Border Region Behavioral Health Center			121989102
Related Category 3 Outcome Measure(s):	121989102.3.3	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 3 P-9 Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. <u>Metric 1</u> P 9.1. Number of new ideas, practices, tools, or solutions tested by each provider. **Baseline**: Idea testing not instituted, data review done monthly, usually related to productivity. **Goal:** Providers introduce 5 new ideas,		annual face-to-face meeting or seminars organized by the RHP. **Goal:** Share and learn from other providers. Providers participate in at least 2 face-to-face meetings. **Data Source:** Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes. Milestone 11 Estimated Incentive Payment: $74,818.50	providers. Providers participate in at least 4 face-to-face meetings **Data Source:** Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes. Milestone 15 Estimated Incentive Payment: $ 72,288.25

121989102.2.1	2.15.1	2.15.1.A-J	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Border Region Behavioral Health Center			121989102
Related Category 3 Outcome Measure(s):	121989102.3.3	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
practices, tools or solutions **Data Source:** Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals. **Milestone 3** Estimated Incentive $ 66,481 **Milestone 4** P-10 Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric 1** P-10-1 Participate in semi-annual face-to-face meeting or seminars organized by the RHP. **Baseline**: Region 5 RHP hosting meetings, webinars since Waiver			

121989102.2.1	2.15.1	2.15.1.A-J	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Border Region Behavioral Health Center			121989102
Related Category 3 Outcome Measure(s):	121989102.3.3	IT-2.4	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
project introduction. **Goal:** Share and learn from other providers. **Data Source:** Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes. **Milestone 4** Estimated Incentive Payment: $ 66,481			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $265,924	Year 3 Estimated Milestone Bundle Amount: $279,756	Year 4 Estimated Milestone Bundle Amount: $299,274	Year 5 Estimated Milestone Bundle Amount: $289,153
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,134,107			

Performing Provider/TPI: Border Region Behavioral Health Center/121989102

Project Option: 2.13.1 Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.

Unique RHP Project Identification Number: 1219891-02.2.2 (Pass 2)

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Project Summary:
Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5. In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 adult and child combined enrolled in approximately 500 at any given time. The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other. Intervention(s): This project designs crisis prevention outpatient services to address factors affecting inpatient admission rates such as chronic homeless services, physical illness, lack of monitoring of medication compliance and decrease in functional status. Need for the project (include data as appropriate): To the degree possible, people should be treated in the community, on an outpatient basis. Current inpatient admission rates (over 100 per year) exceed budget allocations and the system must be analyzed to determine where changes can be made to prevent admissions. New ideas must be tried and evaluated for their effectiveness in preventing admissions. Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): Potentially available to any client of Border Region as many people with behavioral health issues may experience need for crisis services. Populations especially at risk will be identified as part of the project. Estimated Medicaid mix is 50% and 50% indigent. Category 1 or 2 expected patient benefits: Crisis episodes will be prevented or identified and addressed prior to escalating to the need for inpatient services. Over 900 crisis services for Starr County were delivered in the base-line year. It is expected that through the identification of clients prone to crisis and subsequent involvement in crisis prevention, this number may be decreased. Expected client impact from this program is: DY2 -150 clients, DY3 – 175 clients, DY4 – 200 clients, DY5-250 clients. Category 3 outcomes expected patient benefits: Reduced Emergency Department visits for the behavioral health/substance abuse population. Patients will not have to compete with other emergency room visitors for access to services for their needs, access to behavioral health services will be improved.

Project Description:
Border Region Behavioral Health Center will provide an intervention for a target behavioral health population to prevent unnecessary use of services in a specified setting.

Efforts in this project will target preventing crises through design of outpatient protocols intended to prevent crisis in current clientele as well as improve accessibility to community services for non-clients at risk of requiring inpatient treatment and the criminal justice and hospital resources that entails. Although new programs may be designed, emphasis will also be placed upon protocols within and between current programs. Medication compliance will be measured in individuals with Schizophrenia.

Providing over 900 crisis services per year in Region, Border Region needs to implement programs not just to respond to crisis, but to prevent them. Through analysis of existing data and gap analysis, trends will be identified and interventions planned through Plan-Do-Study-Act quality improvement cycles.

Goals and Relationship to Regional Goals:

- Define and describe populations with high use of services in ER, criminal justice and state hospital settings
- Design an intervention to target population for the purpose of preventing unnecessary use of services.
- Ongoing Evaluation and process redesign as indicated by real-time data.

This project incorporates resources from the Pass 1 projects (telemedicine, expanded workforce and integrated primary/behavioral healthcare) to make it effective and will also serve the Pass 1 over-arching goals of reducing potentially preventable readmissions as well as the Pass 2 goals of reducing ED utilization. These resources, identified as needed in current Border Region strategic planning , will figure prominently as the gap analysis is addressed. The expanded workforce, telemedicine and primary care will be tools for the program designers as they addressed in-crisis management and crisis prevention.

Challenges:

The partners implied in this project (criminal justice, Schools, hospitals) are historically disinclined to offer resources to this issue, even if it means crisis management will be more efficiently managed community-wide.

Utilization of high-cost and/or low efficacy but easy access (criminal justice, ED) sources is increasing.

Lack of staff experienced in the design of programs tailored toward specific target groups.

To address these challenges Border Region will:

- Initiate stakeholders meetings as part of the gap analysis to identify strategies productive community partnerships.

- Employ telemedicine technology to reduce the number of hospital admissions which could have been handled by other means

- Expand use of Mobil Crisis Intervention teams

- Partner with Starr Memorial Hospital to perform medical clearance at Border Region, Starr County crisis clinic.

- Expert consultants will be contracted to train staff and provide periodic feedback on implementation of new programs

5 year expected outcome:
Populations of high utilizers are defined and receiving appropriate interventions

- Frequency of crisis interventions is reduced

- Use of ER/criminal justice and state hospitals for persons with behavioral health issues is reduced

- System which can be tested for replicability are introduced.

- Functional improvement is clientele is expected to improve from 150 clients per year demonstrating improvement (DY2) to 250 clients by DY5.

- Clients diagnosed with schizophrenia are expected to demonstrate improved medication compliance (48 in DY4 and 52 in DY5 with medication possession ration >.8)

Starting Point/Baseline:
Users of ER, criminal justice and State Hospital is defined solely as being "in crisis" which implies they are a danger to selves and others. Inpatient admissions for 2013 are expected to be greater than 70 No attempt is made at defining connecting causative factors between admitted individuals or even defining correlative behaviors/histories. There is no predictive work to draw upon to determine who

may be at risk. Currently, Starr County experiences about 70 inpatient admissions per year (adult and child) with the attendant drawing upon criminal justice and hospital resources. Over one thousand crisis encounters were delivered in the time covered by DSRIP year 1.

Admission, LOS records are available for inpatient stays. All outpatient encounters including jail diversion are captured along with outpatient psychiatric medication histories. Supported Housing and Supported Employment programs are also already in place and have been for over 20 years.

The baseline for current functional improvement is 27% of clients served will demonstrate measured functional improvement, or about 150 clients.

Rationale:

Current crisis management systems are insufficient to meet the burgeoning numbers of persons presenting themselves for crisis. Admissions and associated costs of inpatient admissions are unsustainable levels. New approaches are needed to assure that more people in crisis can remain in the community.

Project Components:

Border Region Behavioral Health Center will address all of the project components:

a) Assess size; characteristics and needs of target population(s) for chronic physical health conditions, chronic or intermittent homelessness, and cognitive issues resulting from severe mental illness and/or forensic involvement. Process measure P-1.1
b) Review literature/experience with population similar to target population to determine community-based intervention that are effective in averting negative outcomes such as repeated or extended psychiatric hospitalization, decreased mental and physical functioning status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life. Process measure P.2.1
c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes. Process measure P-2.1
d) Design models which include an appropriate range of community-based services and residential supports. Process measure P-3.1
e) Assess the impact of intervention based on standardized quantitative measures and qualitative analysis relevant to the target population. Data sources to include: standardized assessment of functional, mental and health status; 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 patients population and identify key challenges associated with expansion of the intervention, including special consideration for safety-net populations. Process measure P-4.1

Unique community need identification number the project addresses:

This project relates to Community Need Number 2, shortage of behavioral health professionals and inadequate access to behavioral health care.

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

Traditionally reduction in the use of ER, criminal justice and State hospital use has centered around diverting individuals at the time of crisis. This project will expand that scope to define better at-risk populations and design new programs tailored to the needs of these individuals.

Border Region has historically operated under contract with the State of Texas and has delivered program as dictated by contract terms. Funding for development of programs or initiatives not contract specified has never been available. This project represents an opportunity for Border Region to expand services in ways targeted to specific demographic, cultural and clinical parameters identified for our area. It will also afford opportunity and motivation for staff to learn from contractors and research not previously available.

Related Category 3 Outcome Measure(s):

OD- 9 IT-9.2 2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

The local Emergency Room is the first point of contact for crisis management. This typically involves law enforcement and hospital resources. As the goal of this project is crisis prevention, a practical outcome of a successful program would be less reliance on ER resources.

Relationship to other Projects:

This project can be considered an extension of project 1.13 which deals with gap analysis and redesign of the current crisis system. This project will utilize data generated from project 1.13 and may serve many of the same people, but will design a service system that goes beyond the handling of people in crisis and attempts a broader range of interventions. The execution of this project will be amplified by resources made available in the other projects: Expanded telemedicine system (1.11.2), Enhance workforce (1.14.1) and primary care and behavioral health integration (2.15.2)

Relationship to Other Performing Providers' Projects in the RHP:
TBD

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Project valuation is based on determining reduced costs in the ER, psychiatric inpatient days, criminal justice expenses (court, sheriff and police), lost school attendance, reduced transportation costs (at least half of inpatient admissions must be treated in San Antonio or facilities at least 150 miles from service area), lost time and wages from client's employment, more efficient operations of behavioral health center due to a decrease in "management by crisis", improved overall client satisfaction due to other clients not having to wait while staff and doctors attend to crises.

1219891-02.2.2	***2.13***	***2.13.1 [A-E]***	Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.
[Border Region Behavioral Health Center]			1219891-02.2.2
Related Category 3 Outcome Measure(s): 1219891-02.3.5	*OD-9*	*IT 9.2*	**Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1 Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 1 P-1.1: Numbers of individuals, demographics, location, diagnosis, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization **Data Source:** Completed demographics/utilization study on file/ **Baseline:** over 900 crisis encounters per year**/Goal:** Frequent users and user patterns are identified and demographics established. Milestone 1 Estimated Incentive Payment *(maximum amount):* $	**Milestone 2- P-2** Design community-based specialized interventions for target populations. Metric 1 P-2.1 Project plans which are based on evidence/experience and which address the project goals **Data Source:**. Project documentation **Baseline:** Needs assessment completed**/Goal:** Project plans completed are completed and relate to needs identified in Milestone #1. Staff are trained and competent, project implementation begins. Milestone 2 Estimated Incentive Payment: $201,492.50	**Milestone 4 P-4** Evaluate and continuously improve interventions. **Metric 1** P-4.1 Project planning and implementation documentation demonstrates pan, do, study act quality improvement cycles **Data Source:**. Project documentation **Baseline:** Project plans completed, service began**/Goal:** Improvement cycles yield actionable steps with evidence of implementation Milestone 4 Estimated Incentive Payment: $134,329 **Milestone 5 I-3** Adherence to Anti-psychotics for individuals wit Schizophrenia	**Milestone 7 P-4** Evaluate and continuously improve interventions. Metric 1 P-4.1 Project planning and implementation documentation demonstrates pan, do, study act quality improvement cycles **Data Source:**. Project documentation **Baseline:** Project plans completed, service began**/Goal:** Improvement cycles yield actionable steps with evidence of implementation Milestone 7 Estimated Incentive Payment: $119,403 **Milestone 8 I-3** Adherence to

1219891-02.2.2	***2.13***	***2.13.1 [A-E]***	Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.	
[Border Region Behavioral Health Center]				1219891-02.2.2
Related Category 3 Outcome Measure(s): 1219891-02.3.5	*OD-9*	*IT 9.2*	**Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
$ 420,147	**Milestone 3 P-3** Enroll and serve individuals with targeted complex needs such as chronic physical health conditions, chronic intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities. Metric 1 P-3.1 Number of targeted individuals enrolled/served in the project **Data Source:** Client encounter database system **Baseline:** Over 1000 crisis encounters per year**/Goal:** Total crisis encounters total less than 900 Milestone 3 Estimated Incentive Payment: $201,492.50	Metric 1-3-1 % of individuals with Schizophrenia receiving the specialized interventions who are prescribed an anti-psychotic Rx that had a Proportion of Days Covered (PDC) for antipsychotic medications greater >= 0.8 during the measurement period. **Data Source:** Medication records in client medical record **Baseline:** % of individuals with Schizophrenia on record**/Goal:** Medication Possession Ratios are reported for target population. % of clients >0.8 at least 70% Milestone 5 Estimated Incentive Payment: $134,328 **Milestone 6 I-5** Functional Status Metric 1 I-5.1 % of individuals receiving specialized intervention	Anti-psychotics for individuals wit Schizophrenia Metric 1-3-1 % of individuals with Schizophrenia receiving the specialized interventions who are prescribed an anti-psychotic Rx that had a Proportion of Days Covered (PDC) for antipsychotic medications greater >= 0.8 during the measurement period. **Data Source:** Medication records in client medical record **Baseline:** Results of DY4 **/Goal:** Medication Possession Ratios are reported for target population. % of clients >0.8 at least 75% Milestone 8 Estimated Incentive Payment: $119,403 **Milestone 9 I-5** Functional Status

1219891-02.2.2	***2.13***	***2.13.1 [A-E]***	Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.	
[Border Region Behavioral Health Center]				1219891-02.2.2
Related Category 3 Outcome Measure(s): 1219891-02.3.5	*OD-9*	*IT 9.2*	**Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			who demonstrate improved functional status on standardized instruments **Data Source:** Client functional assessment tool **Baseline:** 27% in FY 12 show improvement**/Goal:** 35% over FY12 Milestone 6 Estimated Incentive Payment: $134,328	Metric I-5.1 % of individuals receiving specialized intervention who demonstrate improved functional status on standardized instruments **Data Source:** Client functional assessment tool **Baseline:** DY 4 results**/Goal:** 20% increase over DY4 baseline Milestone 9 Estimated Incentive Payment: $119,403
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $420,147	Year 3 Estimated Milestone Bundle Amount: $402,985		Year 4 Estimated Milestone Bundle Amount: $402,985	Year 5 Estimated Milestone Bundle Amount: $358,209
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,584,326				

Driscoll Children's Hospital – Category 2: Program Innovation and Redesign

- Driscoll Children's Hospital
- 132812205.2.1
- 2.6.2 –Reduce the Average neonatal ICU days per delivery for the targeted population

Provider: Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

Intervention(s): The goal of this project is to educate and provide support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The Project has two major components—a set of "educational" baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery.

Need for the project: Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU). Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy pregnancies, deliveries, and infant care.

Target population: This project will increase community participation and education through these services targeted to serve low-income populations.

Category 1 or 2 expected patient benefits: By the end of Year 5, Driscoll plans to:

- Expand prenatal educational sessions by 5% in DY 3, serving an additional 15 patients; 10% in DY 4 to serve an additional 30 patients; and 15% in DY 5 to serve an additional 45 patients.
- Expand consultation visits by 5% in DY 3 to serve an additional 25 patients; 10% in DY 4 to serve an additional 50 patients; and 15% in DY 5 to serve an additional 75 patients.
- Expand Cadena Health plan participants by 5% in DY 3 to serve an additional 35 patients; 10% in DY 4 to serve an additional 70 patients; and 15% in DY 5 to serve an additional 105 patients.

Category 3 outcomes: Our goal is to reduce the Neonatal ICU Average Length of Stay for the Cadena plan participants by 5% compared to a non-participating patient.

Collaboration: This project will be performed in collaboration with three other local providers; Doctors Hospital at Renaissance, Valley Baptist Health System, and South Texas Health Systems. Each provider entered into the collaboration agreement freely and with the intention of benefiting RHP 5 through local healthcare delivery transformation. Each collaborator will be responsible for supporting the performing provider in efforts to fully implement a robust and transformative project. As the local community provider, the collaborators will assist Driscoll by participating in the planning, design, and execution of the prenatal education program. This will include but is not limited to participating in the multidisciplinary Health Promotion Task Force and the region-wide learning collaborative. These efforts will provide Driscoll will invaluable information regarding project impact and "lessons learned", opportunities to adjust project target patient populations, identifying special considerations needed for safety-net populations, and reviewing challenges. This project advances RHP 5 goals and community needs assessment by expanding access to prenatal education and consultations to support low-income pregnant women to deliver healthy babies and reduce need for neonatal intensive care services. Driscoll appreciates the willingness of local providers to collaborate on such a project and we

acknowledge that this collaboration is necessary to achieve the project goals and ensure a complete and successful transformation in RHP 5.

Unique Project ID: 132812205.2.1
Performing Provider Name/TPI: *Driscoll Children's Hospital/ 132812205*

Project Description:
Driscoll Children's Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children's Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children's hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children's Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in South Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children's Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c) (3)'s comprised of pediatric subspecialists), The Driscoll Children's Hospital Auxiliary, and the Driscoll Children's Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

In collaboration with Driscoll Health Plan, Driscoll Hospital plans to expand a highly successful prenatal program that promotes healthy behavior and provides supports to low-income women with high-risk pregnancies. The program, called Cadena de Madres Project (Mother's network), seeks to reduce low birth weight and premature deliveries in targeted Texas counties by providing enhanced educational and social support for indigent, predominately Hispanic, women considered to be high risk for adverse birth outcomes. The Project focuses on improving maternity social and healthcare supports available to indigent women during pregnancy. The overall goal of the program is to reduce prematurity and thereby reduce admissions and days in the neonatal intensive care unit (NICU).

The Project has two major components—a set of "educational" baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery. The baby showers focus on encouraging prenatal care, improving nutrition, promoting breast feeding, avoiding dangerous behaviors, and recognizing the signs and symptoms of premature labor. Pregnant women enrolled in Driscoll Children's Health Plan are mailed an invitation each month of their pregnancy. After attending our baby shower sessions, the participant will be educated on how to distinguish healthy choices during their pregnancy and recognize the negative impact of smoking, alcohol, and drugs can have on their health and comprehend the advantages of prenatal care and understand the complications that may occur during their pregnancy. Educational baby showers also recognize signs of preterm labor, and pre labor signs, and understand when medical intervention is needed. Nutritional advice can be reinforced or further advice can be sought from the dietitian, particularly for those with diabetes or gestational diabetes which comprise 13 percent of the population.

The consultation visits encourage postpartum care of the mother, timely infant care, successful breastfeeding, and good nutrition for the mother and the infant, consideration of family planning to gain appropriate birth spacing, and re-enrollment for continuing medical insurance coverage. The consult visitor can also teach important infant safety points like "back to sleep", the importance of proper car seat use, the appropriate use of the medical office and the emergency room for medical issues. Convincing a mother to breast feed promotes further bonding to the new infant. This can be aided by having consultations with a certified lactation consultant. Breast fed infants have less visits to the physician for medical illness than those that bottle feed. Most mothers will consider delaying the next pregnancy until they wean the current infant.

This team approach in prenatal and postnatal care allows for better pregnancy counseling and improved neonatal outcomes. Driscoll will coordinate this initiative with local maternal-fetal medicine specialists, managed care organizations, and community collaborators. To further enhance the project, Driscoll Health System will form a Health Promotion Task Force and will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Health Promotion milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and "lessons learned", reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Health Promotion Task Force.

Project Goals and Challenges:
The goal of this project is to reduce preterm births by educating and providing support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The increased consults, Cadena participants and educational sessions may include one or all of the different program locations.

By the end of Year 5, Driscoll plans to:

- Expand prenatal educational sessions by 5 percent in DY 3 to serve an additional 15 patients; 10 percent in DY 4 to serve an additional 30 patients; and 15 percent in DY 5 to serve an additional 45 patients.
- Expand consultation visits by 5 percent in DY 3 to serve an additional 25 patients; 10 percent in DY 4 to serve an additional 40 patients; and 15 percent in DY 5 to serve an additional 75 patients
- Reduce NICU days per delivery
- Expand Cadena Healthplan participants by 5 percent in DY 3 to serve an additional 35 patients; 10 percent in DY 4 to serve an additional 70 patients; and 15 percent in DY 5 to serve an additional 75 patients

This project advances RHP 5 goals and community needs assessment by expanding access to prenatal education and consultations to support low-income pregnant women deliver healthy babies and reduced need for neonatal intensive care services. The supply of physicians in Internal Medicine and OB/GYN specialties lags behind Texas by 30% and 25%, respectively. Preterm infants are at an

increased risk of disability and early death compared with infants born later in pregnancy. For the U.S. in 2008, 12.3% of all births were preterm. The preterm birth rate for Texas is 13.3%, slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

%Preterm (<37 weeks gestation) - Texas 2012

Metropolitan Statistical Area	% Preterm	State Average	Percent Higher
Brownsville- Harlingen	15.4	13.2	2.2
Corpus Christi	14.9	13.2	1.7
Laredo	13.8	13.2	0.6
Victoria	14.0	13.2	0.8

Starting Point/Baseline:
During State Fiscal Year 2012, Driscoll provided over 300 prenatal educational sessions, 700 Cadena Healthplan participants and over 500 educational consult visits to high risk pregnant women.

Rationale:
Low-income pregnant women are prone to pre-term births for a variety of known as well as unknown reasons. Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This initiative will expand health education to high risk pregnant Medicaid patients as well as provide counseling and education on tobacco and alcohol use for pregnant women.

Project is consistent with RHP 5's community need assessment; this project addresses CN.1 (Shortage of primary and specialty care providers and inadequate access to primary or preventive care).

Related Category 3 Outcome Measure(s):
OD-8 Perinatal Outcome: IT-8.9
Reduce the Neonatal ICU days per delivery for the targeted population, TPI 2.6– Implement Evidence-based Health Promotion Programs.

Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in pre-term births with a resultant decrease in NICU days are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy pregnancies, deliveries, and infant care. This project will increase community participation and education through these services targeted to serve low-income populations.

Relationship to other Projects:

This project supports project 132812205.2.7 in that both support early intervention with high-risk pregnant patients to improve birth outcomes.

Relationship to Other Performing Providers' Projects in the RHP:
This project will support other projects in the region that aim to improve access to OB care in the region, such as 136332705.1.1 at Starr County Hospital, and project 160709501.1.3 at Doctors Hospital at Renaissance, to establish a new Ob/GYN residency program.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative, as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
The quantitative value is based on a determination that Neonatal ICU (NICU) use is a high cost service. Decreasing the number of premature infant admissions less than 37 weeks a resultant decrease in NICU days per delivery is a more efficient use of resources. Expanding health education to high risk pregnant patients as well as increasing the number of provided counseling sessions on tobacco and alcohol use for pregnant women will create significant savings and value. Driscoll intends to accomplish this by expanding prenatal educational sessions by 5% in DY 3, serving an additional 15 patients; 10% in DY 4 to serve an additional 30 patients; and 15% in DY 5 to serve an additional 45 patients. Expanding consultation visits by 5% in DY 3 to serve an additional 25 patients; 10% in DY 4 to serve an additional 50 patients; and 15% in DY 5 to serve an additional 75 patients. Expanding Cadena Health plan participants by 5% in DY 3 to serve an additional 35 patients; 10% in DY 4 to serve an additional 70 patients; and 15% in DY 5 to serve an additional 105 patients.

Since the beginning of the Cadena de Madres Program, the number of Premature Infant Admissions less than 37 weeks has decreased significantly and as a result has reduced NICU costs for Managed Medicaid patients.

Based on the decreasing number of premature infant admissions less than 37 weeks and the decrease in NICU days per delivery, we estimated a total saving and value to the state of approximately $5.4 million per year for this proposed project. However, consistent with DSRIP requirements, the maximum DSRIP funding to be allocated to this project is $10,000,000 (inclusive of Categories 3 and 4).

UNIQUE IDENTIFIER: *132812205.2.1*	***RHP PP REFERENCE NUMBER: 2.6.2***	***PROJECT COMPONENTS: N/A***	**Implement Evidence-based Health Promotion Programs**
Performing Provider Name: Driscoll Children's Hospital			*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*132812205.3.2*	*IT-8.9*	Reduce the Neonatal ICU Days per Delivery for the targeted population

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing the Cadena de Madres Program. **Metric 1** [P-X.1]: Documentation of Task Force establishment **Data Source:** Hospital/health plan record **Milestone 1**: Estimated Incentive Payment *(maximum amount): $708,333* **Milestone 2:** [P-X1] Develop plan to expand Cadena de Madres program to women with high risk pregnancies **Metric 2**: [P- X1.1]: Evidence of plan **Data Source: Hospital/health plan record** **Milestone 2:** Estimated Incentive Payment *(maximum amount): $708,333* **Milestone 3:** [P-X2]: Conduct an initial assessment to expand Cadena participants, prenatal education and consults performed in the Driscoll Service area. **Metric 3:** [P- X2.1]: Documentation of plan assessment **Data Source**: Hospital/health plan	**Milestone 4** [P-X3]: Task Force leads quality improvement initiative for Cadena de Madres program **Metric 4a** [P- X3.1]: Documentation of Quality Improvement meetings held twice per year **Metric 4b**: [P- X3.2] Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program **Data Source:** Hospital/health plan record **Milestone 4**: Estimated Incentive Payment *(maximum amount): $500,000* **Milestone 5:** [I.X] Increase access to prenatal education sessions for target population **Metric 5**: [I- X.1] Increase number of prenatal education sessions for target population by 5 percent above SFY 12 baseline of 300, to serve an additional 15 patients. **Data Source:** Hospital/health plan record **Milestone 5:** Estimated Incentive Payment *(maximum amount): $500,000*	**Milestone 8** [P- X3]: Task Force leads quality improvement initiative for Cadena de Madres program **Metric 8a** [P- X3.1]: Documentation of Quality Improvement meetings held twice per year **Metric 8b**: [P- X3.2] Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program **Data Source:** Hospital/health plan record **Milestone 8**: Estimated Incentive Payment *(maximum amount):* $468,750 **Milestone 9:** [I. X] Increase access to prenatal education sessions for target population **Metric 9 [I.** X**.1]**: Increase number of prenatal education sessions for target population by 10 percent above SFY 12 baseline of 300 to serve an additional 30 patients. **Data Source:** Hospital/health plan record **Milestone 9:** Estimated Incentive Payment *(maximum amount):* $468,750	**Milestone 12** [P- X3]: Task Force leads quality improvement initiative for Cadena de Madres program **Metric 12a** [P- X3.1]: Documentation of Quality Improvement meetings held twice per year **Metric 12b**: [P- X3.2] Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program **Data Source:** Hospital/health plan record **Milestone 12**: Estimated Incentive Payment *(maximum amount): $356,250* **Milestone 13:** [I. X] Increase access to prenatal education sessions for target population **Metric 13**: [I. X.1] Increase number of prenatal education sessions for target population by 15 percent above SFY 12 baseline of 300 to serve an additional 45 patients. **Data Source:** Hospital/health plan record **Milestone 13:** Estimated Incentive Payment *(maximum amount): $356,250*

Unique Identifier: *132812205.2.1*	***RHP PP Reference number: 2.6.2***	***Project Components: N/A***	**Implement Evidence-based Health Promotion Programs**	
Performing Provider Name: Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*132812205.3.2*	*IT-8.9*	Reduce the Neonatal ICU Days per Delivery for the targeted population	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
records **Milestone 3**: Estimated Incentive Payment *(maximum amount):$708,334*	**Milestone 6:** [I-X1] Increase access to prenatal education consults for target population **Metric 6**: [I- X1.1] Increase number of prenatal education consults above baseline for target population by 5 percent above SFY 12 baseline of 500 consults to serve an additional 25 patients. **Data Source:** Hospital/health plan record **Milestone 6:** Estimated Incentive Payment *(maximum amount): $500,000* **Milestone 7:** [I-X2] Increase number of Cadena Healthplan participants **Metric 7**: [I- X2.1] Increase number of Cadena Healthplan participants by 5 percent above SFY 12 baseline of 700 to serve an additional 35 patients. **Data Source:** Hospital/health plan record **Milestone 7:** Estimated Incentive Payment *(maximum amount):$500,000*		**Milestone 10:** [I. X1] Increase access to prenatal education consults for target population **Metric 10**: [I. X1.1] Increase number of prenatal education consults above baseline for target population by 10 percent above SFY 12 baseline of 500 consults to serve an additional 50 patients. **Data Source:** Hospital/health plan record **Milestone 10:** Estimated Incentive Payment *(maximum amount):* $468,750 **Milestone 11:** [I- X2] Increase number of Cadena Healthplan participants **Metric 11**: [I- X2.1] Increase number of Cadena Healthplan participants by 10 percent above SFY 12 baseline of 700 to serve an additional 70 patients. **Data Source:** Hospital/health plan record **Milestone 11:** Estimated Incentive Payment *(maximum amount):$468,750*	**Milestone 14** [I. X1] Increase access to prenatal education consults for target population **Metric 14**: [I. X1.1] Increase number of prenatal education consults above baseline for target population by 15 percent above SFY 12 baseline of 500 patients to serve an additional 75 patients. **Data Source:** Hospital/health plan record **Milestone 14:** Estimated Incentive Payment *(maximum amount): $356,250* **Milestone 15:** [I- X2] Increase number of Cadena Healthplan participants **Metric 15**: [I- X2.1] Increase number of Cadena Healthplan participants by 15 percent above SFY 12 baseline of 700 to serve an additional 105 patients. **Data Source:** Hospital/health plan record **Milestone 15:** Estimated Incentive Payment *(maximum amount):$356,250*
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,125,000	Year 3 Estimated Milestone Bundle Amount: $2,000,000		Year 4 Estimated Milestone Bundle Amount: $1,875,000	Year 5 Estimated Milestone Bundle Amount: $1,425,000

UNIQUE IDENTIFIER: *132812205.2.1*	***RHP PP REFERENCE NUMBER: 2.6.2***	***PROJECT COMPONENTS: N/A***	**Implement Evidence-based Health Promotion Programs**
Performing Provider Name: Driscoll Children's Hospital			*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*132812205.3.2*	*IT-8.9*	Reduce the Neonatal ICU Days per Delivery for the targeted population

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 7,425,000			

Driscoll Children's Hospital

- **Project Title 2.7 –** Implement Evidence-based Disease Prevention Programs
- **Project Option 2.7.1–**Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations
- 132812205.2.2 (Pass 2)

Provider: Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.
Intervention(s): A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby's heart.
Need for the project: A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25% risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States.
Target population: MFM specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies.
Category 1 or 2 expected patient benefits: By the end of Year 5, the project will accomplish the following goals:

- Increase the number of patient encounters in MFM echocardiogram program by 5 percent in DY 3 for an additional 540 encounters; an increase of 7% in DY 4 for an additional 756 encounters; and an increase of 10 percent in DY 5 for an additional 1080 encounters
- Expand MFM clinics and outreach program facility hours by 2.5 percent, adding an additional 67.5 hours in DY 2 and maintaining increased hours in DY 3, 4, and 5 above current baseline of 2700 operating hours,

Category 3 outcomes: IT-8.9 Our goal is to Increase the number of detected related fetal anomalies in high-risk pregnant patients.
Collaboration: This project will be performed in collaboration with three other local providers; Doctors Hospital at Renaissance, Valley Baptist Health System, and South Texas Health Systems. Each provider entered into the collaboration agreement freely and with the intention of benefiting RHP 5 through local healthcare delivery transformation. Each collaborator will be responsible for supporting the performing provider in efforts to fully implement a robust and transformative project. As the local community provider, the collaborators will assist Driscoll by participating in the planning, design, and execution of the MFM program. This will include but is not limited to participating in the multidisciplinary Disease Prevention Task Force and the region-wide learning collaborative. These efforts will provide Driscoll will invaluable information regarding project impact and "lessons learned", opportunities to adjust project target patient populations, identifying special considerations needed for safety-net populations, and reviewing challenges. This project advances RHP 5 goals and community needs assessment by expanding access to early detection program for fetal anomalies in patients with high-risk pregnancies. A fetal echocardiogram program is necessary in the South Texas

region due to the high prevalence of pre gestational diabetes and gestational diabetes. Driscoll appreciates the willingness of local providers to collaborate on such a project and we acknowledge that this collaboration is necessary to achieve the project goals and ensure a complete and successful transformation in RHP 5.

Driscoll Children's Hospital

- **Project Title 2.7 –** Implement Evidence-based Disease Prevention Programs
- **Project Option 2.7.1–**Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations
- 132812205.2.2 (Pass 2)

Project Description:

Driscoll Children's Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children's Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children's hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children's Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in South Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children's Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c) (3)'s comprised of pediatric subspecialists), The Driscoll Children's Hospital Auxiliary, and the Driscoll Children's Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

There is no overlap of this project with RHP 5 (132812205.2.1) or RHP 20 (132812205.2.1) projects because staffing and services will be targeted to the specific counties and patients aligned with each different RHP.

The Driscoll Service area for this project includes four counties in the Rio Grande Valley of South Texas: Cameron, Hidalgo, Starr and Willacy. The population was 1.26 million in 2010, and population growth is anticipated to continue its significant increase in the coming years. The population is predominately Hispanic, ranging from 87% in Cameron County to 98% in Starr County as of 2009. Statewide, 38% of the population is Hispanic.

MFM specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies. All of these expectant mothers can benefit from the care of a maternal-fetal medicine specialist. MFMs receive two to three years of additional training after an OB/GYN residency that focuses on high-risk pregnancies, ultrasound techniques and fetal anomalies.

A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25% risk of a congenital heart defect

in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States. A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby's heart.

This team approach in prenatal diagnosis allows for better pregnancy counseling and improved neonatal outcomes. Driscoll Health System will coordinate this initiative with local Maternal-Fetal Medicine specialists, Pediatric Cardiologists, managed care organizations, and community collaborators. Driscoll Health System will form a Disease Prevention Task Force and will hold quality improvement meetings twice a year to review. The task force will be multidisciplinary in composition and will assess progress on Maternal Fetal Medicine project milestones and metrics. The task force meeting will serve as a structure for activity such as, but not limited to: identifying project impacts and "lessons learned", reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Disease Prevention Project.

Project Goals and Challenges:
Since it was established, the MFM outreach program has proven highly successful in the early detection of fetal anomalies in patients with high risk pregnancies. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region. The challenges with this project are the patient compliance of provider care instructions and the availability of timely access to care.

By the end of Year 5, the project will accomplish the following goals:

- Increase the number of patient encounters in MFM echocardiogram program above the baseline of 10,800 in CY 2011 by 5% in DY 3 for an additional 540 encounters; by 7% in DY 4 for an additional 756 encounters; and by 10 percent in DY5 for an additional 1080 encounters.
- Expand MFM clinics and outreach program facility hours by 2.5 percent above the baseline of 2700 operating hours annually, for a total of 67.5 additional hours each year in DY2, 3, 4, and 5
- Increase the number of detected related fetal anomalies in high-risk pregnant patients

This project advances RHP 5 goals and community needs assessment by expanding access to early detection program for fetal anomalies in patients with high-risk pregnancies. The supply of physicians in Internal Medicine and OB/GYN specialties lags behind Texas by 30% and 25%, respectively. Preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. The preterm birth rate for Texas is 13.3%, which is slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

%Preterm (<37 weeks gestation) - Texas 2012

Metropolitan Statistical Area	% Preterm	State Average	Difference
Brownsville- Harlingen	15.4	13.2	2.2
Corpus Christi	14.9	13.2	1.7
Laredo	13.8	13.2	0.6
Victoria	14.0	13.2	0.8

Starting Point/Baseline:
The MFM clinics and outreach program facilities in Driscoll's service area for baseline measurement will begin at approximately 2,700 hours of operation in CY 2011 The MFM echocardiogram program in Driscoll's service area for baseline measurement will begin at approximately 10,800 completed procedures in CY 2011.

Rationale:
Low-income pregnant women are at higher risk for pre-term births for a variety of known as well as unknown reasons. Expectant mothers and their unborn babies who are at high risk for certain health problems such as heart disease, high blood pressure, diabetes or other endocrine disorders, kidney or gastrointestinal disease, infectious diseases and maternal immune disorders should seek maternal-fetal medicine specialists. Healthy women whose pregnancy is at high risk for complications includes abnormal maternal serum screening, twins, triplets or more, advanced maternal age, recurrent pregnancy loss and more. Every year, Driscoll's Transport Team transfers more than 840 neonatal and pediatric patients to or from Driscoll's Children's Hospital to receive the highest standard of care in the region. Maternal-fetal medicine specialists offer a wide range of care including a variety of therapies and programs that make sure that any high-risk baby in South Texas will have the best chances of living a healthy, normal life. This initiative will improve access to Maternal and Fetal Medicine care programs for Medicaid recipients. Driscoll Children's Hospital does not include any project components or receive any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

Project is consistent with RHP 5's community need assessment; this project addresses CN.1 (Shortage of primary and specialty care providers and inadequate access to primary or preventive care).

Related Category 3 Outcome Measure(s):
OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies

The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. Increased access to MFM clinics/outreach programs will provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Fetal anomalies are defined as any conditions

that are not normal anatomical structure or function. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.
Driscoll disagrees that IT.8.9 is not a standalone measure. We did not find any reference in the PFM that supported the HHSC suggested revision.

Relationship to other Projects:
Unique Project ID:132812205.2.2 – Implement Evidence-based Disease Promotion Programs supports Pass 1 - Unique Project ID:2.1-Implement Evidence-based Health Prevention Programs through early intervention with high-risk pregnant patients. The related Category 4 Population-focused measure would not apply to this project plan at this time.

Relationship to Other Performing Providers' Projects in the RHP:
This project will support other projects in the region that aim to improve access to OB care in the region, such as 136332705.1.1 at Starr County Hospital, and project 160709501.1.3 at Doctors Hospital at Renaissance, to establish a new Ob/GYN residency program.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative, as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
The quantitative value is based on a determination that the NICU is a high cost service. Decreasing the number of patients and the average length of stay (ALOS) for a NICU patient is a more efficient use of resources. Increasing the hours and use of a MFM clinic/outreach program and increasing the number of Maternal Fetal echocardiogram procedures will create significant savings and value. Driscoll intends to accomplish this by increasing the number of patient encounters in MFM echocardiogram program by 5 percent in DY 3 for an additional 540 encounters; an increase of 7% in DY 4 for an additional 756 encounters; and an increasing of 10 percent in DY 5 for an additional 1080 encounters Expand MFM clinics and outreach program facility hours by 2.5 percent, adding an additional 67.5 hours in DY 2 and maintaining increased hours in DY 3, 4, and 5 above current baseline of 2700 operating hours,

Driscoll provides MFM services to the community for multiple reasons, one of which is to help reduce ALOS for NICU patients. Since the beginning of the MFM program, ALOS for a NICU patient has decreased significantly, resulting in reductions of NICU payment dollars between FY2010 and FY2012.

The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of

congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Pediatric Cardiologists working in collaboration with the Maternal Fetal Medicine program give Perinatalogists adjunctive support in diagnosing congenital heart disease, aiding in management of arrhythmias and congestive heart failure from various causes. Additionally, it allows for detailed counseling using the expertise of a Pediatric Cardiologist.

Maternal fetal echocardiogram programs provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. In addition, having an established prenatal diagnosis allows for plans to be set for delivery in facility with a level three neonatal service. Based on the change in NICU ALOS between Calendar 2010 and 2012 plus the Calendar 2012 NICU admissions, we estimate a total saving and value to the state of approximately $5.4 million per year for this proposed project. Based on these reasons and value of project to the region, the maximum DSRIP funding to be allocated to this project is $16 million (inclusive of Categories 3 and 4).

Unique Identifier: 132812205.2.2	***RHP PP Reference number:*** 2.7.1	***Project Components:*** ***N/A***	**Implement Evidence-based Disease Prevention Programs**
Performing Provider Name: Driscoll Children's Hospital			*TPI: 132812205*
Related Category 3 Outcome Measure(s):	132812205.3.3	*IT-8.9*	*Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing Driscoll's Maternal Fetal Medicine (MFM) Program. **Metric 1** [P-X.1]: Documentation of Task Force establishment **Data Source:** Hospital/health plan record **Milestone 2**: Estimated Incentive Payment *(maximum amount): $1,133,333* **Milestone 2 [P-1]:** Develop plan /strategy to expand the Maternal Fetal Medicine Program in Driscoll serve area **Metric 2:** [P-1.1] Document innovational strategy and plan **Data Source:** **Milestone 2**: Estimated Incentive Payment *(maximum amount): $1,133,333* **Milestone 3 [P-X1]:** Increase hours of accessibility of MFM clinics/outreach program **Metric 3** [P- X1.1]: Increase MFM	**Milestone 4**[P-X2]: Task Force leads quality improvement initiative for MFM program **Metric 4a** [P- X2.1]: Documentation of Quality Improvement meetings held twice per year **Metric 4b**: [P- X2.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM **Data Source:** Hospital/health plan record **Milestone 4**: Estimated Incentive Payment *(maximum amount): $1,066,666* **Milestone 5 [I-7]:** Increase access to MFM program **Metric 5** [I-7.2]: Increase number of MFM echocardiogram program procedures by 5 percent above CY 2011 baseline of 10,800 for an additional 540 procedures. **Data Source:** Hospital/health plan record **Milestone 5**: Estimated Incentive Payment *(maximum amount): $1,066,667* **Milestone 6 [P-** X1**]:** Increase hours of	**Milestone 7** [P- X2]: Task Force leads quality improvement initiative for MFM program **Metric 7a** [P- X2.1]: Documentation of Quality Improvement meetings held twice per year **Metric 7b**: [P- X2.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM **Data Source:** Hospital/health plan record **Milestone 7**: Estimated Incentive Payment *(maximum amount): $1,000,000* **Milestone 8 [I-7]:** Increase access to MFM program **Metric 8** [I-7.2]: Increase number of MFM echocardiogram program procedures by 7 percent above CY 2011 baseline of 10,800 for an additional 756 procedures. **Data Source:** Hospital/health plan record **Milestone 8**: Estimated Incentive Payment *(maximum amount): $1,000,000* **Milestone 9 [P-** X1**]:** Increase hours of accessibility of MFM clinics/outreach	**Milestone 10** [P- X2]: Task Force leads quality improvement initiative for MFM program **Metric 10a** [P- X2.1]: Documentation of Quality Improvement meetings held twice per year **Metric 10b**: [P- X2.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM **Data Source:** Hospital/health plan record **Milestone 10**: Estimated Incentive Payment *(maximum amount): $760,000* **Milestone 11 [I-7]:** Increase access to MFM program **Metric 11** [I-7.2]: Increase number of MFM echocardiogram procedures by 10 percent above the CY 2011 baseline of 10,800 for an additional 1080 procedures. **Data Source:** Hospital/health plan record **Milestone 11**: Estimated Incentive Payment *(maximum amount): $ 760,000* **Milestone 12 [P-** X1**]:** Increase hours of accessibility of MFM clinics/outreach

Unique Identifier: 132812205.2.2	***RHP PP Reference number:*** 2.7.1	***Project Components:*** ***N/A***	**Implement Evidence-based Disease Prevention Programs**	
Performing Provider Name: Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s):	132812205.3.3	*IT-8.9*	*Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
clinics/outreach program hours by 2.5% for an additional 67.5 hours above CY 2011 baseline of 2,700. **Data Source:** Hospital/health plan record **Milestone 3**: Estimated Incentive Payment *(maximum amount): $1,133,334*	accessibility of MFM clinics/outreach program **Metric 6** [P- X1.1]: Maintain 2.5% target increase of MFM clinics/outreach program hours in DY 2 for an additional 67.5 hours above the baseline of 2,700 **Data Source:** Hospital/health plan record **Milestone 6**: Estimated Incentive Payment *(maximum amount): $1,066,667*		program **Metric 9** [P- X1.1]: Maintain 2.5% target increase of MFM clinics/outreach program hours in DY 2 for an additional 67.5 hours above the baseline of 2,700 **Data Source:** Hospital/health plan record **Milestone 9** Estimated Incentive Payment *(maximum amount): $1,000,000*	program **Metric 12** [P- X1.1]: Maintain 2.5% target increase of MFM clinics/outreach program hours in DY 2 for an additional 67.5 hours above the baseline of 2,700 **Data Source:** Hospital/health plan record **Milestone 12**: Estimated Incentive Payment *(maximum amount): $760,000*
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,400,000	Year 3 Estimated Milestone Bundle Amount: $3,200,000		Year 4 Estimated Milestone Bundle Amount: $3,000,000	Year 5 Estimated Milestone Bundle Amount: $2,280,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,880,000				

Starr County Memorial Hospital

Process Improvement in ED

136332705.2.1

Provider:	Starr County Memorial Hospital (SCMH) is a major healthcare provider in Starr County serving as a sole community hospital for the region. The nearest acute care hospital is over 50 minutes away, so the community turns to SCMH for a high percentage of their medical needs.
Intervention(s): Clearly state the intervention(s).	SCMH, serving as a sole community hospital, and as a method of primary health care for the indigent population, it becomes important that the hospital has streamlined processes in place that will help eliminate the need for diversion.
Need for the project: A brief description of the need for the project including data as appropriate.	The emergency dept at SCMH serves as a critical access point of primary health care for a large percent of the indigent and Medicaid population. Under these circumstances, the ED's capacity reaches maximum limiting the amount of people it can help.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is the indigent care and Medicaid population that often seek services either at the rural health clinic or through the emergency department at SCMH. Although the majority of the ED patient base is derived from walk-in emergencies, a portion of the patients are also transferred over from the rural health clinic. SCMH wants to ensure that it will be able to handle all cases as they come in as to prevent any advancement in conditions.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	By DY3 SCMH will be implementing policies and procedures that will boost the throughput of the ED enabling it to service more patients at any given time. Patient satisfaction will be an underlying goal of this throughput improvement, so continuous quality improvements will be made where the adjustments are needed and will produce the most value to the patients.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1: The hospital is seeking to improve it's processes to produce safer and higher quality care for its patients. As these adjustments are made, patient satisfaction will be crucial in SCMH strategic advancement. IT-3.3: The expected benefit of a 30-day readmission reduction for diabetes will be providing the patients with the necessary tools and education to self-maintain their diabetic condition so that their health can stabilize and improve versus deteriorate and end up back in the ED in a worse condition than they were before.

Apply Process Improvement Methodology throughout the ED [2.8]

Starr County Memorial Hospital [136332705.2.1]

Project Description:

Description:
Starr County Memorial Hospital is a 48 Bed Acute Care Sole Community Hospital in Starr County. In 2010, the population of the county is listed as 60,968 and the median income as $24,441. The county has total area of 1,229 square miles and the nearest acute care hospital is over 50 minutes away.
Starr County is one of the largest underserved areas in the RHP5. Starr County Memorial Hospital serves as the primary choice for emergent, and sometimes primary care, for the local community. Starr County is known to have a very high incidence of Diabetes and as a consequence all the comorbidities associated with it. Many of these patients seek access to care in the ER department thus causing a higher congestion of patients. Unfortunately, when there is a high influx of patients, the waiting times can become long and yield patient dissatisfaction and unavailability of access to care.
The target population for this project is all of the Starr County residents and also the areas of close proximity to the county (Zapata, Sullivan City, LaJoya). The Starr County Hospital patient payer mix served in the ER are 35% indigent, _22% Medicare, __31%Medicaid and _12_% private insurances. Our goal is to improve our capability to serve all patients presenting to the ER, regardless of the time of day or ability to pay, in a timely effective manner.
This Hospital's ER department is certified as a Level IV Trauma Center. The ER department is the only available access to care for the entire community 24 hours/day, 7days/week. All out- patient clinics in the community are closed for service at 9 P.M. A very meticulous analysis will be made to evaluate the following:

- Bottlenecks within the ED service line
- Current processes that are in place for throughputs
- Reporting turnaround time from the ancillary departments, and the
- qualifications of the physician's and staff assigned to the ER

One such method of analysis will be the Lean methodology of continuous care quality improvement with a focus on value creation; Value in the sense that all future thinking and protocol modifications will be dictated around creating optimizations with the needs of the patients in mind to increase organization effectiveness.Last year alone (FY11), Starr County Memorial Hospital's emergency department (ED) had approximately 1500[73] patients leave its facility without having received treatment by a physician. This project will aim towards directly reducing the number of patients that went without treatment from a physician and also reduce waiting times. In order for that to happen, this project will not only have to have proper analysis for correct department physical set up, but also in-depth training of our providers and staff to have a successful implementation of patient registration, triage, and physician intervention. This will result in appropriate medical intervention and better patient satisfaction
Goals & Relationship to Regional Goals: The goal of implementing this project at our facility will be to increase capacities and turnaround times in the ED without sacrificing the quality and safety of services

[73] Starr County proprietary information

rendered to the patient population. Throughout the 5 years of this project, a 20% increase in capacity would be ideal due to multiple area enhancements throughout the organization. As a region, the goals of the partnership center around increasing accessibility to healthcare services to a community that is historically underserved. With diabetes and obesity acting as the primary or underlying cause of many hospitalizations, access to a hospital's ED remains a vital access point to healthcare in the region. This project directly enhances RHP5's goals by implementing measures that will increase the ED's capacity to care for those who have nowhere else to turn. This project addresses community need number 5 (CN5), Access to Healthcare Service.

Challenges/Issues: Starr County depends turns to our hospital, as one of the major healthcare providers, to care for the indigent care. As numbers increase, the capacity of our current facility quickly reaches its maximum, leaving many patients without the quality care that can lead to prevention of more serious&costly conditions. There is generally a lack of providers in the facility, as well as a need for protocol improvements that can be addressed by continuous quality improvement.

Starting Point / Baseline:

The review process will begin in DY2 where key areas for improvement are decided upon, employee suggestions have been assessed, and various methods are taken into consideration for implementation. By DY3, the foundation for full implementation will be completed, with improvement targets of process adoption and overall improvements being sought after by DY4. The baselines will be taken from FY11 for comparisons in DY4 and DY5.

Patient Impact:

With additional resources that can be acquired through project implementation, there would be capacity for approximately 1200 additional patient consultations a year. The results of greater efficiency throughout the ED will help ensure that diversion does not happen when the ED is needed the most. The complete patient impact cannot be realized until the baseline is set at the end of DY2, and full implementation is underway in DY3. As a result of the project implementation throughout DY3, improvements in patient throughput will be able to be seen by the end of the demonstration year. Patient impact will be influenced at the end of DY4 with a 8% goal of improvement, and in DY5 with a 10% increase in improvement for patient throughput over the DY2 baseline. In both those years combined, an estimated 1,800 patient consoles will be provided.

The primary goal will be to provide efficient services from the time the patient enters the ED, serviced, and discharged. With an increased capability of 1200 patient consultations a year, those are patients that can be categorized for further healthcare management, and referred out to the Rural Health Clinic where their conditions can continue to be managed and potentially reduce ED utilization as a means of primary health care.

Issue Resolution: With a new focus on rapid improvement through resource investment in key areas for optimal value creation, bottlenecks will be identified and improved upon. With resource availability a central challenge, the focus will be on processes and/or additions that create the most value for our patients while still boosting throughput time.

5 year Expected Outcome for provider and patients: Over the five year period, Starr County Memorial Hospital expects to identify value hindering bottlenecks throughout the ED, implement adequate adjustments, and stay on track with a lean methodology mindset that revolves around constant quality improvement and patient value creation. **As mentioned, thegoal is a 20% decrease in throughput time while increasing quality and safety for our patients.** While a decrease of throughput time is desired, increased physician availability will also be a goal. **Starr County Memorial Hospital wants to**

decrease the baseline by 5% in the first year (DY3), then by 3% increases every year through year five (DY4&5).

Rational:

This project was selected due to the fact that Starr County Memorial Hospital serves as the sole community provider within the region, and will ensure that the ED seeks constant improvement in safety, quality, and efficiency as it continues to provide access to healthcare services within the community.

To help ensure project adoption by the staff, an employee suggestion system will have to be implemented that will allow for an in-depth view of various areas where continuous process improvement can be implemented **(core component: B)**. Once steps have been taken to obtain employee suggestions, performance measures must be developed for safety, quality, and efficiency in such a way that analysis can be completed to gauge improvements in designated areas **(core component: C)**.

Workflows will have to be readjusted to create efficiencies, as well as protocols in place to remove variability. Due to these assessments not yet being completed, it is not yet known to what extent new software will be necessary to help integrate the workflows and provide real-time feed back to facilitate adjustments. **(Core components: D & E)**

With continuous quality improvement an ever present goal, staffing will be the most crucial component of any implementation. Training will be mandatory for clinical and administrative staff to help facilitate a culture change that strives for improvement and understanding of the hospital's goals. **(Core component A)** Evaluations of key areas for improvements and initial implementation of rapid cycle improvement will be completed by the end of DY3 to ensure that there is adequate time to create processes, protocols, software procurement (if necessary), and implement a training program.

The middle of DY4 is when evaluations can be made on the actual impact of the process improvement program and assess any opportunities to expand or adjust methods based on the results of performance indicators**(Core Component: F).** In efforts to maintain and increase adoption of the methodologies, workflows, and policies, continuous training will be implemented for the staff. For those that have gone through the training already, a bi-annual training course will be provided. All new and/or remaining staff at Starr County Memorial Hospital will be required to complete the training/educational courses based off of mutual availability **(Improvement Milestone 1 [I-X])**.

Once there is sufficient, comparable data in DY4 a baseline will be set for the following demonstration years. As the core component [F] states, this data will be used for the evaluation of the newly implemented process improvement program. The DY4 performance outcome data will be used for comparison in DY5 as a result of improvement milestone 2 [I-16], "Improve Quality and efficiency using innovative project option."

Related Category 3 Outcome Measures:

Starr County is an area with a high percentage of uninsured patients, a low level of primary care utilization, and limited rural health clinic resources. For this reason, people turn to the hospital to have their urgent care tended to. Unfortunately, with the demographics of the county, the "Right Care, Right Setting" is the emergency department for much of the community. The primary reason that improvements in patient flows are desired is so that prevention healthcare services can be rendered to the patients before a percentage of them develop more complications. The outcome measures will be within OD-3& OD-6, to increase the amount of care available to our patients that have been previously turned away (over 1500 per year), and to increase patient satisfaction over all. With goals of the right care being increased, the CG-CAHPS goals will have to revolve around timely care, quality, and satisfaction (OD-6).

According to a study done in Starr County, in 2012, by Sharon Brown, a professor in the School of Nursing at the University of Texas at Austin, 50 percent of residents 35 and older either have diabetes or have a close relative who does[74]. With this current statistic, OD-3 was chosen for implementation. OD-3 focuses on the 30-day readmission rate for those that are diagnosed with Diabetes. With the assistance of the increased throughput in the ED and utilization of EMR, new initiatives can be put into place such as follow-up plans, high-risk user case management, and referral patterns to the rural health clinic, each geared towards improving on preventable conditions and readmissions.

Project Valuation:

The valuation of this project is derived from its importance to the provider and to the local community as a whole. The ED serves as access point to receiving emergency care for those people who cannot receive it elsewhere, or lacked the ability to receive preventative healthcare. Creating processes that will boost the efficiency and capacity of the ED will be of a great benefit to the increased number of patients that will now be able to receive the quality care they need to stabilize and control their conditions. Of these conditions, diabetes is the predominate condition that is either the primary reason for their visit or an underlying cause.[75] When a broader view is taken of the circumstances, a high volume of the patients receiving services are those that fall into the Medicaid or indigent population and are also diabetic.

Many times the reason for the ED visit will be due to a lack of preventative or follow up care, which places the patient in the ED for the first time, or makes them frequent users as follow up care typically isn't sought after. A major part of the valuation of this project is the impact the ED can have on the patient's life, especially when one of the improvement targets revolves around the 30-day diabetes readmissions rate. Once the patient has received care, proper diabetic education will be provided either at the hospital or they will be referred out to the rural health care where the help can be received. These types of services will be monitored by the hospital to ensure that proper education is administered to the patients to help prevent them having to utilize the ED at SCMH as a readmission.

[74] http://www.utexas.edu/know/2012/06/25/rgv-diabetes-research/

[75] RHP5 Community Needs Assessment.

136332705.2.1	2.8.1	2.8.1.P-1.1 2.8.1.P-7.1 2.8.1.P-8.1 2.8.1.I-16.1	Improvement of ED Patient Flow
Starr County Memorial Hospital			136332705
OD6 & OD3	IT-6.1 IT-3.3	136332705.3.4 136332705.3.5	% improvement over baseline of patient satisfaction scores Diabetes 30 day readmission rate

Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Core Component: B & C [B] Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. [c] Define key safety, quality and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures **Baseline/Goal:** Complete the review and decide on what areas to improve on. **Data Source:** Documentation of the review with detailed	**Core Component: D, E, A** [D] Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement. [E] Implement software to integrate workflows and provide real-time performance feedback [A] Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture **Baseline/Goal:** Complete the documentation and beginning stages for implementation of	**Core Component: F** [F] Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators. **Baseline/Goal:** Core Component [F] will mark the baseline for outcomes at the end of DY4 now that continuous quality improvement methods are now in implementation. **Data Source:** Documentation of outcomes in key metrics that were developed in DY2 (B&C) *Milestone 3 Estimated Incentive Payment: $140,625.00*	**Improvement Milestone 2 [I-16]:** Improve Quality and efficiency using innovative project option. **Metric 1 [1-16.1]:** Achieve X percentage improvement based on performance indicators: **numerator:** Most current outcome data over determined key areas **Denominator*:*** Outcome data over key areas in DY4. **Goal:** Create improvement in patient throughput by 10% over DY2 baseline – approximately an additional 1000 patient consultations. **Data Source:** Documentation of outcomes in key metrics that were developed in DY2 (B&C) *Milestone 5 Estimated Incentive Payment: $213,750.00*

analysis of which improvement will create the most efficient continuous process improvement. *Milestone 1 Estimated Incentive Payment (maximum amount): $318,750.00*	the continuous process improvement methods in DY3 **Data Source:** Provider submitted documentation of rapid improvement such as idea sheets, cost analysis, training materials, etc. *Milestone 2 Estimated Incentive Payment (maximum amount): $300,000.00*	**Improvement Milestone 1 [I-X]:** Increase/Continue staff training to ensure the new protocols, methods, and culture are continuing to be upheld throughout the entire organization. **Metric 1 [I-X.1]:** Increased awareness and adherence to guidelines by staff (including providers) ***Data Source:*** Sign-In logs, Training material **Goal:** - 40% of total provider/staff trained at the end of DY4 - 8% Increase of patients being able to access services through the ED dept over the DY2 baseline. **Data Source:** Patient documentation with service codes. *Milestone 4 Estimated Incentive*	

		Payment: $140,625.00	
Year 2 Estimated Milestone Bundle Amount: $318,750.00	Year 3 Estimated Milestone Bundle Amount: $300,000.00	Year 4 Estimated Milestone Bundle Amount: $281,250.00	Year 5 Estimated Milestone Bundle Amount: $213,750.00
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $1,113,750.00			

Tropical Texas Behavioral Health (TTBH) – Category 2:

Tropical Texas Behavioral Health

- ***Integrate Primary and Behavioral Health Care Services***
- ***138708601.2.1***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will develop primary care clinics co-located within three TTBH clinics serving communities throughout the Rio Grande Valley, staffed by teams including a Primary Care Physician (PCP), nurse and medical support staff, to deliver primary care services to the behavioral health population served.
Need for the project: A brief description of the need for the project including data as appropriate.	Persons with severe mental illness are at elevated risk for co-morbid chronic medical illnesses and face unique challenges in the management of those illnesses relative to the general population, leading to elevated risk of premature mortality. For the population we serve, these health risks are compounded by health issues and disparities unique to the population along the Texas/Mexico border including increased uninsured status, poverty, cost and/or transportation barriers to routine medical services, and elevated rates of overweight, obesity, kidney disease, liver disease, tuberculosis and diabetes.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is the behavioral health population served by TTBH. In FY 2011 we served over 23,000 unduplicated individuals. We anticipate that at least 75% of persons to be served will be either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the number of individuals receiving integrated primary health care at co-located clinics annually to 300 persons served in DY3, 600 served in DY4 and 900 served in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be

	determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
2.15 Integrate Primary and Behavioral Health Care Services
Unique RHP Project identification number: 138708601.2.1
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 2.15.1 Will add a Primary Care Physician (PCP), nurse and support staff at each of TTBH's 3 main clinic locations (serving Hidalgo, Cameron and Willacy Counties) to provide primary care services to the behavioral health population served.

Project Description:
Integrate primary care and behavioral health care services in order to improve care and access to needed services. TTBH will co-locate primary healthcare clinics at each of our three largest behavioral health clinics to provide integrated primary health care through a healthcare home model to 900 individuals receiving behavioral health services. This project is an innovation for the Center, as TTBH has never provided primary care services in our more than 45 year history as the Rio Grande Valley's LMHA. Integrated primary care will include services promoting education, prevention, recovery and wellness. The co-location of primary care within TTBH's behavioral health clinics will facilitate access to preventative primary care for individuals who frequently access routine care through hospital emergency departments or who forgo routine medical care until undiagnosed or untreated illnesses require intervention in the emergency department or result in inpatient admission. TTBH has identified our 3 largest clinic sites for the co-location of primary care services. The clinics are well-established within the local communities and the locations are familiar to the residents. The sites have established utilities and building services, and while relatively accessible at the present time, they will be more so with the implementation of added transportation services. Services will be delivered by primary care staff employed by TTBH and coordinated and documented in our existing EHR; facilitating co-scheduling and information sharing between physical health and behavioral health providers, in addition to data collection and reporting. Internal protocols and processes for communication and referral between behavioral and physical health providers will be established during the development of the primary care clinics. Behavioral and physical health staff will receive training on the protocols as applicable, including training on team approaches to treatment, information sharing through consultative meetings and case conferences and co-developed comprehensive treatment planning. The results will be improved coordination of behavioral and primary health care, improved health outcomes and wellness for persons served through early primary care intervention, and reduced costs to the health care system as a result of reduced inappropriate emergency department usage and inpatient admissions.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement

activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Co-locate primary healthcare clinics at three of our behavioral health clinics including the addition of a Primary Care Physician (PCP), nurse and support staff to provide primary care services to the behavioral health population served.
- Increase the number of individuals receiving physical and behavioral health care at TTBH clinics to 900 persons served by DY5.
- Improve coordination of behavioral and primary health care, health outcomes and wellness for persons served through early primary care intervention.
- Reduce costs to the health care system through reductions in inappropriate emergency department usage and inpatient admissions.

This project meets the following regional goals:

- Improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions as part of our region's transformation to a quality-based health care system.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking.
- Increase the capacity of safety net providers in the region to provide patient-centered care and care management to improve health literacy, self-care management skills and more effective navigation of the health care system.

Challenges and How Addressed:

Challenges:

- Appropriate space and equipment for the delivery of primary care in our behavioral health clinics.

- Recruitment and retention of primary care providers including physicians, nurses and support staff.

Addressed by:

- Continued progress on the planned expansion of three outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Implementing marketing strategies for recruitment.
- Enhanced recruitment through maintenance of the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.
- Tuition reimbursement.
- Offering re-location reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5 year Expected Outcome for Provider and Patients:
We expect to see increased utilization of routine and preventative primary care services and to increase the number of individuals receiving physical and behavioral health care at TTBH clinics annually to 900 persons served by DY5.

Starting Point/Baseline:
Baseline is zero. This is an innovative project for TTBH; the Center has not previously delivered primary care services for persons with co-occurring medical and behavioral health needs.

Rationale:
The elevated rates of co-morbid chronic medical illnesses in people with mental illness, the unique challenges they face in effectively managing their illnesses and their high rates of premature mortality relative to the general population have been well documented. In a 2006 technical report on Morbidity and Mortality in People with Serious Mental Illness (SMI), the Medical Directors Council of the National Association of State Mental Health Program Directors suggested that people with SMI die, on average, 25 years earlier than the general population. The report asserted the increased mortality and morbidity rates were largely due to preventable conditions including cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza) and infectious diseases (including HIV/AIDS). The researchers argued that having SMI may be a risk factor and lead to problems in access to health care due to, among other things, the lack of motivation, fearfulness, and social instability of persons with SMI, and the fragmentation of mental health and primary health care systems.

Factors identified as placing people with SMI at higher risk of morbidity and mortality included higher rates of smoking, alcohol consumption, poor nutrition /obesity, lack of exercise, unsafe sexual behavior, drug use and exposure to infectious diseases, as well as homelessness, victimization/trauma, unemployment, poverty, incarceration, and social isolation. The report also cited research suggesting the population of people with SMI had high use of somatic emergency

services, fewer routine preventive services, lower rates of cardiovascular procedures and worse diabetes care. For those in the Rio Grande Valley living with mental illness, these health concerns are compounded by the overarching health issues impacting the general population along the Texas/Mexico Border more negatively than other areas of the state and nationally, and in relation to science-based nationally established health benchmarks. Examples include an increased likelihood of being uninsured; difficulty accessing health care; not seeing a physician regularly due to cost or transportation barriers; a decreased likelihood of having routine blood pressure or cholesterol tests; higher rates of kidney disease, liver disease, tuberculosis, diabetes, overweight and obesity; and a higher rate of reported depressive symptoms accompanied by a lower likelihood of seeking mental health treatment.

The benefits of integrating primary and behavioral health both from a health improvement and a health system cost perspective have also been demonstrated. A recent study involving the integration of primary care services within a mental health clinic treating veterans with mental illness reported that "enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals." The study found that the veterans who received primary care services co-located within the mental health setting realized "significantly improved goal attainment for blood pressure, low-density lipoprotein cholesterol, triglycerides, and BMI." Researchers have also demonstrated that for populations served in community mental health centers, the implementation of care management delivered in an integrated primary care setting can result in sustainable improvements in physical health outcomes (e.g. cardiovascular risk, physical functioning and pain) and patient and provider satisfaction, as well as significant potential cost savings to health care systems relative to care as usual (i.e., referral to their primary care provider).

Co-location of Primary care services improves access to care by reducing the cost and inconvenience to those served of arranging for added transportation to multiple locations for behavioral and physical health care. Through this project, TTBH will co-locate primary health care clinics at each of our three main behavioral health clinics. These co-located clinics will allow TTBH to provide a targeted group of persons receiving behavioral health services with access to integrated primary health care, including services to promote education, prevention, recovery and wellness through a health care home design.

Project Components:

Through our project to integrate primary care service into our behavioral health clinics we propose to meet the required project components as follows:

a) *Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.* TTBH will co-locate primary care services within three of our existing behavioral health clinics. This will allow for the delivery of primary care services in clinic locations and settings very familiar to the individuals and families of the counties we serve; for "one-stop" access to mental health and medical services, reducing the need for transportation to multiple service locations; and is conducive to the facilitation of "warm hand-offs" between behavioral health and primary care service providers.
b) *Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.* As primary care services

will be delivered by TTBH primary care staff using the same Electronic health record already in place for the delivery of behavioral health services, provider agreements are not needed.

c) *Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.* Communication and sharing of clinical data will be accomplished though clinician access to a single Electronic health record in accordance with TTBH Technology and Information Systems security protocols. Protocols for the identification and referral of clients to primary care services will be developed during the program planning and development process.

d) *Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.* This will be accomplished through marketing and hiring strategies including: competitive hiring and salary structure based on years of experience; career ladder advancement opportunities; productivity incentives; attracting providers through the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps; tuition reimbursement; re-location reimbursement and opportunities for training and education to enhance staff competencies and promote professional development.

e) *Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing.* Appropriate protocols will be developed during the program planning and development process.

f) *Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system*. As primary care services will be delivered and documented using the same Electronic health record already in place for the delivery of behavioral health services, this is already in place.

g) *Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.* This will be researched and addressed as needed through the program planning and development process.

h) *Arrange for utilities and building services for these settings.* This will be addressed as part of our planned expansion of existing clinic sites.

i) *Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.* This will be accomplished through our existing Quality Management/Utilization Management structures, as described in the project description.

j) *Conduct quality improvement for project using methods such as rapid cycle improvement.* This will be accomplished through our existing Quality Management/Utilization Management structures as described in the project description, through the planned learning collaborative activities with Border Region Behavioral Health and other regional partners as appropriate and through the activities of the various Community Mental Health Center consortia sponsored by the Texas Council of Community Centers.

Milestones and Metrics:

The following milestones and metrics were chosen for the TTBH Integrate Primary and Behavioral Health Care Services project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-5 (P-5.2); P-7 (P-7.1)
- Improvement Milestones and Metrics: I-8 (I-8.1)

Unique Community Needs Identification Numbers:
This project addresses community need CN.3, inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
The project to integrate primary and behavioral health care services is a completely new initiative for TTBH. Currently, integration of primary and behavioral health care for those we serve is minimal including referrals to outside primary care physicians, local Federally Qualified Healthcare Clinics and other area clinics. This involves separate service sites and systems, a lack of effective communication and data sharing if any, and requires that the person served or their family navigate complicated health care systems. Through this project, those receiving behavioral health services with co-morbid chronic high-risk medical illnesses will have access to primary and behavioral health care that utilizes shared facilities and systems, and regular collaboration and communication between providers, to achieve a true team approach to address all of their recovery needs.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Expanding infrastructure and capacity for preventative primary health care services will support the completion of the medical clearances needed for many psychiatric inpatient admissions by the

physicians employed at the co-located clinics and reduce the use of emergency departments for this service (Project 138708601.2.3). It is also necessary to accommodate the implementation of integrated care management functions to educate persons served about their primary and behavioral health conditions, monitor their response and adherence to treatment and coordinate care (Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, to develop and participate in a learning collaborative related to our respective projects to integrate primary and behavioral health care services.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to a research done by University of Texas Austin Center for Social Work, the monetary value per life-year gained due to the interventions is $50,000.
- Overall Project Valuation: The total valuation for Integrated Primary Care is $16,810,467

Project	***Project Option***	***Project Component(s)***	***Integrate Primary and Behavioral Health Care Services***
138708601.2.1	***2.15.1***	***2.15.1.a – 2.15.1.j***	
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.4*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 1 [P-5.2]: Number of primary care providers newly located in behavioral health settings. • Baseline/Goal: Baseline N/A, goal is to develop a plan to co-locate primary care services at TTBH's 3 main clinics including building construction and renovation, purchase of necessary equipment, development of policies and procedures and recruitment, hiring and training of staff. • Data Source: Documentation of work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,924,751.50 **Milestone 2** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports	**Milestone 3** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of unduplicated individuals served receiving both physical and behavioral health care at the established locations. • Baseline/Goal: In FY2012 TTBH served approximately 23,000 unduplicated individuals. The goal is to increase the percentage of unduplicated persons receiving both physical and behavioral health care to 1.3% of baseline. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $2,058,419 **Milestone 4** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.	**Milestone 5** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of unduplicated individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of unduplicated persons receiving both physical and behavioral health care to 2.6% of baseline. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $2,170,697 **Milestone 6** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):*	**Milestone 7** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of unduplicated individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of unduplicated persons receiving both physical and behavioral health care to 3.9% of baseline. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $2,251,366 **Milestone 8** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):*

Project ***138708601.2.1***	***Project Option*** ***2.15.1***	***Project Component(s)*** ***2.15.1.a – 2.15.1.j***	***Integrate Primary and Behavioral Health Care Services***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.4*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,924,751.50	Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,058,419		$2,170,697	$2,251,366
Year 2 Estimated Milestone Bundle Amount: $3,849,503	Year 3 Estimated Milestone Bundle Amount: $4,116,838		Year 4 Estimated Milestone Bundle Amount: $4,341,394	Year 5 Estimated Milestone Bundle Amount: $4,502,732
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $16,810,467				

- ***Tropical Texas Behavioral Health***
- ***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.).***
- ***138708601.2.2***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will create a law enforcement taskforce comprised of specially trained and certified Mental Health Officers, serving across the TTBH catchment area, with the objective of decreasing preventable admissions and readmissions into the criminal justice system.
Need for the project: A brief description of the need for the project including data as appropriate.	People with severe mental illness are significantly disproportionally represented among criminal justice populations. A number of factors increase the likelihood that a person with mental illness will come in contact with the criminal justice system in their lifetimes (one is lack of access to mental health services). Studies have estimated the prevalence of severe mental illness in jail and prison populations from 8% to as high as 31%, as compared to 3% in the general population.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is adults and youth in our communities who come in contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness, who may therefore be appropriate for diversion from the criminal justice system into routine behavioral health care services. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the volume of interventions by the Mental Health Officer taskforce with individuals appropriate for diversion into treatment from 1,000 in DY3, to 1,200 in DY4 and to 1,400 by DY5. Assuming an arrest per service call rate of 5.8% for the Mental Health Officers on the taskforce, this project seeks to reduce the rate through diversion of appropriate cases to behavioral health treatment by .5% in DY3, 1% in DY4, and 1.5% in DY5.

Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
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)
Unique RHP Project identification number: 138708601.2.2
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 2.13.2 Will recruit and hire 18 certified Mental Health Officers to serve on a mental health taskforce serving all counties in TTBH's catchment area; increase opportunities to divert individuals with mental illness from the criminal justice system to treatment alternatives as appropriate.

Project Description:
Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. Through funding associated with this project, 18 certified Mental Health Officers will be recruited to serve on a specially trained law enforcement task force with the objective of decreasing preventable admissions and readmissions into the Criminal Justice System. In 2011, the police departments in the three largest cities in the Valley (McAllen, Harlingen and Brownsville) reported an average rate of arrests per service call of approximately 5.8%. Assuming the same arrest rate for officers on the mental health taskforce, by Waiver DY5 TTBH will target a decrease of at least 1.5% in the arrest rate for the Mental Health Officers as a result of an increase in the number of individuals identified as appropriate for diversion from jail into behavioral health treatment services.

The task force will be will be created through the execution of an interlocal agreement between several local county and municipal law enforcement agencies. The task force will hire new/additional officers, employed by the respective participating law enforcement agencies/departments, to serve on the task force. The personnel, supplies and operating expenses for the task force will be funded by this project. Officers serving on the task force will have the authority to intervene in cases involving individuals exhibiting signs and symptoms of a possible mental illness anywhere outside of the jurisdiction in which they are regularly employed throughout Willacy, Cameron and Hidalgo Counties, in accordance with applicable statutes and the terms of the agreement. Through the interlocal agreement and the task force, the participating agencies will cooperate to improve the identification of individuals who come in contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness and who may therefore be appropriate for diversion from the criminal justice system into routine behavioral health care services. This will reduce the need for intervention by other elements of local law enforcement, hospital emergency department visits and medical and psychiatric inpatient hospital admissions. The program will also improve health outcomes for persons served, supporting the objective of delivering the right care at the right time in the right setting, and improve the experience of care.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality

improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Recruit and hire 18 certified Mental Health Officers to serve on a taskforce serving all counties in TTBH's catchment area.
- Increase opportunities to divert individuals with mental illness from the criminal justice system to treatment alternatives as appropriate.
- Decrease in preventable admissions and readmissions into the criminal justice system by 1.5% from baseline for persons encountered by Mental Health Officers.
- Reduce interventions with this population by other elements of local law enforcement, in hospital emergency departments and medical and psychiatric inpatient hospital admissions.
- Improve health outcomes for persons served, delivering the right care at the right time in the right setting.

This project meets the following regional goals:

- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access and timely utilization of appropriate care, including behavioral health services.
- Increase the availability of and access to behavioral health services by expanded mental health workforce capacity to help prevent admission/readmission to inpatient psychiatric care.

Challenges and How Addressed:

Challenges:

- Execution of an interlocal agreement between TTBH and multiple local law enforcement agencies to establish the Mental Health Officer Taskforce.
- Recruitment and retention of officers to serve on the taskforce.

Addressed by:

- Leveraging longstanding collaborative relationships with local law enforcement agencies to achieve an agreement acceptable to all parties involved.
- Provide opportunities for officer training and education to enhance staff competencies and promote professional development.

5 year Expected Outcome for Provider and Patients:

By DY5, we expect the volume of interventions by the Mental Health Officer taskforce with individuals appropriate for diversion into treatment to increase annually to a total at least 1,400 and to show a 1.5% decrease in preventable admissions and readmissions into the criminal justice system relative to the arrests per service call rate of 5.8%.

Starting Point/Baseline:
As the Mental Health Officer taskforce is the first initiative of its kind in the Rio Grande Valley, there are no baseline data for service encounters. The project assumes a baseline rate of arrests per service calls by law enforcement of 5.8% based on 2011 data reported by the police departments in the three largest cities in the Rio Grande Valley.

Rationale:
What has been referred to as the "criminalization of mental illness" describes the problem that developed in the U.S. mental health care system during the 1960s and 1970s when the planned availability of community behavioral health services failed to meet the increased demand resulting from large scale efforts to deinstitutionalize persons with mental illness. The lack of sufficient availability of community-based behavioral health treatment options is one of a number of factors increasing the likelihood that a person with mental illness will come in contact with the criminal justice system in their lifetimes. Others issues include reluctance to seek treatment for a mental illness due to the associated stigma; fear of navigating a complex system of care; complications from co-morbid substance use disorders; joblessness and homelessness. Consequently, over time the criminal justice system has played an increasingly significant role in intervening with people with mental illness. The numbers of individuals with mental illnesses in jails and prisons exceeds the number receiving treatment in psychiatric hospitals by a 3:1 ratio; in Texas the ratio has been reported to be as high as 8:1. People with mental illness are significantly disproportionally represented among criminal justice populations. Studies have estimated the prevalence of severe mental illness in jail and prison populations from 8% to as high as 31%, as compared to approximately 3% in the general population. Further, more than 70% of inmates with severe mental illness also have co-morbid substance abuse or dependence disorders.

In its 2006 report, the Crisis Services Redesign Committee charged by the Texas Department of State Health Services (DSHS) with developing recommendations to address gaps in the mental health and substance abuse crisis services delivered by local mental health authorities (LMHAs) identified six core services they said "should be the centerpiece of the mental health system of care for individuals in crisis", among them was a Crisis Intervention Team / Mental Health Deputy / Peace Officer program, and cites support for the implementation of these programs within the Texas Health and Safety Code.

The benefits of using specially trained Mental Health Officers to accomplish diversion of individuals with mental illness from inappropriate incarceration into therapeutic treatment settings have been demonstrated in a number of other parts of the state. In a 2008 cost analysis of the Bexar County jail diversion program from September 2003 to June 2005, a frontline component of which is the use of Deputy Mobile Outreach Teams and Crisis Intervention Teams comprised of deputy sheriffs and other officers with specialized mental health training, the Center for Health Care Services (CHCS), the Bexar County LMHA, reported that "combining criminal justice and treatment costs during pre-booking

diversion was associated with $3,200 in lower costs per person during the first 6 months after diversion" and that "in the absence of pre-booking diversion, cross-system (i.e., criminal justice and treatment) costs would have been more than $1.2 million higher during the 6 months immediately after diversion. In 2003, Permian Basin Community Center (PBCC), the LMHA serving Brewster, Ector, Midland and Pecos counties initiated its Mental Health Deputy Program, designed to both divert individuals from incarceration when appropriate and assist with transport of individuals in crisis to appropriate treatment facilities. In 2008, PBCC reported it was 75% cheaper to provide behavioral treatment to offenders with mental illness on an outpatient basis than it was while they were incarcerated, and that having officers trained to conduct mental health assessments in the field saved time and money for law enforcement, the LMHA and the communities served. In FY 10, the PBCC Mental Health Deputy Units responded to more than 1,100 calls for assistance and diverted 206 out of 241, or 85% of the individuals determined to be eligible for diversion from incarceration. In FY 11, PBCC reported their Mental Health Deputies responded to more than 1,300 calls, and diverted 91% of eligible individuals from incarceration into treatment, with more than half of those diverted admitted to ongoing outpatient behavioral health services through the LMHA. Houston's Police Department piloted its first Crisis Intervention Team (CIT) in 1999. The Department's Mental Health Unit (MHU), established in 2006, currently includes seven distinct sub-departments including 3 Crisis Intervention Response Teams (CIRT). In 2011, the Houston Police Department's MHU reported that since the creation of its first CIRT in 2008, CIRTs alone have responded to over 14,000 Crisis Intervention Team calls, filed more than 4,600 emergency detention orders, and that less than 1 percent of the crisis situations had resulted in arrests. The Houston Police Department's MHU operates in close collaboration with the Mental Health Mental Retardation Authority of Harris County, the county's LMHA, which supports the delivery of the mental health training for the department's officers and supplies the licensed professional mental health staff providing clinical support for the CIRTs. During the period from 2007 to 2011, the Houston Police MHU reported more than 7,500 jail diversions. The Council of State Governments Justice Center and the U.S. Justice Department's Bureau of Justice Assistance have identified the Houston Police Department as one of only six law enforcement/mental health sites in the country to serve as centers for peer-to-peer learning for other criminal justice and mental health agencies.

To ensure the most appropriate outcomes when individuals with mental illness encounter law enforcement, and given that interactions with individuals with mental illness take up a considerable, and growing, amount of law enforcement officers' direct service time, the interests of persons served and the law enforcement and health care systems are best served by the development of elements within law enforcement with the necessary training to effectively intervene with this population. This delivery system reform project will support the operation of a Mental Health Peace Officer task force serving throughout TTBH's catchment area, drawing on the experience and successes of similar programs implemented by LMHAs in other parts of the state. The officers in the program will be licensed peace officers from several county and municipal law enforcement agencies who have previous patrol experience and will receive specialized and ongoing training through the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) and TTBH clinical staff as needed, to maintain a high level of knowledge and skill in intervening with persons with mental illness in the community. The task force will collaborate with TTBH's MCOT teams and other service departments to ensure 24-hour access to necessary behavioral health consultations, appropriate outcomes for the individuals served and to optimize the effectiveness of the program.

Project Components:
Project option 2.13.2 does not have additional core components.

Milestones and Metrics:
The following milestones and metrics were chosen for the Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-2 (P-2.1); P-4 (P-4.1)
- Improvement Milestones and Metrics: I-X (I-X.1); I-1 (I-1.1)

Unique Community Needs Identification Numbers:
This project addresses community need CN. 2, related to shortage of behavioral health professionals and inadequate access to behavioral health care.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
The Mental Health Officer taskforce will be the first initiative of its kind in the Rio Grande Valley.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
The Mental Health Officer task force is linked to the overall expansion of TTBH's behavioral health care capacity (Project 138708601.1.1) and supports the Center's goals to expand the delivery of

comprehensive behavioral health services to more people with co-occurring substance use disorders (Project 138708601.1.2) and co-occurring Intellectual and Developmental Disabilities (Project 138708601.1.3).

Relationship to Other Performing Providers' Projects in the RHP:
This project is unique to the region as we will provide interventions for our behavioral health population to prevent unnecessary admissions and readmissions to the criminal justice system i.e. jails. We will coordinate our service capacity to support this community.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 5, Hidalgo County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

- Jail Diversion: According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. Interventions by Mental Health Officers have the potential to divert individuals from jail. In DY2, TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day.
- Overall Project Valuation: The total valuation for MH Officers project is $13,443,573 by end of DY5.

Project ***138708601.2.2***	***Project Option*** ***2.13.2***	***Project Component(s)*** ***N/A***	***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.)***
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.5*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Design community-based specialized interventions for target populations. Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals. • Baseline/Goal: Baseline N/A, goal is the development and execution of an interlocal agreement between participating municipal and county law enforcement agencies, and the recruitment, hiring and training of personnel. • Data Source: Project documentation including work plan and implementation time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,861,232 **Milestone 2** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports	**Milestone 3** [I-X]: Increase volume of interventions by Mental Health Officers. Metric 1 [I-X.1]: Documentation of increased number of service encounters by officers on MH Officer Taskforce. • Baseline/Goal: Baseline is zero. Goal is for MH Officer Taskforce to record at least 1,000 service contacts with individuals with a potentially preventable admission or readmission into the criminal justice system. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $1,137,796.66 **Milestone 4** [I-1]: Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Percent decrease in preventable admissions and readmissions into Criminal Justice System. • Baseline/Goal: The major municipal Police Departments in the Rio Grande Valley reported an arrest per service call rate of 5.8% in 2011. The goal is a decrease in preventable	**Milestone 6** [I-X]: Increase volume of interventions by Mental Health Officers. Metric 1 [I-X.1]: Documentation of increased number of service encounters by officers on MH Officer Taskforce. • Baseline/Goal: Baseline is zero. Goal is for MH Officer Taskforce to record at least 1,200 service contacts with individuals with a potentially preventable admission or readmission into the criminal justice system. • Data Source: Encounter data Milestone 6 Estimated Incentive Payment: $1,199,858.33 **Milestone 7** [I-1]: Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Percent decrease in preventable admissions and readmissions into Criminal Justice System. • Goal: Decrease in preventable admissions and readmissions into the Criminal Justice System by 1% from baseline for persons encountered by Mental Health Officers.	**Milestone 9** [I-X]: Increase volume of interventions by Mental Health Officers. Metric 1 [I-X.1]: Documentation of increased number of service encounters by officers on MH Officer Taskforce. • Baseline/Goal: Baseline is zero. Goal is for MH Officer Taskforce to record at least 1,400 service contacts with individuals with a potentially preventable admission or readmission into the criminal justice system. • Data Source: Encounter data Milestone 9 Estimated Incentive Payment: $902,714.66 **Milestone 10** [I-1]: Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Percent decrease in preventable admissions and readmissions into Criminal Justice System. • Goal: Decrease in preventable admissions and readmissions into the Criminal Justice System by 1.5% from baseline for persons encountered by Mental Health Officers.

Project ***138708601.2.2***	***Project Option*** ***2.13.2***	***Project Component(s)*** ***N/A***	***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.)***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.5*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,861,232	admissions and readmissions into the Criminal Justice System by .5% from this baseline for persons encountered by Mental Health Officers. • Data Source: Encounter data Milestone 4 Estimated Incentive Payment: $1,137,796.67 **Milestone 5** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,137,796.67		• Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $1,199,858.33 **Milestone 8** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,199,858.34	• Data Source: Encounter data Milestone 10 Estimated Incentive Payment: $902,714.67 **Milestone 11** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 11 Estimated Incentive Payment *(maximum amount):* $902,714.67
Year 2 Estimated Milestone Bundle Amount: $3,722,464	Year 3 Estimated Milestone Bundle Amount: $3,413,390		Year 4 Estimated Milestone Bundle Amount: $3,599,575	Year 5 Estimated Milestone Bundle Amount: $2,708,144
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $13,443,573				

- ***Tropical Texas Behavioral Health***
- ***Integrate Primary and Behavioral Health Care Services***
- ***138708601.2.3***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will utilize the medical staff assigned to our planned co-located primary care clinics to complete medical clearance evaluations necessary for psychiatric hospital admissions during normal business hours, resulting in decreased utilization of local emergency departments for this purpose.
Need for the project: A brief description of the need for the project including data as appropriate.	Currently, persons served by TTBH who are in need of medical clearance for psychiatric hospitalization must be transported by law enforcement to hospital emergency departments, where the officers must wait for completion of the clearance before transporting the person to the applicable inpatient facility.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is adults and youth in our service area requiring inpatient psychiatric hospitalization. In FY12, approximately half of the 1,800 admissions to psychiatric hospitals through TTBH, or 900 admissions, required medical clearances; all of them completed in local emergency rooms. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the volume of medical clearance assessments completed in our co-located primary care clinics by 3% of the baseline of 900 admissions or 27 medical clearances in DY3, by 4% of baseline or 36 medical clearances in DY4 and by 5% of baseline or 45 medical clearance services in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
2.15 Integrate Primary and Behavioral Health Care Services
Unique RHP Project identification number: 138708601.2.3
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 2.15.1 Will co-locate primary care services at TTBH's main clinic locations; reduce the use of local emergency departments for medical clearances required for psychiatric hospital admissions.

Project Description:
Integrate primary care and behavioral health care services in order to improve care and access to needed services. TTBH will co-locate primary healthcare clinics at each of our three main behavioral health clinics and, utilizing the physicians and medical support staff assigned to the clinics, increase the volume of medical clearance assessments completed to 45 services by Waiver DY5. Completing medical clearances internally will improve the quality of care and reduce costs. If the person evaluated for inpatient admission is admitted to TTBH services, detailed medical information may be readily available to the physician completing the medical clearance. This would be especially important if the person served is unwilling or unable to provide accurate information during the crisis. Information from medical clearances gathered internally will be more readily available to behavioral health staff for post-discharge follow-up and if an individual is admitted to outpatient services upon discharge. Completing medical clearances internally will reduce the involvement of law enforcement and the utilization of hospital emergency department resources that are more appropriately dedicated to medical emergencies. It will also allow the evaluation to be completed in a setting that may be familiar to the person in crisis and allow the behavioral health clinicians to facilitate "warm hand-offs" to primary care staff, improving the experience of care.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):
Project goals:

- Reduce the use of local emergency departments for medical clearances required for psychiatric hospital admissions.
- Increase the number of persons receiving medical clearances at co-located TTBH primary care clinics to 45 persons served by DY5.
- Improve coordination of behavioral and primary health care, health outcomes and wellness for persons served through early primary care intervention.
- Reduce costs to the health care system through reductions in inappropriate emergency department usage.

This project meets the following regional goals:

- Improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions as part of our region's transformation to a quality-based health care system.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking.
- Increase the capacity of safety net providers in the region to provide patient-centered care and care management to improve health literacy, self-care management skills and more effective navigation of the health care system.

Challenges and How Addressed:

Challenges:

- Appropriate space and equipment for the delivery of primary care in our behavioral health clinics.
- Recruitment and retention of primary care providers including physicians, nurses and support staff.

Addressed by:

- Continued progress on the planned expansion of three outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.

- Implementing marketing strategies for recruitment.
- Enhanced recruitment through maintenance of the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.
- Tuition reimbursement.
- Offering re-location reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5 year Expected Outcome for Provider and Patients:
We expect to increase the volume of internal medical clearance assessments completed annually to 45 completed services by Waiver DY5, resulting in a corresponding reduction the utilization of hospital emergency department resources for this purpose.

Starting Point/Baseline:
Baseline is zero. Currently, all individuals requiring medical clearance for inpatient psychiatric admission are evaluated in local hospital emergency departments.

Rationale:
TTBH serves a population with unique health and health care related challenges relative to the rest of the state and the country including the elevated rates of co-morbid chronic disease and substance abuse experienced by persons with mental illness; numerous health risk factors specific to the population residing along the Texas/Mexico border and in particular, to Hispanics and low-income families within the region; and a confluence of barriers to appropriate care faced by all of these groups. This suggests the considerable benefit potential to those served and to the local and state health care systems of making integrated primary care available at each of the Center's largest behavioral health clinics in the Valley. An additional benefit of the planned integration of primary care will be the ability for TTBH to complete, in-house, medical evaluations to clear individuals in need of inpatient psychiatric hospitalization. Further, use of emergency room resources by individuals with mental illness for non-emergent medical or psychiatric issues has been linked to emergency room crowding and delays in access to treatment for those needing emergency medical care. In 2011, the Bazelon Center for Mental Health Law reported that individuals with mental illness have higher rates of emergency room use and are more likely to use the emergency room on multiple occasions than persons without psychiatric disorders, and that while overall use of emergency rooms in the U.S. increased by 23% between 1997 and 2007 (a much higher rate than would be expected due to population growth), mental health-related emergency room visits during the period from 1992 to 2003 increased by 75%. The report went on to say that a majority of emergency room physicians attributed longer wait times and decreased service capacity in emergency rooms to the increased usage by persons with mental illness. Currently, persons served by TTBH who are in need of medical clearance for psychiatric hospitalization must be transported by law enforcement to hospital emergency departments. Officers must then wait at the emergency room for the clearance to be completed before transporting the person to the applicable inpatient facility. The process results in significant avoidable costs including loss of time and money, safety concerns for the communities served by the officers removed from the field for considerable durations to facilitate the process and the use of hospital emergency department resources that could be dedicated to true medical emergencies. Through this project, TTBH will utilize the physicians, nurses and medical support staff

assigned to our planned co-located primary care clinics (referenced in Project 138708601.2.1) to complete medical clearance evaluations in-house during normal business hours. (Refer to Project 138708601.2.1 for information addressing fulfillment of the project option core components as required by the RHP Planning Protocols).

Project Components:
Through our project to integrate primary care service into our behavioral health clinics we propose to meet the required project components as follows:

a) *Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.* TTBH will co-locate primary care services within three of our existing behavioral health clinics. This will allow for the delivery of primary care services in clinic locations and settings very familiar to the individuals and families of the counties we serve; for "one-stop" access to mental health and medical services, reducing the need for transportation to multiple service locations; and is conducive to the facilitation of "warm hand-offs" between behavioral health and primary care service providers.
b) *Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.* As primary care services will be delivered by TTBH primary care staff using the same Electronic health record already in place for the delivery of behavioral health services, provider agreements are not needed.
c) *Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.* Communication and sharing of clinical data will be accomplished though clinician access to a single Electronic health record in accordance with TTBH Technology and Information Systems security protocols. Protocols for the identification and referral of clients to primary care services will be developed during the program planning and development process.
d) *Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.* This will be accomplished through marketing and hiring strategies including: competitive hiring and salary structure based on years of experience; career ladder advancement opportunities; productivity incentives; attracting providers through the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps; tuition reimbursement; re-location reimbursement and opportunities for training and education to enhance staff competencies and promote professional development.
e) *Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing.* Appropriate protocols will be developed during the program planning and development process.
f) *Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system*. As primary care services will be delivered and documented using the same Electronic health record already in place for the delivery of behavioral health services, this is already in place.
g) *Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.* This will be researched and addressed as needed through the program planning and development process.

h) *Arrange for utilities and building services for these settings.* This will be addressed as part of our planned expansion of existing clinic sites.
i) *Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.* This will be accomplished through our existing Quality Management/Utilization Management structures, as described in the project description.
j) *Conduct quality improvement for project using methods such as rapid cycle improvement.* This will be accomplished through our existing Quality Management/Utilization Management structures as described in the project description, through the planned learning collaborative activities with Border Region Behavioral Health and other regional partners as appropriate and through the activities of the various Community Mental Health Center consortia sponsored by the Texas Council of Community Centers.

Milestones and Metrics:
The following milestones and metrics were chosen for the TTBH Integrate Primary and Behavioral Health Care Services project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-X (P-X.1); P-7 (P-7.1)
- Improvement Milestones and Metrics: I-8 (I-8.1)

Unique Community Needs Identification Numbers:
This project addresses community need CN. 3, related to inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
The project to integrate primary and behavioral health care services is a completely new initiative for TTBH. Currently, integration of primary and behavioral health care for those we serve is minimal including referrals to outside primary care physicians, local Federally Qualified Healthcare Clinics and other area clinics. This involves separate service sites and systems, a lack of effective communication and data sharing if any, and requires that the person served or their family navigate complicated health care systems. Through this project, those receiving behavioral health services with co-morbid chronic high-risk medical illnesses will have access to primary and behavioral health care that utilizes shared facilities and systems, and regular collaboration and communication between providers, to achieve a true team approach to address all of their recovery needs.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many

aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
This project is dependent on the implementation of the Center's project to develop the infrastructure and capacity necessary to integrate preventative primary health care with existing behavioral health services (Project 138708601.2.1), and is linked to the implementation of integrated care management functions to educate persons served about their primary and behavioral health conditions, monitor their response and adherence to treatment and coordinate care (Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, to develop and participate in a learning collaborative related to our respective projects to integrate primary and behavioral health care services.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678.
- Overall Project Valuation: The total project valuation is $106,488.

Project	***Project Option***	***Project Component(s)***	***Integrate Primary and Behavioral Health Care Services***	
138708601.2.3	***2.15.1***	***2.15.1.a – 2.15.1.j***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.6*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Develop and implement clinical protocols, program policies and staff training for the completion of medical clearance evaluations in co-located TTBH primary care clinics. Metric 1 [P-X.1]: Submission of medical clearance protocols, program policies and staff training materials. • Baseline/Goal: Baseline N/A, goal is to develop and implement protocols, policies and training to be utilized by medical staff in the co-located primary clinics to complete in-house medical clearance evaluations of individuals in need of inpatient psychiatric hospitalization. • Data Source: Documentation of development and implementation of clinical protocols, program policies and staff training. Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,718 **Milestone 2** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and	**Milestone 3** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals served receiving both physical and behavioral health care at the established locations. • Baseline/Goal: As this will be a new service, the baseline of persons receiving the specified service is zero. In FY2012 approximately half of the 1,800 admissions to psychiatric hospitals through TTBH required medical clearances and all clearances were completed in local emergency rooms. The goal is to increase the percentage of persons receiving medical clearance services in co-located TTBH primary care clinics by 3% of the baseline of 900 admissions, to 27 persons served. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $15,634.50 **Milestone 4** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation		**Milestone 5** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of persons receiving medical clearance services in co-located TTBH primary care clinics by 4% of the baseline of 900 admissions, to 36 persons served. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $16,487.50 **Milestone 6** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.	**Milestone 7** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of persons receiving medical clearance services in co-located TTBH primary care clinics by 5% of the baseline of 900 admissions, to 45 persons served. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $12,404 **Milestone 8** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.

Project	***Project Option***	***Project Component(s)***	***Integrate Primary and Behavioral Health Care Services***	
138708601.2.3	***2.15.1***	***2.15.1.a – 2.15.1.j***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.6*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $8,718	demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $15,634.50		Milestone 6 Estimated Incentive Payment *(maximum amount):* $16,487.50	Milestone 8 Estimated Incentive Payment *(maximum amount):* $12,404
Year 2 Estimated Milestone Bundle Amount: $17,436	Year 3 Estimated Milestone Bundle Amount: $31,269		Year 4 Estimated Milestone Bundle Amount: $32,975	Year 5 Estimated Milestone Bundle Amount: $24,808
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $106,488				

- ***Tropical Texas Behavioral Health***
- ***Expand Chronic Care Management Models***
- ***138708601.2.4***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will add a Nurse Care Manager at three TTBH clinics serving communities throughout the Rio Grande Valley and implement a patient self-management program for specified individuals with co-morbid chronic medical and mental illnesses.
Need for the project: A brief description of the need for the project including data as appropriate.	Persons with severe mental illness are at elevated risk for co-morbid chronic medical illnesses and face unique challenges in the management of those illnesses relative to the general population, For the population we serve, these health risks are compounded by health issues and disparities unique to the population along the Texas/Mexico border including increased uninsured status, poverty, cost and/or transportation barriers to routine medical services, and elevated rates of overweight, obesity, kidney and liver disease, etc.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is adults and youth in our behavioral health population with chronic co-morbid medical conditions at elevated risk of deterioration of their medical and/or mental illness. New enrollments into care management services will increase annually to 30 individuals in DY2, 60 in DY3, 90 in DY4 and 120 in DY5. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the number of individuals receiving care management services who have self-management goals annually to 50% of persons with the specified condition or multiple chronic condition served in DY3, 55% in DY4 and 60% in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
2.2 Expand Chronic Care Management Models
Unique RHP Project identification number: 138708601.2.4
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Project Option 2.2.5 Will add 1 Nurse Care Manager at each of TTBH's main clinics and implement a patient self-management program for specified individuals with co-morbid chronic medical and mental illnesses.

Project Description:
Develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. TTBH will add 1 Nurse Care Manager to the staff of the primary care clinics co-located at each of our 3 main behavioral health clinics, implement a patient self-management program and increase the number of individuals receiving care management services and who have self-management goals to 300 persons served. TTBH's nurse care managers will coordinate the care of clients with chronic co-morbid medical conditions who are identified as being at elevated risk of deterioration of their medical and/or mental illness; increasing the need for emergency care or other more costly services. Through assessment and the development of a person-centered self-care plan, the care manager will work collaboratively with the person served to help them set goals for improved self-management of their specific condition and to problem solve barriers using community resources, personal support systems and formal treatment services. By maintaining rapport with the person served and their providers, educating the person served about their conditions, monitoring symptoms and communicating findings to the person served and providers, and negotiating solutions to emergent problems, the care managers will help improve the chances that persons served will achieve their self-management and recovery goals. This will result in increased utilization of routine and preventative health services, improved health outcomes and experience of care, and decreased utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Add 1 Nurse Care Manager at three of our behavioral health clinics and implement a patient self-management program for individuals with co-morbid chronic medical and mental illnesses.
- Increase new enrollments into care management services annually to 30 individuals in DY2, 60 in DY3, 90 in DY4 and 120 in DY5.
- Increase the percentage of individuals with co-morbid chronic medical conditions who receive care management services and have self-management goals annually and to 300 persons served by DY5.
- Increase utilization of routine and preventative primary care services.
- Improve health outcomes and experience of care.
- Decrease utilization of more expensive emergency and inpatient medical services.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions as part of our region's transformation to a quality-based health care system.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of best practices to improve access and timely utilization of appropriate care.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.
- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking.
- Increase the capacity of safety net providers in the region to provide patient-centered care and care management to improve health literacy, self-care management skills and more effective navigation of the health care system.

Challenges and How Addressed:

Challenges:

- Appropriate space and equipment for primary healthcare services in our behavioral health clinics.
- Recruitment and retention of primary care providers including Nurse Care Managers.

Addressed by:

- Continued progress on the planned expansion of three outpatient clinics to increase capacity to serve all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.

- Productivity incentive opportunities.
- Implementing marketing strategies for recruitment.
- Enhanced recruitment through maintenance of the agency's Health Professional Shortage Area (HPSA) designation with the National Health Service Corps.
- Tuition reimbursement.
- Re-location reimbursement.
- Training and education to enhance staff competencies and promote professional development.

5 year Expected Outcome for Provider and Patients:
We expect to see increased utilization of care management services in persons with co-morbid chronic high-risk medical conditions, to enroll at least 120 unique individuals into services over the term of the waiver and to increase the percentage of those served who have self-management goals annually to 60% of persons with the specified chronic condition(s) served by DY5.

Starting Point/Baseline:
Baseline is zero. This is an innovative project for TTBH; the Center has not delivered primary care services or care management for co-occurring medical and behavioral health needs previously.

Rationale:
The elevated rates of co-morbid chronic medical illnesses in people with mental illness, the unique challenges they face in effectively managing their illnesses and their high rates of premature mortality relative to the general population have been well documented. In a 2006 technical report on Morbidity and Mortality in People with Serious Mental Illness (SMI), the Medical Directors Council of the National Association of State Mental Health Program Directors suggested that people with SMI die, on average, 25 years earlier than the general population. The report asserted the increased mortality and morbidity rates were largely due to preventable conditions including cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza) and infectious diseases (including HIV/AIDS). The researchers argued that having SMI may be a risk factor and lead to problems in access to health care due to, among other things, the lack of motivation, fearfulness, and social instability of persons with SMI, and the fragmentation of mental health and primary health care systems.

Factors identified as placing people with SMI at higher risk of morbidity and mortality included higher rates of smoking, alcohol consumption, poor nutrition /obesity, lack of exercise, unsafe sexual behavior, drug use and exposure to infectious diseases, as well as homelessness, victimization/trauma, unemployment, poverty, incarceration, and social isolation. The report also cited research suggesting the population of people with SMI had high use of somatic emergency services, fewer routine preventive services, lower rates of cardiovascular procedures and worse diabetes care. For those in the Rio Grande Valley living with mental illness, these health concerns are compounded by the overarching health issues impacting the general population along the Texas/Mexico Border more negatively than other areas of the state and nationally, and in relation to science-based nationally established health benchmarks. Examples include an increased likelihood of being uninsured; difficulty accessing health care; not seeing a physician regularly due to cost or transportation barriers; a decreased likelihood of having routine blood pressure or cholesterol tests;

higher rates of kidney disease, liver disease, tuberculosis, diabetes, overweight and obesity; and a higher rate of reported depressive symptoms accompanied by a lower likelihood of seeking mental health treatment.

The benefits of integrating primary and behavioral health both from a health improvement and a health system cost perspective have also been demonstrated. A recent study involving the integration of primary care services within a mental health clinic treating veterans with mental illness reported that "enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals." The study found that the veterans who received primary care services co-located within the mental health setting realized "significantly improved goal attainment for blood pressure, low-density lipoprotein cholesterol, triglycerides, and BMI."

Researchers have also demonstrated that for populations served in community mental health centers, the implementation of care management delivered in an integrated primary care setting can result in sustainable improvements in physical health outcomes (e.g. cardiovascular risk, physical functioning and pain) and patient and provider satisfaction, as well as significant potential cost savings to health care systems relative to care as usual (i.e., referral to their primary care provider). Similarly, two pilot programs implemented in 2009 by the Pennsylvania Department of Public Welfare and the Center for Health Care Strategies to integrate physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness and co-occurring physical health conditions, including the use of care navigators to coordinate care and treatment related information sharing between physical and behavioral health providers and promote the early recognition of symptoms that could lead to a decline in physical or mental health, demonstrated success at reducing the rate of mental health hospitalizations, all-cause readmissions and emergency department visits.

Project Components:
Project option 2.2.5 does not have additional core components.

Milestones and Metrics:
The following milestones and metrics were chosen for the TTBH Integrate Primary and Behavioral Health Care Services project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-11 (P-11.1); P-X (P-X.1)
- Improvement Milestones and Metrics: I-18 (I-18.1)

Unique Community Needs Identification Numbers:
This project addresses community need CN.3, related to inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:
TTBH has not previously delivered integrated primary care or care management services to the behavioral health population served.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
The nurse care managers will be an integral component of the primary care treatment teams that will staff TTBH's co-located primary care clinics, contributing to the integration of primary and behavioral health care services (Project 138708601.2.1). In addition to the focus on co-occurring medical conditions, assessments completed by the care managers may identify new or worsening issues necessitating referrals to the Center's expanded COPSD services (Project 138708601.1.2).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center to develop and participate in a learning collaborative related to our respective projects for the implementation of integrated care management functions for persons with co-morbid chronic diseases and behavioral health disorders.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to a research by the University of Texas Austin Center for Social Work, the monetary value per life-year gained due to the interventions is $50,000.
- Overall Project Valuation: The total valuation for nurse care managers is $12,360,811.

Project	***Project Option***	***Project Component(s)***	***Expand Chronic Care Management Models***	
138708601.2.4	***2.2.5***	***N/A***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.7*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-11]: Develop and implement a program to assist patient to better self-manage their chronic conditions. Metric 1 [P-11.1]: Increase number of patients enrolled in self-management program. • Baseline/Goal: Baseline is zero (new program). Goal is to develop a plan to co-locate primary care services at TTBH's 3 main clinic locations, implement care management services and enroll 30 individuals in a chronic care self-management program. • Data Source: Documentation of work plan and time frames, and client data from EHR. Milestone 1 Estimated Incentive Payment *(maximum amount):* $57,051.50 **Milestone 2** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how	**Milestone 3** [P-11]: Develop and implement a program to assist patient to better self-manage their chronic conditions. Metric 1 [P-11.1]: Increase number of patients enrolled in self-management program. • Goal is to enroll 30 additional unique individuals in a chronic care self-management program. • Data Source: Documentation of work plan and time frames, and client data from EHR. Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,102, 201 **Milestone 4** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. • Baseline/Goal: Baseline is zero (new program). Goal is to increase the percentage of individuals with the specified chronic condition/MCC in the registry with at least one recorded self-management goal to 50% of persons with the		**Milestone 6** [P-11]: Develop and implement a program to assist patient to better self-manage their chronic conditions. Metric 1 [P-11.1]: Increase number of patients enrolled in self-management program. • Goal is to enroll 30 additional unique individuals in a chronic care self-management program. • Data Source: Documentation of work plan and time frames, and client data from EHR. Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,246,052.66 **Milestone 7** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. • Goal: Increase the percentage of individuals with the specified chronic condition/MCC in the registry with at least one recorded self-management goal to 55% of persons with the specified condition/MCC.	**Milestone 9** [P-11]: Develop and implement a program to assist patient to better self-manage their chronic conditions. Metric 1 [P-11.1]: Increase number of patients enrolled in self-management program. • Goal is to enroll 30 additional unique individuals in a chronic care self-management program. • Data Source: Documentation of work plan and time frames, and client data from EHR. Milestone 9 Estimated Incentive Payment *(maximum amount):* $1,733,982.33 **Milestone 10** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. • Goal: Increase the percentage of individuals with the specified chronic condition/MCC in the registry with at least one recorded self-management goal to 60% of persons with the specified condition/MCC.

Project	***Project Option***	***Project Component(s)***	***Expand Chronic Care Management Models***	
138708601.2.4	***2.2.5***	***N/A***		
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.7*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $57,051.50	specified condition/MCC. • Data Source: EHR Milestone 4 Estimated Incentive Payment: $1,102, 201 **Milestone 5** [P-X]: Evaluate and continuously improve services <u>Metric 1</u>: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,102, 201		• Data Source: EHR Milestone 7 Estimated Incentive Payment: $1,246,052.67 **Milestone 8** [P-X]: Evaluate and continuously improve services <u>Metric 1</u>: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,246,052.67	• Data Source: EHR Milestone 10 Estimated Incentive Payment: $1,733,982.33 **Milestone 11** [P-X]: Evaluate and continuously improve services <u>Metric 1</u>: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 11 Estimated Incentive Payment *(maximum amount):* $1,733,982.34
Year 2 Estimated Milestone Bundle Amount: $114,103	Year 3 Estimated Milestone Bundle Amount: $3,306,603		Year 4 Estimated Milestone Bundle Amount: $3,738,158	Year 5 Estimated Milestone Bundle Amount: $5,201,947
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $12,360,811				

- ***Tropical Texas Behavioral Health***
- ***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.)***
- ***138708601.2.5 (Pass 2)***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will increase access to peer-provided behavioral health services through the addition of 1 veteran peer provider, 3 MH peer providers, 2 family partners and 1 program supervisor at three TTBH clinics serving communities throughout the Rio Grande Valley, and increase the percentage of individuals receiving peer provided services who also demonstrate improved functioning.
Need for the project: A brief description of the need for the project including data as appropriate.	Budgetary issues, limited access to mental health services and shortages of mental health professionals throughout Texas have prompted a number of initiatives to transform the healthcare delivery system. Among these are the utilization of peer-provided treatment and peer-led services. Peer providers offer an effective adjunct to traditional treatment through sharing of the lived experience of recovery from mental illness.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is the behavioral health population served by TTBH. In FY 2011 we served over 23,000 unduplicated individuals. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the volume of peer provider encounters by 10% over baseline to 860 in DY3, by 25% over baseline to 975 in DY4 and by 50% over baseline to 1,170 total encounters by DY5, and increase the percentage of individuals receiving peer-provided services who demonstrate improved functional status on a standardized instrument to 15% of persons served in DY3, 20% in DY4 and 25% in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:

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.)

Unique RHP Project Identification Number: 138708601.2.5

Performing Provider/TPI: Tropical Texas Behavioral Health/138708601

Project Option 2.13.2 Will increase access to peer-provided behavioral health services through the addition of 1 veteran peer provider, 3 MH peer providers, 2 family partners and 1 program supervisor at each of TTBH's clinic locations and increase the percentage of individuals receiving peer provided services who demonstrate improved functioning.

Project Description:

Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. TTBH will add 6 trained peer providers (3 adult mental health peer providers, 2 family partners and 1 veteran peer provider) and 1 program supervisor at each of our three main clinic locations, and increase the volume of peer provider encounters by 50% over baseline to 1,170 total encounters in Waiver DY5. By expanding the delivery of peer-led services, including services to families and military veterans, TTBH will implement this innovative and evidence-based treatment modality for an increasing number of individuals and families in the Valley than was previously possible. This will result in increased utilization of early intervention, preventative and routine behavioral health services, improved health outcomes and experience of care for persons served and peer providers, and a decrease in the utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are

routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Increase access to peer-provided behavioral health services through the addition of 1 veteran peer provider, 3 adult mental health peer providers, 2 family partners for youth and family mental health services and 1 program supervisor at each of three TTBH clinic locations.
- Increase the volume of peer provider service encounters to 1,170 total encounters in Waiver DY5.
- Increase utilization of early intervention, preventative and routine behavioral health services.
- Improve health outcomes for persons served and peer providers.
- Improve the experience of care for persons served.
- Decrease utilization of more expensive emergency interventions.

This meets the following regional goals:

- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.
- Increase access to primary and specialty care services, including behavioral health services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

Challenges and How Addressed:

Challenges:

- Appropriate space and equipment for expansion of peer-led behavioral health services.
- Recruitment and retention of behavioral health peer providers.

Addressed by:

- Continued progress on planned expansion of three outpatient clinics to increase service capacity for all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Opportunities for tuition reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5 Year Expected Outcome for Provider and Patients:

TTBH will expand behavioral health service capacity to enhance access to the right care at the right time in the right setting and improve behavioral health outcomes and the experience of care for those served. By waiver DY5, TTBH will expand capacity at three of our clinics for the delivery of peer-led behavioral health services, and expects to increase the increase the volume of peer provider encounters by 50% over baseline to 1,170 total encounters in Waiver DY5 and the percentage of individuals receiving peer provided services who demonstrate improved functional status on a standardized instrument (e.g. ANSA, CANS, etc.) to 25% of persons served by the programs. This will result in increased utilization of preventative and routine behavioral health services, improved health outcomes for persons served and those delivering services, an improved experience of care for persons served and decreased utilization of emergency behavioral health interventions.

Starting Point/Baseline:

In FY 2011 TTBH delivered 780 peer provider service encounters.

Rationale:

Budget shortfalls, limited access to mental health services, the shortage of mental health professionals throughout Texas and the recent shift in the state's approach to mental health care from the traditional medical model to recovery oriented services have led to a number of statewide

initiatives to transform the healthcare delivery system. Among these are the utilization of peer-provided treatment and peer-led services. While the medical model of treatment is expensive, focused primarily on symptom management, constrained by the shortage of available healthcare professionals and typically involves a treatment relationship in which patients adopt a passive role relative to the treating provider, peer providers offer an effective adjunct to traditional treatment that utilizes an informal, non-hierarchical treatment relationship to promote recovery and which has the potential to reduce the cost of providing care.

According to a national consensus statement, "mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." Peer providers have the unique ability to facilitate and support behavioral health recovery through the sharing of their lived experiences of having recovered from mental illness themselves. Evidence suggests that in some instances the information conveyed through the real-life experiences of peers, communicated in familiar, non-clinical language can have a greater impact on a person's belief in their ability to achieve recovery than information they receive from a health care professional. Further, peer-provided services result in a more participatory and fulfilling experience of care for both the patient and the provider. Peer-led services promote the recovery of the person served through affiliation with someone with similar life experiences while at the same time furthering the recovery of the peer provider, who is empowered by the experience of helping another.

In 1999, the U.S. Surgeon General's report on mental health cited research demonstrating the range of benefits to consumers of mental health services resulting from peer supported services, self-help groups and peer-operated mental health programs (such as drop-in centers) including the meaningful work gained by consumer staff serving as role models for other clients, enhanced sensitivity of the service system to the needs of people with mental disorders and improved health outcomes reported by those served including symptom reduction, greater self-confidence and self-esteem, improved coping skills and community integration and fewer hospitalizations. According to Chinman et al (2006), peer supports directly address many of the patient and treatment system factors that contribute to poor outcomes for people with severe mental illness: social isolation by enhancing social networks; disconnection from outpatient treatment through empathic engagement; demoralization through the hope provided by the role modeling of coping skills; overburdened providers through the supplementation of existing treatment; fragmentation of services through systems navigation supports; and lack of emphasis on recovery through advocacy for community integration over symptom management. They, and others, point to several studies that have shown the inclusion of "consumer as provider" services as an adjunct to traditional outpatient mental health treatment modalities is associated with positive outcomes including gains in quality of life, improved

social functioning, reduced substance use, higher rates of employment and fewer hospitalizations compared to treatment services that did not include a peer support component.

Project Components:

Project option 2.13.2 does not have additional core components.

Milestones and Metrics:

The following milestones and metrics were chosen for the TTBH peer provided behavioral health services project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-2 (P-2.1); P-4 (P-4.1)
- Improvement Milestones and Metrics: I-X (I-X.1); I-5 (I-5.1)

Unique Community Needs Identification Number:

This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health care.

How the Project represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:

By increasing the availability of peer provided behavioral health services at our clinics across the Lower Rio Grande Valley, this project will expand on the accomplishments of our existing peer-led service programs, which include peer providers for adults, family partners for the families of children served and peer supports for military veterans. By maximizing the availability of this promising practice, we will better ensure the region's health care delivery system is adequately developed to address the routine behavioral health care needs of our rapidly growing, yet historically underserved service area and reduce the unnecessary use of more costly emergency psychiatric interventions.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:

TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications.

Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to Other Projects:

The expansion of peer provider services is linked to the overall expansion of TTBH's behavioral health service capacity (Project 138708601.1.1). Peer-led services may result in increased identification of medical issues appropriate for treatment through the Center's planned development of primary care and care management services (Projects 138708601.2.1 and 138708601.2.5), and/or co-occurring substance use issues requiring intervention through the planned expansion of COPSD services (Project 138708601.1.3). Some of the adult mental health and veteran peer providers associated with this expansion of our outpatient peer support services will be encouraged to take on key roles in the development and operation of our planned peer-run drop-in centers (Project 138708601.2.6).

Relationship to Other Performing Providers' Projects in the RHP:

TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, and the Rio Grande Valley Council, the local substance abuse Outreach, Screening, Assessment and Referral (OSAR) services provider, to develop and participate in a learning collaborative related to our respective projects to behavioral health peer provider services.

Plan for Learning Collaborative:

TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. We will make our website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to research by the University of Texas Austin Center for Social Work, the monetary value per life-year gained due to the interventions is $50,000.
- Overall Project Valuation: The total valuation for peer providers is $7,239,960.

Project ***138708601.2.5***	***Project Option*** ***2.13.2***	***Project Component(s)*** ***N/A***	***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.).***
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.9*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Design community-based specialized interventions for targeted populations. Metric 1 [P-2.1]: Project plans which are based on evidence /experience and which address the goals. • Baseline/Goal: Baseline N/A. Goal is to develop a plan to expand service capacity at all TTBH clinic locations for the delivery of peer provider services including building construction and renovation, purchase of necessary equipment and recruitment, hiring and training of staff. • Data Source: Project documentation including work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $458,861 **Milestone 2** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles	**Milestone 3** [I-X]: Increase volume of service encounters by peer providers. Metric 1 [I-X.1]: Documentation of increased number of service encounters by peer provider staff. • Baseline/Goal: Baseline is 780. Goal is for peer provider staff to increase service contacts by 10% over baseline to at least 860 contacts. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $333,446.33 **Milestone 4** [I-5]: Functional status. Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) • Baseline/Goal: Baseline N/A. Goal is 15% of individuals receiving peer provided services will demonstrate improved functional status on standardized instrument (e.g. ANSA, CANS, etc.). • Data Source: Selected	**Milestone 6** [I-X]: Increase volume of service encounters by peer providers. Metric 1 [I-X.1]: Documentation of increased number of service encounters by peer provider staff. • Baseline/Goal: Baseline is 780. Goal is for peer provider staff to increase service contacts by 25% over baseline to at least 975 contacts. • Data Source: Encounter data Milestone 6 Estimated Incentive Payment: $611,564.66 **Milestone 7** [I-5]: Functional status. Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) • Goal: Goal is 20% of individuals receiving peer provided services will demonstrate improved functional status on standardized instrument (e.g. ANSA, CANS, etc.).	**Milestone 9** [I-X]: Increase volume of service encounters by peer providers. Metric 1 [I-X.1]: Documentation of increased number of service encounters by peer provider staff. • Baseline/Goal: Baseline is 780. Goal is for peer provider staff to increase service contacts by 50% over baseline to at least 1,170 contacts. • Data Source: Encounter data Milestone 9 Estimated Incentive Payment: $1,162,401.66 **Milestone 10** [I-5]: Functional status. Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) • Goal: Goal is 25% of individuals receiving peer provided services will demonstrate improved functional status on standardized instrument (e.g. ANSA, CANS, etc.).

Project	***Project Option***	***Project Component(s)***	***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.).***
138708601.2.5	***2.13.2***	***N/A***	
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.9*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
• Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $458,861	standardized functional assessment instrument. Milestone 4 Estimated Incentive Payment: $333,446.33 **Milestone 5** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 5 Estimated Incentive Payment *(maximum amount):* $333,446.34	• Data Source: Selected standardized functional assessment instrument. Milestone 7 Estimated Incentive Payment: $611,564.67 **Milestone 8** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $611,564.67	• Data Source: Selected standardized functional assessment instrument. Milestone 10 Estimated Incentive Payment: $1,162,401.67 **Milestone 11** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 11 Estimated Incentive Payment *(maximum amount):* $1,162,401.67
Year 2 Estimated Milestone Bundle Amount: $917,722	Year 3 Estimated Milestone Bundle Amount: $1,000,339	Year 4 Estimated Milestone Bundle Amount: $1,834,694	Year 5 Estimated Milestone Bundle Amount: $3,487,205
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $7,239,960			

- ***Tropical Texas Behavioral Health***
- ***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.)***
- ***138708601.2.6 (Pass 2)***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will establish Peer-Run Drop-In Centers at three TTBH clinics serving communities throughout the Rio Grande Valley, and increase the percentage of individuals receiving services at peer-run drop-in centers who demonstrate improved functioning.
Need for the project: A brief description of the need for the project including data as appropriate.	Budgetary issues, limited access to mental health services and shortages of mental health professionals throughout Texas have prompted a number of initiatives to transform the healthcare delivery system. Among these are the utilization of peer-provided treatment and peer-led services. Peer providers offer an effective adjunct to traditional treatment through sharing of the lived experience of recovery from mental illness.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is the behavioral health population served by TTBH. In FY 2011 we served over 23,000 unduplicated individuals. Approximately 74% of persons served are either Medicaid eligible or indigent, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the number of unduplicated individuals served at peer-run drop-in centers from 50 in DY3, to 125 in DY4 and to 200 by DY5, and increase the percentage of individuals receiving services at peer-run drop-in centers who demonstrate improved functional status on a standardized instrument to 15% of persons served in DY3, 20% in DY4 and 25% in DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-6.1(5) Percent improvement over baseline of patient satisfaction scores. Our goal is to demonstrate improvement in the overall health status/functional status of persons served through improvement over baseline in patient satisfaction scores. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:

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.)

Unique RHP Project Identification Number: 138708601.2.6

Performing Provider/TPI: Tropical Texas Behavioral Health/138708601

Project Option 2.13.2 Will establish Peer-Run Drop-In Centers at TTBH's main clinic locations and increase the percentage of individuals receiving services at the drop-in centers who demonstrate improved functioning.

Project Description:

Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. TTBH will develop a plan to establish a peer-run drop-in center at three of our clinics, and to increase the volume of individuals served annually through the drop-in centers to 200 people served by waiver DY5. Through the drop-in centers, TTBH will support the creation of settings in which people with mental illness pursue their own recovery, and foster recovery in others, through their development of and participation in support services that they choose and operate. The drop-in centers will offer an array of programs including support groups, advocacy training and activities for rehabilitation and socialization in an environment that promotes empowerment and recovery by encouraging the persons served to plan and operate the center's programs, and through the supportive peer relationships formed in the process. Participants in the drop-in centers will benefit from the services, activities and information available to them, including self-help groups, assistance with basic needs, social gatherings, education, advocacy, links to community services, employment information and guest speakers or workshops. Utilization of the early intervention, preventative and recovery-oriented services available through peer-run drop-in centers will result in improved health outcomes for persons served and peer providers, and a decrease in the utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to

service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Goal(s) and Relationship to Regional Goal(s):

Project goals:

- Establish peer-run drop-in centers at three of our clinics across the Rio Grande Valley.
- Support the efforts of individuals served to develop programs, activities and services of their choosing that promote their recovery by facilitating recovery in others.
- Increase the volume of individuals served annually through the drop-in centers to 200 unduplicated people served by waiver DY5.
- Increase the percentage of individuals receiving services at peer-run drop-in centers who demonstrate improved functional status on a standardized instrument to 15% of persons served in DY3, 20% in DY4 and 25% in DY5.
- Increase access to and utilization of preventative and recovery-oriented behavioral health services.
- Improve health outcomes for persons served and peer providers.
- Decrease utilization of emergency interventions.

This meets the following regional goals:

- Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.
- Increase access to primary and specialty care services, including behavioral health services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.

- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

Challenges and How Addressed:

Challenges:

- Appropriate space and equipment for peer-led behavioral health services including peer-run drop in centers.
- Recruitment and retention of behavioral health peer providers.

Addressed by:

- Continued progress on planned expansion of three outpatient clinics to increase service capacity for all counties in the TTBH catchment area.
- Competitive hiring and salary structure based on years of experience.
- Structured career ladder advancement opportunities for each position.
- Productivity incentive opportunities.
- Opportunities for tuition reimbursement.
- Opportunities for training and education to enhance staff competencies and promote professional development.

5 Year Expected Outcome for Provider and Patients:

Through the creation of peer-run drop-in centers serving the three counties in our catchment area, we will expand behavioral health service capacity, enhance access to the right care at the right time in the right setting and improve behavioral health outcomes and the experience of care for those served. By waiver DY5, TTBH will implement the drop-in centers at our 3 largest clinics and expects to increase the number of unduplicated individuals served at peer-run drop-in centers from at least 50 in DY3, to 125 in DY4 and to 200 by DY5, and increase the percentage of individuals receiving peer provided services who demonstrate improved functional status on a standardized instrument (e.g. ANSA) to 25% of persons served by the programs. This will result in increased utilization of preventative and routine behavioral health services, improved health outcomes for persons served

and those operating the centers, improved experience of care for persons served and decreased utilization of emergency behavioral health interventions.

Starting Point/Baseline:

Baseline is zero. Peer-run drop-In centers will be a new component of the TTBH service array.

Rationale:

Budget shortfalls, limited access to mental services and the shortage of mental health professionals across Texas, and a recent shift in the state's approach to mental health care from the traditional medical model to a recovery orientation, have led to a number of statewide initiatives to transform the healthcare delivery system. Among these is the utilization of peer-provided and peer-led services. While the medical model of treatment is expensive, focused primarily on symptom management, constrained by the shortage of available healthcare professionals and typically involves a treatment relationship in which patients adopt a passive role, peer providers offer an exceptionally effective adjunct to traditional treatment in an informal, non-hierarchical treatment relationship that promotes recovery and can reduce the overall costs of care.

According to a national consensus statement, “mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.” Peer providers have the unique ability to facilitate and support recovery in people with mental illness through the sharing of their lived experience of having recovered from mental illness themselves. Evidence suggests that in some instances the information conveyed through the real-life experiences of peers, communicated in familiar, non-clinical language can have a greater impact on a person’s belief in their ability to achieve recovery than information they receive from a health care professional. Further, peer-provided services result in a more participatory and fulfilling experience of care for both the individual and the provider. Peer-led services promote the recovery of the person served through affiliation with another person with similar life experiences, while furthering the recovery of the peer provider, who is empowered by the experience of helping another.

In 1999, the U.S. Surgeon General’s report on mental health cited research demonstrating the range of benefits to consumers of mental health services resulting from peer supported services, self-help groups and peer-operated mental health programs (such as drop-in centers) including the meaningful work gained by consumer staff serving as role models for other clients, enhanced sensitivity of the service system to the needs of people with mental disorders and improved health outcomes reported

by those served including symptom reduction, greater self-confidence and self-esteem, improved coping skills and community integration and fewer hospitalizations. According to Chinman et al (2006), peer supports directly address many of the patient and treatment system factors that contribute to poor outcomes for people with severe mental illness: social isolation by enhancing social networks; disconnection from outpatient treatment through empathic engagement; demoralization through the hope provided by the role modeling of coping skills; overburdened providers through the supplementation of existing treatment; fragmentation of services through systems navigation supports; and lack of emphasis on recovery through advocacy for community integration over symptom management. They, and others, point to several studies that have shown the inclusion of "consumer as provider" services as an adjunct to traditional outpatient mental health treatment modalities is associated with positive outcomes including gains in quality of life, improved social functioning, reduced substance use, higher rates of employment and fewer hospitalizations compared to treatment services that did not include a peer support component.

Project Components:

Project option 2.13.2 does not have additional core components.

Milestones and Metrics:

The following milestones and metrics were chosen for the TTBH peer run drop-in center project based on the project option and the needs of the target population:

- Process Milestones and Metrics: P-2 (P-2.1); P-4 (P-4.1)
- Improvement Milestones and Metrics: I-X (I-X.1); I-5 (I-5.1)

Unique Community Needs Identification Number:

This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health care.

How the Project represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:

The project to create peer-run drop-in centers is a new initiative for TTBH. Currently, peer-led services are provided in TTBH's limited available office space or in community locations including the homes of persons served or space provided on a temporary basis by collaborating agencies. Current

capacity does not allow for the expanded scope and continuity of peer-led services envisioned through this project.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

IT-6.1(5) Percent improvement over baseline of patient satisfaction scores (patient's overall health status/functional status).

Reasons/rationale for selecting the outcome measures:

TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications.

Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:

The development of peer-run drop-in centers is linked to the overall expansion of TTBH's behavioral health service capacity (Project 138708601.1.1). Identification of worsening behavioral health symptoms or co-occurring illness as a result of interactions between peer providers and persons served at the drop-in centers may result in referrals to the TTBH's planned co-located primary care and chronic care management services (Projects 138708601.2.1 and 138708601.2.4), and/or expanded COPSD services (Project 138708601.1.3). As some adult mental health and veteran peer

providers will play key roles in the development and operation of the drop-in centers, our expansion of peer provider services and staff (Project 138708601.2.5) is linked to the success of this project.

Relationship to Other Performing Providers' Projects in the RHP:

TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, and the Rio Grande Valley Council, the local substance abuse Outreach, Screening, Assessment and Referral (OSAR) services provider, to develop and participate in a learning collaborative related to our respective projects to behavioral health peer provider services.

Plan for Learning Collaborative:

TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. We will make our website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY5 is calculated to be $3,258,000.
- Overall Project Valuation: The total project valuation is $6,337,501.

Project ***138708601.2.6***	***Project Option*** ***2.13.2***	***Project Component(s)*** ***N/A***	***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.)***
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.10*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Design community-based specialized interventions for targeted populations. Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals. • Baseline/Goal: Baseline N/A. Goal is to develop a plan to establish peer-run drop-in centers at TTBH's 3 main clinic locations, including building construction and renovation, purchase of necessary equipment, development of necessary policies and procedures, and recruitment, hiring and training of peer provider staff. • Data Source: Documentation of work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $275,150.50 **Milestone 2** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act	**Milestone 3** [I-X]: Increase the number of persons receiving services at peer-run drop-in centers. Metric 1 [I-X.1]: Documentation of increased number of unduplicated persons served at peer-run drop-in centers. • Baseline/Goal: Baseline is zero. Goal is to serve at least 50 unduplicated individuals at peer-run drop-in centers in DY3. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $354,828.33 **Milestone 4** [I-5]: Functional status. Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA). • Baseline/Goal: Baseline N/A. Goal is 15% of individuals receiving services at peer-run drop-in centers will demonstrate improved functional status on standardized instrument (e.g.	**Milestone 6** [I-X]: Increase the number of persons receiving services at peer-run drop-in centers. Metric 1 [I-X.1]: Documentation of increased number of unduplicated persons served at peer-run drop-in centers. • Baseline/Goal: Goal is to serve at least 125 unduplicated individuals at peer-run drop-in centers in DY4. • Data Source: Encounter data Milestone 6 Estimated Incentive Payment: $642,988.33 **Milestone 7** [I-5]: Functional status. Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA). • Goal: Increase percentage of individuals receiving services at peer-run drop-in centers will demonstrate improved functional status on standardized instrument to 20%.	**Milestone 9** [I-X]: Increase the number of persons receiving services at peer-run drop-in centers. Metric 1 [I-X.1]: Documentation of increased number of unduplicated persons served at peer-run drop-in centers. • Baseline/Goal: Goal is to serve at least 200 unduplicated individuals at peer-run drop-in centers in DY5. • Data Source: Encounter data Milestone 9 Estimated Incentive Payment: $931,250 **Milestone 10** [I-5]: Functional status. Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA). • Goal: Increase percentage of individuals receiving services at peer-run drop-in centers will demonstrate improved functional status on standardized instrument

Project ***138708601.2.6***	***Project Option*** ***2.13.2***	***Project Component(s)*** ***N/A***	***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.)***
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.10*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $275,150.50	ANSA). • Data Source: Selected standardized functional assessment instrument. Milestone 4 Estimated Incentive Payment: $354,828.33 **Milestone 5** [P-4]: Evaluate and continuously improve interventions <u>Metric 1</u>: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 5 Estimated Incentive Payment *(maximum amount):* $354,828.34	• Data Source: Selected standardized functional assessment instrument. Milestone 7 Estimated Incentive Payment: $642,988.33 **Milestone 8** [P-4]: Evaluate and continuously improve interventions <u>Metric 1</u>: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $642,988.34	to 25%. • Data Source: Selected standardized functional assessment instrument. Milestone 10 Estimated Incentive Payment: $931,250 **Milestone 11** [P-4]: Evaluate and continuously improve interventions <u>Metric 1</u>: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 11 Estimated Incentive Payment *(maximum amount):* $931,250
Year 2 Estimated Milestone Bundle Amount: $550,301	Year 3 Estimated Milestone Bundle Amount: $1,064,485	Year 4 Estimated Milestone Bundle Amount: $1,928,965	Year 5 Estimated Milestone Bundle Amount: $2,793,750
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $6,337,501			

- ***Tropical Texas Behavioral Health***
- ***Establish/Expand a Patient Care Navigation Program***
- ***138708601.2.7 (Pass 2)***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will provide community-based mental health care navigation services to uninsured children with special health care needs and their families enrolled in the Cameron County Department of Health and Human Services (CCDHHS) Children with Special Health Care Needs Case Management (CSHCN-CM) Program. The program will improve access to integrated primary and mental health care, minimize the impact of mental health problems and reduce the need for more costly interventions for children (the target).
Need for the project: A brief description of the need for the project including data as appropriate.	In addition to elevated levels of medical care, children with special health care needs often have more emotional, behavioral or developmental problems requiring mental health care or educational services than other same age peers. Currently, the CCDHHS CSHCN-CM Program does not provide mental health care services, necessitating referrals to address this need.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is the primary care population served by the CCDHHS CSHCN-CM Program. In FY 12, the program served 161 clients and families from Cameron and Willacy counties. 100% of children/families served by the CCDHHS CSHCN Program are uninsured, so we expect they will benefit significantly from these services.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase the number of unduplicated targeted patients enrolled in the Mental Health Navigation Program from 30 in DY2, to 90 additional unique patients served in each of DYs 3, 4 and 5, for a total of 300 unique patients served by DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-10.7 Children with Special Health Care Needs mental health risk rate Our goal is to increase the number of children and families in the CCDHHS CSHCN-CM Program evaluated for risk of mental health conditions annually over the waiver term, while also demonstrating a decrease in the percentage of children and families served who are identified at high risk for emotional and behavioral

	problems- targets will be determined in DY2 for DY3

Identifying Project and Provider Information:

2.9 Establish/Expand a Patient Care Navigation Program

Unique RHP Project Identification number: 138708601.2.7

Performing Provider Name/TPI: Tropical Texas Behavioral Health/138708601

Project Option 2.9.1 Will establish community-based mental health care navigation services for uninsured children with special health care needs and their families enrolled in the Cameron County Department of Health and Human Services Children with Special Health Care Needs Case Management Program.

Project Description:

This project will establish and provide family-centered, culturally sensitive and community-based mental health care navigation services to uninsured children with special health care needs and their families enrolled in the Cameron County Department of Health and Human Services (CCDHHS) Children with Special Health Care Needs Case Management Program (CSHCN-CM) through a Mental Health Care Navigation Program. The mental health care navigation program for uninsured children with special health care needs and their families will provide for a collaborative team of mental health care navigators including two (2) Licensed Professional Counselors and four (4) Social Workers who will be responsible for navigating uninsured children with special health care needs and their families through the mental health care navigation program at four (4) CCDHHS clinic sites in Cameron County, and one (1) in Willacy County. This project is an innovation as mental health care navigation services have not previously been available to this population. The Mental Health Care Navigation program will include assessing the special needs child and their family for mental health care needs and making appropriate referrals to the Licensed Professional Counselor. The Licensed Professional Counselor will provide mental health care counseling by office visit or home visit so that clients will have enhanced access to services, allowing them to receive the right care at the right time in the right setting. The Mental Health Care Navigation Program will improve mental health care outcomes and the experience of care for those served. By Waiver Demonstration Year (DY) 5, the project will expand mental health care service capacity at clinic locations in Cameron and Willacy counties and provide services to 300 unduplicated, unique individuals. Over the term of the waiver, the project will significantly reduce the number of people waiting to access comprehensive and culturally sensitive mental health care services, resulting in increased utilization of routine mental health care navigation services, improved health outcomes and experience of care, and decreased need for more costly emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments. Each navigator will be responsible to maintain a caseload of 15 unduplicated, unique clients per year. During DY2 each navigator will recruit their initial 5 clients and recruit 15 unique clients each consecutive year for three years (DY3-DY5); thus, maintaining a

caseload of 15 unique clients per navigator during DY3-DY5. It is expected that by the end of each DY the care team will have provided services to 90 unduplicated, unique clients except for DY2 in which only 30 unique clients will be serviced. By the end of DY5, the care team will have provided services to 300 unduplicated, unique clients.

All services funded by this waiver will be monitored through Tropical Texas Behavioral Health's (TTBH) Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary.

Goal(s) and Relationship to Regional Goal(s):

The goal of this project is to provide mental health care navigation services to uninsured children with special health care needs and their families by having a mental health care navigator access and navigate clients to a Licensed Professional Counselor for services. Mental health care navigation services will be accessed by client(s) through an office visit or home visit.

Project Goals:

- Establish a mental health care navigation program for CCDHHS CSHCN-CM uninsured children with special healthcare needs and their families.
- Develop procedures, training program and continuing education for care navigators.
- Increase mental health care navigation services to 90 unduplicated persons served per year.
- Increase number of Primary Care Physician (PCP) referrals for patients without a medical home, who use the ED, urgent care, and/or hospital services.
- Improve coordination of mental health care navigation program, health outcomes and wellness.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

Challenges and How Addressed:

Challenges:

The primary challenges for this project will be to gain patient trust and address transportation barriers to service access.

Addressed by:

This project will be offered for the first time to our uninsured children with special health care needs and their families. With the proper care navigator training and effective procedures this project will be successful; specifically through cultural competency training and the flexibility of the care team making home visits in order to break down transportation barriers. The home visit will also assist the care team in addressing the full spectrum of the participants' needs.

5-Year Expected Outcome for Provider and Patients:

The CCDHHS Mental Health Navigation Program expects to improve the well-being of participants by providing a healthcare system level intervention that uses mental health care navigators to link primary care providers, patients, and mental health specialists. Early interventions such as navigation programs have been shown to minimize the impact of mental health problems in children and significantly reduce the need for more costly interventions. Studies have shown that early identification of mental health needs in children, particularly CSHCN, is critical to obtaining mental health services and families play a crucial role in obtaining and coordinating care for CSHCN, including mental health screening, diagnosis, and treatment. The program will increase the number of unduplicated targeted patients enrolled in the Mental Health Navigation Program to 300 by DY5.

Starting Point/Baseline:

Currently, a mental health care navigation program does not exist for uninsured children with special health care needs and their families enrolled in the CCDHHS CSHCN-CM Program. Therefore, the baseline for number of participants as well as the navigators begins at zero in DY2.

Rationale:

Mental health care navigators assist children and their families to navigate through the fragmented system of support organizations and other components of mental health care services. Services provided by the mental health care navigators will include:

- Facilitating follow-up appointments;
- Coordinating care among providers; and
- Community outreach and building partnership with local agencies and groups.

The mental health care navigator will build rapport with the uninsured children and their families enrolled in the CCDHHS CSHCN-CM Program. Mental health navigators have close ties with the local community and serve as important links between the underserved communities and the health care system. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities. Mental health care navigators will be:

- Compassionate, sensitive, and culturally attuned to the people and community
- Knowledgeable about the environment and mental health care system
- Connected with critical decision makers inside the system

A project to develop a mental health care navigation team specifically for uninsured children with special health care needs is needed in Cameron and Willacy counties. According to the National Survey of Children with Special Health Care Needs Chart Book 2005-2006, 38.5% of children with special needs required elevated service use and were in need of more medical care, mental health care services or education services than other children of the same age. 28.4% of children with special health care needs were reported to have emotional/behavioral/developmental problems requiring treatment or counseling.

In fiscal year 2012, the CCDHHS CSHCN-CM program provided services to 161 clients and their families residing in Cameron and Willacy counties. Currently, the CSHCN-CM Program does not provide mental health care services. Therefore, approximately 60 clients were referred for mental health care service assistance. Although some clients received services from faith-based

organizations, CSHCN-CM Case Managers report that a number of barriers made it difficult for clients to receive the much needed services.

Project Components:

Through the Mental Health Care Navigation program, we propose to meet all required project components:

a) *Identify frequent ED users and use navigators a part of a preventable ED reduction program. Train health care navigators in cultural competency.* Uninsured children with special health care needs and their families using the emergency department for primary care services, children/family members without a designated PCP or medical home and children with social or economic barriers to accessing primary care will be offered navigation services. Mental health care navigators will create social services notes in the client file which will be part of the client's CSHCN case management record. These notes will include reason for services, assessment, subsequent referrals and follow-up actions. All navigators will undergo training in providing culturally competent care and receive education regarding health care disparities and social determinates of health, community outreach and chronic disease management.
b) *Deploy innovative health care personnel, such as case managers/social workers, Professional mental health counselors as patient navigators.* The program will hire mental health care navigators with a background in community health and social services. Navigators will access and provide mental health services to the uninsured children with special health care needs enrolled in the CCDHHS CSHCN-CM Program.
c) *Connect patients to primary and preventive care.* Navigators will have regular contact with the client's CSHCN Case Manager who has direct contact with area primary care providers for care management services, preventive care, and other educational and social services. Navigators will provide a list of providers for client's to choose from. Navigators will be available to meet with providers to answer any specific questions.
d) *Increase access to care management and/or chronic care management, including education in chronic disease self-management.* Navigators will have regular contact with the client's CSHCN Case Manager who has direct contact with area primary care providers for care management services, preventive care, and other educational and social services. Navigators will provide a list of providers for client's to choose from. Navigators will be available to meet with providers to answer any specific questions.
e) *Conduct quality improvement for project using methods such as rapid cycle improvement.* This will be accomplished through TTBH's existing Quality Management/Utilization Management structures as described in the project description, through participation in a learning collaborative with the University of Texas Health Science Center at San Antonio (UTHSCSA)

and other regional partners as appropriate and through the activities of the Community Mental Health Center consortia sponsored by the Texas Council of Community Centers.

Milestones and Metrics:
The following milestones and metrics were chosen for the project to Establish/Expand a Patient Care Navigation Program based on the project option and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-5 (P-5.1); P-8 (P-8.1)
Improvement Milestones and Metrics: I-6 (I-6.5)

Unique Community Needs Identification Numbers the project addresses:

This project addresses community need CN.3, inadequate integration of care for individual with co-occurring medical and mental illness or multiple chronic conditions.

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

Currently, a mental health care navigation program does not exist for uninsured children with special health care needs and families enrolled in the CCDHHS CSHCN-CM program. The CCDHHS CSHCN-CM program offers case management services, but as the clients are uninsured children with special medical needs from low income families, this initiative will give the clients access to much needed mental health care services they cannot afford. The mental health care navigation program will facilitate access to, or pay for, transportation to receive these services.

Related Category 3 Outcome Measures:

OD-10 Quality of Life/Functional Status:

IT-10.7 Children with Special Health Care Needs Mental Health Risk Rate.

Reasons/rationale for selecting the outcome measures:

Mental health care navigators will assist uninsured children with special needs and their families to gain access to mental health care services. According to the Healthy People 2020 report, the greatest opportunity for prevention is among young people. Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting. Mental health and physical health are closely connected. Mental health plays a major role in a person's ability to maintain good physical health.

Mental illnesses, such as depression and anxiety, affect the ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. This speaks to significant opportunities to promote wellness through the introduction of mental health care navigators to help patients to successfully negotiate the mental health care system and access services.

Relationship to other Projects:

This project's addresses the integration of care through an emphasis on mental health care navigation for medically fragile children and their families. The implementation of innovative mental health care navigation services is linked to the overall expansion of behavioral healthcare capacity (Project 138708601.1.1). Services delivered through the project may result in referrals involving the delivery of mental health services to children with co-occurring Intellectual and Developmental Disabilities (Project 138708601.1.4). Care navigation will also facilitate referrals to address ongoing medical concerns, supporting TTBH's efforts to improve the integration of primary and behavioral health care (Project 138708601.2.1) and the self-management of co-morbid chronic illnesses (Project 138708601.2.4).

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

TTBH will coordinate with UTHSCSA and other regional partners to develop and participate in a learning collaborative to evaluate our respective delivery system reform initiatives to establish patient care navigation services in RHP 5.

Plan for Learning Collaborative:

TTBH will host bi-weekly conference calls with UTHSCSA and other regional partners engaged in similar delivery system reform projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will also request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to research by the University of Texas Austin Center for Social Work, the monetary value per life-year gained is $50,000.

Overall project valuation: The total project valuation is $5,070,000.

Project	***Project Option***	***Project Component(s)***	***Establish/Expand a Patient Navigation Program***
138708601.2.7	***2.9.1***	***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.11*	*3.IT-10.7*	*Children with Special Health Care Needs Mental Health Risk Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**

Milestone 1 [P-1]: Conduct a needs assessment to identify the current status and needs of the patient population to be targeted with the Patient Navigation Program.
Metric 1 [P-1.1]: Provide report identifying the following:
• Targeted patient population characteristics.
• Gaps in services and service needs.
• How program will identify, triage and manage target population.
• Available site, state, county, and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients.
  • Baseline/Goal: Baseline is zero. Goal is to produce a comprehensive report documenting all points above.
  • Data Source: Site gap analysis; Program documentation; EHR; State and county data sources.
	Milestone 4 [P-3]**:** Provide care management/navigation services to targeted patients.
	Metric 1 [P-3.1]: Increase targeted patients enrolled in the mental health care program.
	• Base line: 30 patients
	• Goal: Enroll 15 unique clients per navigator while maintaining a 15 patient caseload per navigator.
	• Data Source: Enrollment reports.
	
	Milestone 4 Estimated Incentive Payment *(maximum amount):* $507,000
	
	Milestone 5 [P-5]: Provide reports on the types of navigation services provided to patients, using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.
	Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.
	• Baseline is 0. Currently navigation services are not
		Milestone 7 [P-3]: Provide care management/navigation services to targeted patients.
		Metric 1 [P-3.1]: Increase targeted patients enrolled in the mental health care program.
		• Goal: Enroll 15 unique clients per navigator while maintaining a 15 patient caseload per navigator.
		• Data Source: Enrollment reports.
		
		Milestone 7 Estimated Incentive Payment *(maximum amount):* $380,250
		
		Milestone 8 [P-5]: Provide reports on the types of navigation services provided to patients, using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.
		Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.
		• Goal: Provide mental health care navigation services to children with special health
			Milestone 11 [P-3]: Provide care management/navigation services to targeted patients.
			Metric 1 [P-3.1]: Increase targeted patients enrolled in the mental health care program.
			• Goal: Enroll 15 unique clients per navigator while maintaining a 15 patient caseload per navigator.
			• Data Source: Enrollment reports
			
			Milestone 11 Estimated Incentive Payment *(maximum amount):* $380,250
			
			Milestone 12 [P-5]: Provide reports on the types of navigation services provided to patients, using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.
			Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.
			• Goal: Provide mental health care navigation services to children with special health

Project ***138708601.2.7***	***Project Option*** ***2.9.1***	***Project Component(s)*** ***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	***Establish/Expand a Patient Navigation Program***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.11*	*3.IT-10.7*	*Children with Special Health Care Needs Mental Health Risk 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 Estimated Incentive Payment *(maximum amount):* $169,000 **Milestone 2** [P-2]: Establish a mental health care navigation program to provide services to medically fragile children with special health care needs and their families who are at risk of receiving disconnected and fragmented care including program to train the mental health care navigators, develop procedures, establish continuing navigator education and train the navigators in cultural competency. Metric 1 [P-2.1]: Number of mental health care navigators hired and trained, number of mental health care navigation procedures, number of continuing education sessions for mental health care navigators. • Base line: Mental health care navigators did not exist for children with special health care needs and their families; therefore baseline for all is 0. • Goal: Develop the training program with procedures	provided to children with special health care needs and their families. • Goal: Provide mental health care navigation services to children with special health care needs and their families enrolled in the mental health care program. • Data Source: Reports documenting the types of navigation services provided to individuals enrolled in the mental health program. Milestone 5 Estimated Incentive Payment *(maximum amount):* $507,000 **Milestone 6** [P-8]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face –to- face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Metric 1 [P-8.1]: Participate in semi-		care needs and their families enrolled in the mental health care program. • Data Source: Reports documenting services provided to individuals enrolled in the mental health program. Milestone 8 Estimated Incentive Payment *(maximum amount):* $380,250 **Milestone 9** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.5]: Number /percent of patients with a primary care provider who are given a scheduled primary care provider appointment. • Baseline is 0. Currently navigation services are not provided to children with special health care needs and their families. • Goal: 50% of clients served by navigation program will have PCP appointments facilitated by the care navigators.	care needs and their families enrolled in the mental health care program. • Data Source: Reports documenting services provided to individuals enrolled in the mental health program. Milestone 12 Estimated Incentive Payment *(maximum amount):* $380,250 **Milestone 13** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.5]: Number /percent of patients with a primary care provider who are given a scheduled primary care provider appointment. • Goal: 75% of clients served by navigation program will have PCP appointments facilitated by the care navigators. • Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program

Project ***138708601.2.7***	***Project Option*** ***2.9.1***	***Project Component(s)*** ***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	***Establish/Expand a Patient Navigation Program***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.11*	*3.IT-10.7*	*Children with Special Health Care Needs Mental Health Risk 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)**
and continuing education for mental health care navigators. After developing the training program with procedures and continuing education train and deploy a team of six (6) navigators comprised of two (2) Licensed Professional Counselors and four (4) Social Workers or Case Managers. • Data Source: Documentation of workforce development plan for mental health care navigator recruitment, hiring, training and education including Human Resources documentation. Milestone 2 Estimated Incentive Payment *(maximum amount):* $169,000 **Milestone 3** [P-3]**:** Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase targeted patients enrolled in the mental health care program.	annual face-to-face meetings or seminars organized by the RHP. • Baseline is zero. Goal is to participate in all semi-annual face to face meetings or seminars. • Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, sign-in sheets and/or meeting notes. Milestone 6 Estimated Incentive Payment *(maximum amount):* $507,000		• Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 9 Estimated Incentive Payment *(maximum amount):* $380,250 **Milestone 10** [P-8]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face -to- face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Metric 1 [P: 8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. • Goal: Participate in all semi-annual face to face meetings or seminars. • Data Source: Documentation of semiannual meetings including meeting agendas,	Milestone 13 Estimated Incentive Payment *(maximum amount):* $380,250 **Milestone 14** [P-8]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face –to- face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P- 8.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. • Goal: Participate in all semi-annual face to face meetings or seminars • Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, sign-in sheets, and/or

Project ***138708601.2.7***	***Project Option*** ***2.9.1***	***Project Component(s)*** ***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	***Establish/Expand a Patient Navigation Program***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.11*	*3.IT-10.7*	*Children with Special Health Care Needs Mental Health Risk 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)**
• Base line: 0 patients • Goal: Enroll 5 individuals per care navigator. • Data Source: Enrollment reports. Milestone 3 Estimated Incentive Payment *(maximum amount):* $169,000			slides from presentation, sign-in sheets, and/or meeting notes. Milestone 10 Estimated Incentive Payment *(maximum amount):* $380,250	meeting notes. Milestone 14 Estimated Incentive Payment *(maximum amount):* $380,250
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $507,000	Year 3 Estimated Milestone Bundle Amount: $1,521,000		Year 4 Estimated Milestone Bundle Amount: $1,521,000	Year 5 Estimated Milestone Bundle Amount: $1,521,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $5,070,000				

- ***Tropical Texas Behavioral Health***
- ***Establish/Expand a Patient Care Navigation Program***
- ***138708601.2.8 (Pass 2)***

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	Tropical Texas Behavioral Health (TTBH) is the Local Mental Health Authority (LMHA) serving Cameron, Hidalgo and Willacy counties in South Texas; a 3,100 square mile area with a population of approximately 1.2 million. In FY 2011, TTBH served more than 23,000 unduplicated individuals.
Intervention(s): Clearly state the intervention(s).	This project will provide community-based mental health care navigation services to women enrolled in the Cameron County Department of Health and Human Services (CCDHHS) Maternal and Child Health Program who are identified at high risk for postpartum depression through a Postpartum Depression Intervention Care Navigation (PDICN) program. The project will improve mental health care outcomes and the experience of care for women at risk for postpartum depression, and their families, in Cameron County.
Need for the project: A brief description of the need for the project including data as appropriate.	Currently, services available through the CCDHHS Maternal and Child Health Program do not include a mental health treatment component for women/families at risk due to symptoms of postpartum depression.
Target population: Who is the target population for the project, including: (a) number of patients the project will serve; (b) how Medicaid and/or indigent patients will benefit from the project	The target population is women and families served by the CCDHHS Maternal and Child Health Program. In FY 10, the program provided maternity services to approximately 1,054 women. Approximately 25% of persons served are either Medicaid eligible or indigent.
Category 1 or 2 expected patient benefits: Clearly state the expected benefit of the project to patients based on Category 1 or 2 milestones.	The project seeks to increase in the number of unduplicated women enrolled in the postpartum intervention care navigation program from 30 in DY2, to 60 additional unique patients served in each of DYs 3, 4 and 5, for a total of 210 unique patients served by DY5.
Category 3 outcomes: Clearly state the expected benefit of the project to patients based on Category 3 outcome targets.	IT-8.9 Postpartum depression risk rate. Our goal is to increase the number of women in the CCDHHS Maternal and Child Health Program evaluated for risk of postpartum depression symptoms annually over the waiver term, while also demonstrating a decrease in the percentage of women/families served who are identified at high risk for related emotional and behavioral problems. Specific improvement targets will be determined in DY2 for implementation in DY3.

Identifying Project and Provider Information:
2.9 Establish/Expand a Patient Care Navigation Program
Unique RHP Project Identification number: 138708601.2.8
Performing Provider Name/TPI: Tropical Texas Behavioral Health/138708601
Project Option 2.9.1 Will establish community based mental health care navigation services for women enrolled in the Cameron County Department of Health and Human Services Maternal and Child Health Program who are identified at high risk for postpartum depression.

Project Description:
This project will establish and provide family-centered, culturally sensitive and community based mental health care navigation services to women enrolled in the Cameron County Department of Health and Human Services (CCDHHS) Maternal and Child Health Program who are identified at high risk for postpartum depression, and their families, through a Postpartum Depression Intervention Care Navigation (PDICN) program. The PDICN program will operate out of four (4) CCDHHS clinic sites and provide for a collaborative team of mental health care navigators including one (1) Licensed Professional Counselor (LPC) and two (2) Social Workers responsible for navigating identified high risk postpartum women and their families through the program, and three (3) Community Health Care Workers who will assist with the identification and referral of targeted program participants to the navigators. This project represents a delivery system innovation as care navigation services for women at risk for postpartum depression have not previously been available in our communities.

The PDICN program will include assessment of postpartum women for depression and making appropriate referrals to the LPC. The LPC will provide mental health care counseling by office visit or home visits so that patients will have enhanced access to services, allowing them to receive the right care at the right time in the right setting. According to the RHP Plan Community Needs Assessment, nearly half (47%) of families in RHP 5 earn less than $25,000. Additionally, 40% of all families live below the federal poverty line. Many patients cannot afford to seek professional mental health care services.

The PDICN program will improve mental health care outcomes and the experience of care for those served. By Waiver Demonstration Year (DY) 5, the project will expand mental health care service capacity at four (4) CCDHHS clinic locations in Cameron County and provide services to 210 unduplicated individuals. Over the term of the waiver, the project will significantly reduce the number of people waiting to access comprehensive and culturally sensitive postpartum depression intervention mental health care services, resulting in increased utilization of routine mental health care navigation services, improved health outcomes and experience of care, and decreased child abuse, suicide and need for more costly emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments. During DY2, each of the three mental health navigators will recruit/establish an initial caseload of 10 clients and recruit 20 unique clients each consecutive year in DYs 3-5; maintaining a caseload of 20 unique clients per navigator during DY3-DY5. It is expected that by the end of each DY the care team will have provided services to 60 unduplicated, unique clients for a total of 210 unduplicated, unique clients served over the four-year waiver term.

All services funded by this waiver will be monitored through Tropical Texas Behavioral Health's (TTBH) Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary.

Goal(s) and Relationship to Regional Goal(s):
The goal of this project is to provide postpartum depression intervention navigation services to postpartum women and their families by having a mental health care navigator access and navigate patients to a Licensed Professional Counselor for mental health care services. Postpartum depression intervention navigation services will be accessed by clients through an office visit or home visit.

Project goals:

- Establish a Postpartum Depression Intervention Care Navigation (PDICN) program for postpartum women and their families.
- Develop procedures, training program and continuing education for mental health care navigators.
- Increase PDICN services to 60 unduplicated individuals served per year.
- Increase number of Primary Care Physician (PCP) referrals for patients without a medical home, who use the ED, urgent care, and/or hospital services.
- Develop and implement coordination of postpartum intervention navigation program, health outcomes and wellness.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

Challenges and How Addressed:
Challenges:
The primary challenges for this project will be to gain patient trust and address transportation barriers to service access. This project will be offered for the first time to postpartum women and their families in Cameron County.

Addressed by:
With the proper navigator training and effective procedures, this project will be successful; specifically through cultural competency training and the flexibility of the care team making home

visits in to address transportation barriers to service access. The home visits will also assist the care team to address the full spectrum of the family's needs.

5-Year Expected Outcome for Provider and Patients:
It is expected that this project will improve mental health care outcomes and the experience of care for those served. By DY 5, the project will expand the availability of mental health care navigation services to 210 unduplicated women at risk for postpartum depression, and their families, in Cameron County. The project will significantly reduce the number of targeted individuals waiting to access comprehensive and culturally sensitive mental health care services, resulting in increased utilization of routine mental health care navigation services, improved health outcomes and experience of care and the need for more costly emergency interventions. According to the Island Parent Group, research shows that the presence of a non-depressed caregiver in a baby's life will reduce the impact of postpartum depression significantly. If a parent's depression interferes with his or her ability to take care of their baby, care given by a non-depressed partner or family member will be of great benefit.

Starting Point/Baseline:
Currently, a postpartum depression intervention care navigation program does not exist for women and families enrolled in the CCDHHS Maternal and Child Health Program. Therefore, the baseline for number of program participants and care navigators begins at zero in DY2, and will increase to 30 persons served by the end of DY2.

Rationale:
Mental health care navigators will assist identified high risk women and their families navigate through the fragmented system of support organizations and other mental health care service components. Services provided by the mental health care navigators will include:

- Facilitating follow-up appointments;
- Coordinating care among providers; and
- Community outreach and building partnership with local agencies and groups.

The mental health care navigator will build rapport with the identified high risk postpartum women and their families enrolled in the CCDHHS Clinical Services Program. The mental health navigators will have close ties with the local community and serve as important links between the underserved communities and the health care system. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities. Mental health care navigators will be:

- Compassionate, sensitive, and culturally attuned to the people and community
- Knowledgeable about the environment and mental health care system
- Connected with critical decision makers inside the system

A project to develop a postpartum depression intervention mental health care navigation team, specifically for postpartum women, is needed in Cameron County. In fiscal year 2010, the CCDHHS Clinical Services Program provided maternity services to approximately 1,054 women. Currently, the Clinical Services Program does not provide mental health care for individuals with postpartum depression. TTBH proposes to add a mental health care component to the existing CCDHHS Clinical Services Program. The proposal includes the provision of care navigation services in four (4) Cameron

County public health clinic locations that will identify women and families at risk, monitor social-emotional development, and provide effective and appropriate treatment to ensure mothers and their families achieve optimum mental health and development.

Project Components:
Through the Postpartum Depression Intervention Care Navigation (PDICN) Program, we propose to meet all required project components as follows:

a) *Identify frequent ED users and use navigators a part of a preventable ED reduction program. Train health care navigators in cultural competency.* Postpartum women and their families using the emergency department for primary care services, children/family members without a designated PCP or medical home and children with social or economic barriers to accessing primary care will be offered navigation services. Mental health Navigators will create social services notes in the client file which will be part of the client's clinical record. These notes will include reason for services, assessment, subsequent referrals and follow-up actions. All navigators will undergo training to provide culturally competent care and receive continuing education regarding health care disparities and social determinates of health, community outreach and chronic disease management.
b) *Deploy innovative health care personnel, such as community health care workers, case managers/social workers, professional mental health counselors as mental health navigators.* The PDICN program will hire mental health care navigators with a background in community health, social services. Navigators will access and provide postpartum depression intervention mental health care services to the identified high risk women and their families enrolled in the CCDHHS Maternal and Child Health program.
c) *Connect patients to primary and preventive care.* Navigators will have regular contact with the client's primary care providers for care management services, preventive care, and other educational and social services. Navigators will be available to meet with providers to answer any specific questions.
d) *Increase access to care management and or chronic care management, including education in chronic disease self-management.* Navigators will have regular contact with the client's primary care providers for care management services, preventive care, and other educational and social services. Navigators will be available to meet with providers to answer any specific questions.
e) *Conduct quality improvement for project using methods such as rapid cycle improvement*. This will be accomplished through TTBH's existing Quality Management/Utilization Management structures as described in the project description, through participation in a learning collaborative with the University of Texas Health Science Center at San Antonio (UTHSCSA) and other regional partners as appropriate and through the activities of the Community Mental Health Center consortia sponsored by the Texas Council of Community Centers.

Milestones and Metrics:
The following milestones and metrics were chosen for the project to Establish/Expand a Patient Care Navigation Program based on the project option and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-5 (P-5.1); P-8 (P-8.1)

- Improvement Milestones and Metrics: I-6 (I-6.5)

Unique Community Needs Identification Numbers the project addresses:
This project addresses community need CN.3, inadequate integration of care for individual with co-occurring medical and mental illness or multiple chronic conditions.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, a postpartum depression intervention care navigation program does not exist for women and families enrolled in the CCDHHS Clinical Program. The Program does not offer care management services at this time due to lack of qualified staff. Patients cannot afford to pay for mental health care services or transportation to receive these services elsewhere. The PDICN program will navigate high risk postpartum women and their families through the navigation program and link them to the services needed.

Related Category 3 Outcome Measures:
OD-8 Prenatal Outcomes
IT-8.9 Postpartum Depression Risk Rate

Reasons/rationale for selecting the outcome measures:
Mental health navigators will assist identified high risk women and their families to gain access to mental health care services. According to the Healthy People 2020 report, interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting. Mental health and physical health are closely connected. Mental health plays a major role in a person's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect the ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. This speaks to significant opportunities to promote wellness through the introduction of mental health care navigators to help patients to successfully negotiate the mental health care system and access services.

Relationship to other Projects:
This project's addresses the integration of care through an emphasis on mental health care navigation for women and families at risk due to symptoms of postpartum depression. The implementation of innovative mental health care navigation services is linked to the overall expansion of behavioral healthcare capacity (Project 138708601.1.1) and could result in mental health care referrals related to issues associated with co-occurring mental health and substance use disorders (Project 138708601.1.2). Care navigation will also facilitate referrals to address ongoing medical concerns, supporting TTBH's efforts to improve the integration of primary and behavioral health care (Project 138708601.2.1) and the self-management of co-morbid chronic illnesses (Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with UTHSCSA and other regional partners to develop and participate in a learning collaborative to evaluate our respective delivery system reform initiatives to establish patient care navigation services in RHP 5.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with UTHSCSA and other regional partners engaged in similar delivery system reform projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will also request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to research by the University of Texas Austin Center for Social Work, the monetary value per life-year gained is $50,000.
- Overall project valuation: The total project valuation is $3,549,000.

Project ***138708601.2.8***	***Project Option*** ***2.9.1***	***Project Component(s)*** ***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	***Establish/Expand a Patient Navigation Program***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.12*	*3.IT-8.9*	*Postpartum Depression Risk Rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**

Milestone 1 [P-1]: Conduct a needs assessment to identify the current status and needs of the patient population to be targeted with the Patient Navigation Program.
Metric 1 [P-1.1]: Provide report identifying the following:
• Targeted patient population characteristics.
• Gaps in services and service needs.
• How program will identify, triage and manage target population.
• Available site, state, county, and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients.
  • Baseline/Goal: Baseline is zero. Goal is to produce a comprehensive report documenting all points above.
  • Data Source: Site gap analysis; Program documentation; EHR; State and county data sources.
	Milestone 4 [P-3]**:** Provide care management/navigation services to targeted patients.
	Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the post-partum intervention care navigation program.
	  • Base line: 30 patients
	  • Goal: Enroll 20 unique patients per LPHA/Social Worker navigator in the Post-partum Intervention Care Navigation program.
	  • Data Source: Enrollment and data reports.
	
	Milestone 4 Estimated Incentive Payment *(maximum amount):* $338,000
	
	Milestone 5 [P-5]: Provide reports on the types of navigation services provided to patients, using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.
	Metric 1 [P-5.1]: Collect and report on all the types of patient navigator
			Milestone 7 [P-3]: Provide care management/navigation services to targeted patients.
			Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the Post-Partum Intervention navigation program.
			  • Goal: Enroll 20 unique clients per LPHA/Social Worker Navigator while maintaining a 20 patient caseload per navigator.
			  • Data Source: Enrollment reports
			
			Milestone 7 Estimated Incentive Payment *(maximum amount):* $253,500
			
			Milestone 8 [P-5]: Provide reports on the types of navigation services provided to patients, using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.
			Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.
			  • Goal: Provide patient
				Milestone 11 [P-3]: Provide care management/navigation services to targeted patients.
				
				Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the Post-Partum Intervention navigation program.
				  • Goal: Enroll 20 unique clients per LPHA/Social Worker Navigator while maintaining a 20 patient caseload per navigator.
				  • Data Source: Enrollment reports
				
				Milestone 11 Estimated Incentive Payment *(maximum amount):* $253,500
				
				Milestone 12[P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.
				Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.

Project	***Project Option***	***Project Component(s)***	***Establish/Expand a Patient Navigation Program***
138708601.2.8	***2.9.1***	***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	
Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.12*	*3.IT-8.9*	*Postpartum Depression Risk 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 Estimated Incentive Payment *(maximum amount):* $169,000 **Milestone 2** [P-2]: Establish a health care navigation program to provide support to women identified at high risk for post-partum depression and their families, who are at risk of receiving disconnected and fragmented care, including program to train the navigators, develop procedures, establish continuing navigator education and train the navigators in cultural competency. Metric 1 [P-2.1]: Number of mental health care navigators hired and trained, number of mental health care navigation procedures, number of continuing education sessions for mental health care navigators. • Base line: At the beginning of DY2 mental health care navigators did not exist for Post-partum women and their families; therefore baseline for all is 0. • Goal: Develop the training program with procedures and continuing education for mental health care	services provided. • Baseline is zero. • Goal: Provide patient navigation services to women identified as high-risk for post-partum depression and their families enrolled in the post-partum Intervention navigation program. • Data Source: Reports documenting the types of navigation services provided to individuals enrolled in the post-partum intervention navigation program. Milestone 5 Estimated Incentive Payment *(maximum amount):* $338,000 **Milestone 6** [P-8]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face –to- face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to	navigation services to women identified as high-risk for post-partum depression and their families enrolled in the Post-Partum Intervention navigation program. • Data Source: Reports documenting services provided to individuals enrolled in the mental health program. Milestone 8 Estimated Incentive Payment *(maximum amount):* $253,500 **Milestone 9** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.5]: Number /percent of patients with a primary care provider who are given a scheduled primary care provider appointment. • Baseline: 0, currently navigation services are not provided to post-partum women at high-risk for post-partum depression and their families.	• Goal: Provide patient navigation services to women identified as high-risk for post-partum depression and their families enrolled in the Post-Partum Intervention navigation program. • Data Source: Reports documenting services provided to individuals enrolled in the post –partum intervention navigation program. Milestone 12 Estimated Incentive Payment *(maximum amount):* $253,500 **Milestone 13** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1(I-6.5): Number /percent of patients with a primary care provider who are given a scheduled primary care provider appointment. • Goal: 75% of clients served by navigation program will have PCP appointments facilitated by the care

Project ***138708601.2.8***	***Project Option*** ***2.9.1***	***Project Component(s)*** ***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	***Establish/Expand a Patient Navigation Program***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.12*	*3.IT-8.9*	*Postpartum Depression Risk 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)**
navigators. After developing the training program with procedures and continuing education train and deploy a team of three (3) mental health care navigators comprised of one (1) LPC and two (2) Social Workers, assisted by three (3) Community Healthcare Workers. • Data Source: Documentation of workforce development plan for mental health care navigator recruitment, hiring, training and education including Human Resources documentation. Milestone 2 Estimated Incentive Payment *(maximum amount):* $169,000 **Milestone 3** [P-3]**:** Provide care management/navigation services to targeted patients. <u>Metric 1</u> [P-3.1]: Increase in the number or percent of targeted patients enrolled in the post-partum intervention care navigation program. • Base line: 0 patients	"raise the floor" for performance). <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. • Baseline is zero. Goal is to participate in all semi-annual face to face meetings or seminars. • Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, sign-in sheets and/or meeting notes. Milestone 6 Estimated Incentive Payment *(maximum amount):* $338,000		• Goal: 50 % of clients served by navigation program will have PCP appointments facilitated by the care navigators. • Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 9 Estimated Incentive Payment *(maximum amount):* $253,500 **Milestone 10** [P-8]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face -to- face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). <u>Metric 1</u> [P: 8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. • Goal: Participate in all semi-annual face to face meetings	navigators. • Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program Milestone 12 Estimated Incentive Payment *(maximum amount):* $253,500 **Milestone 14** [P-8]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face –to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1</u> [P: 8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. • Goal: Participate in all semi-annual face-to-face meetings or seminars

Project ***138708601.2.8***	***Project Option*** ***2.9.1***	***Project Component(s)*** ***2.9.1.a, 2.9.1.b, 2.9.1.c, 2.9.1.d, 2.9.1.e***	***Establish/Expand a Patient Navigation Program***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.12*	*3.IT-8.9*	*Postpartum Depression Risk 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)**
• Goal: Enroll 10 unique patients per LPHA/Social Worker navigator in the Post-partum Intervention Care Navigation program. • Data Source: Enrollment and data reports. Milestone 3 Estimated Incentive Payment *(maximum amount)*: $169,000			or seminars. • Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, sign-in sheets, and/or meeting notes. Milestone 10 Estimated Incentive Payment *(maximum amount):* $253,500	organized by the RHP. • Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, sign-in sheets, and/or meeting notes. Milestone 14 Estimated Incentive Payment *(maximum amount):* $253,500
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $507,000	Year 3 Estimated Milestone Bundle Amount: $1,014,000		Year 4 Estimated Milestone Bundle Amount: $1,014,000	Year 5 Estimated Milestone Bundle Amount: $1,014,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,549,000				

Performing Provider: University of Texas Health Science Center San Antonio
Project Name: Implement medical homes in HPSA and other rural and impoverished areas
Project Identifier: 085144601.2.1

Provider:	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas including RHP 5. It extends to campuses in the metropolitan border communities of Laredo (RHP 20) and the Rio Grande Valley (RHP 5). More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.
Interventions:	This project will implement a certified patient centered medical home (PCMH) model of care to provide safety net primary healthcare services to targeted patients who live in HPSA, rural, and impoverished areas of Cameron and Willacy County. This will be achieved through a partnership with Su Clinica Familiar, a primary care clinic that serves the poor and underserved in RHP5.
Need for the project:	Over 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. No integrated chronic care management programs are currently available in RHP5. Therefore there is a need to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over utilization. The PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. There are no PCMH programs in RHP5.
Target population:	The target population includes the uninsured and under-served, those below 200% of poverty, migrant and seasonal farmworkers, Hispanics, women and children. Approximately 77.34% of our patients are at or below 100% of Poverty, 96.09% are at or below 200% of Poverty. Of the 31,415 patients, 51.17% are uninsured, 34.85% are on Medicaid/CHIP, 5.62% are on Medicare, and 8.36% are covered by other 3rd party forms of payment. All patients are expected to benefit from the Patient Centered Medical Home model and from the meaningful exchange of health information.
Category 1 or 2 expected patient benefits:	This project will impact patients and health costs through addressing chronic conditions focused on diabetes. We estimate that a 7-10% reduction in uncontrolled to controlled A1c results on over 4000 patients with diabetes which is a potential savings of several million dollars. Prevented hospitalizations is another area where we will reap cost savings since diabetics when hospitalized have at least one extra day in the hospital and an extra ½ day in the ICU (RHP 5 assessment data). The key functional element of the project is to become a certified patient centered medical home for primary care access for 31,000 patients.
Category 3 outcomes:	Once process and implementation milestones are reached, the clinic expects a decrease in the percentage of diabetic patients whose HbA1c levels are greater than 9.0% (poor control). For the baseline year of 2011, that percentage was 34.27%.

Project Title: Implement medical homes in HPSA and other rural and impoverished areas

Project Option 2.1.3 –using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative: Medical Home

Unique Project ID: 085144601.2.1
Performing Provider Name/TPI: University of Texas Health Science Center San Antonio 085144601

Project Description:

The UTHSCSA Regional Academic Health Center (RAHC) proposes to work with Su Clinica Familiar to implement a certified patient centered medical home (PCMH) model of care to provide safety net primary healthcare services to targeted patients who live in HPSA, rural, and impoverished areas of Cameron and Willacy County.

The project would improve access to comprehensive, primary and preventive care through the implementation of the medical home model. The project would cover five existing service sites located in Brownsville, Raymondville (2), Santa Rosa, and Harlingen. These sites touch 31,000 medical and dental patients, equating to approximately 6.0% of the total population of Cameron and Willacy counties.

The project greatly enhances the current comprehensive, primary health and wellness services for Cameron and Willacy counties in South Texas by developing a medical home model that will improve the service to patients and greatly improve the efficiency and effectiveness of helping them control their chronic health conditions. The clinic responds to the needs of the community by providing quality primary care and prevention services regardless of ability to pay. The community clinic is accredited by the Joint Commission. The target population includes the uninsured and under-served, those below 200% of poverty, migrant and seasonal farmworkers, Hispanics, women and children. The clinic's service area ranks as one of the poorest in the nation.

Although Su Clinica Familiar is a Federally Qualified Health Center and receives grant funding to help with operations, no federal grant dollars will be expended for the positions budgeted for in the 1115 waiver contract. These positions are vital to the successful progression to a level three PCMH certification and to the improvement in health care outcomes for the population in RHP 5.

The Provider partnership between UTHSCSA-RAHC and Su Clinica consists of the following Full Time Equivalents (FTEs): Primary Care Physicians (22.01 FTE); Other providers including Nurse Practitioners/Physician Assistants/Certified Nurse Midwives/Podiatrist (13.10 FTE); Dentists and Dental Hygienists (8.7 FTE). Services include: pediatrics, internal medicine, family practice, OB/GYN, Behavioral Health, Dental, minor surgery, podiatry, pharmacy, and WIC services. Outreach, Lab & x-ray, 24-hour on-call hospital coverage, health professions training, nutrition, health education, social services, case management, integrated eligibility screening, and specialty referral coordination round out the core services. It also includes project coordinators, data managers, data analysts, expertise in health promotion, communications and health information exchange, and community health workers.

Through a partnership with the University of Texas Health Science Center at San Antonio's Regional Academic Health Center (RAHC), the clinic addresses medical provider shortages by providing medical residents and medical students a unique

opportunity to gain frontline experience in treating many of the perplexing medical conditions prevalent along the U.S.-Mexico border. The 5 clinics of Su Clinica network participate in the Medicaid Managed Care program, Title V Maternal & Child Health, Title V Dental, CHIP Perinatal, Texas Family Planning, Healthy Start program, & CHIP Outreach. UTHSCSA/RAHC and SU Clinica also work closely with area hospitals including Knapp Medical Center, Valley Baptist Medical Center, and Valley Regional Medical Center.

The 5 partner clinics currently serve 4,373 patients who have been diagnosed with diabetes. The patient centered medical home model will be able to provide a more effective model of care focused on prevention and a patient/medical team model that will lower risk of severe sequelae from diabetes and reduce visits to emergency departments and hospitalization.

Given the low income levels, high uninsured rates, and high percentage of Hispanics living in RHP 5, we propose to serve 34 following zip codes through this project: 78520 through 78598.

Patient benefit DY4: Goal: At least 50% of Su Clinica patients assigned to medical homes including at least 50% of those 4000+ with diabetes and related chronic conditions.

.Patient benefit DY5: At least 75% of Su Clinica patients assigned to medical home including 100% of those with diabetes and related chronic conditions.

GOAL:

RHP 5 is a medically underserved area with a population that is 40-60% uninsured and that has no public hospital or hospital district. All of the hospitals are private for profit and are therefore limited in their ability to meet the needs of the population for primary and specialty care, based on current reimbursement/financing mechanisms and levels of insurance. Furthermore, the population suffers from very substantial health disparities, particularly related to obesity, diabetes and related conditions as described and documented in detail in the needs assessment.

Two supplementary goals of the project are to:

- Develop meaningful digital health information collection and exchange between providers of care for this demographic segment, and
- Develop actionable health information and analytical capability for reporting project performance, patient risk stratification and population management.

The key functional element of the project is to become a certified patient centered medical home for primary care access. By achieving patient centered medical home status, the 5 clinics can have a lasting and meaningful impact on the over 31,000 patients, reduce the growth in health care costs by working collaboratively with other healthcare partners, and increase patient satisfaction with the healthcare system.

The project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, team-based model
- Build a regional, coordinated model of care designed to reduce costs, lower duplicative work, and increase patient satisfaction.

Challenges

The transformation to a new model of integrated patient centered care is not trivial, as it involves the redesign of service delivery and reorientation of care team thought processes.

The entire organization must undergo a coordinated transformation at the same time that clinical systems are being converted to electronic health records, new government regulations are being implemented, and reimbursement systems revised.
Strong leadership from all partners, the RAHC and Su Clinica administration and clinical team are essential for success. Just as important, the patient must also be educated in the new system and must buy in to the new system of care. Staff must be retrained and work processes must be revised, all while maintaining productivity and reducing costs.
Finally, implementing comprehensive change within a population that is overwhelming Hispanic and Spanish speaking with low health literacy can be a challenge.

5-Year Expected Outcome for Provider and Patients:

- Creation of a Patient Centered Medical Home through transformation of the delivery of health services at Su Clinica Familiar.
- Improvements in coordination with area hospitals are expected through the implementation of the Health Information Exchange.
- Involvement of internal medicine residents and psychiatry residents in caring for patients in a Patient Centered Medical Home environment.
- A significant decrease in the percentage of diabetic patients whose HbA1c levels are greater than 9.0% (poor control).

Starting Point/Baseline.

- There are no PCMH programs in region 5. Working with the RAHC the clinics of Su Clinica will become the first such programs in the region.
- The community clinics currently use an electronic medical records system and has already participated in a number of training opportunities regarding the patient centered medical home.
- The Administrative Leadership Team is knowledgeable of patient centered medical home concepts and has integrated the goal of PCMH certification into the organization's board approved strategic plan.
- Currently, no RHP5 sites, including Su Clinica sites have been certified as a patient centered medical home so the baseline is zero in DY2.
- With respect to diabetes, the clinic collects data on the percentage of patients with HbA1c greater than 9% (poor control). For the baseline year of 2011, that percentage with HbA1c >9% was 34.27%.

Rationale.

Federal, state, and local health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers.

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care.

With respect to the concept of the Patient Centered Medical Home, the National Committee for Quality Assurance (NCQA) found the following:

> Primary care is a foundation of the health care system. The NCQA PCMH standards reflect elements that make primary care successful. Primary care clinicians are often the first point of contact for an individual; thus, patient access to care is an important issue. Just as patient-centeredness is an integral part of the program, so too is a practice's ability to track care over time and across settings. The amount of clinical information for some patients—particularly those with chronic illnesses—and the fragmented nature of the U.S. health system make this aspect of primary care challenging. Merely having an electronic health record system in a practice is not enough. The health information system itself must be achieve meaningful use to improve quality of care.

Implementing a patient centered medical home model in an area of the state with the highest uninsurance rates, high rates of diabetes, high percentage of Hispanic population, and lowest incomes in the nation will have a positive effect on reducing health disparities within the region and therefore the state of Texas. This is a new project for the performing provider and for RHP5 as no PCMH currently exists.

Required core project components:
a) Empanelment: Assign all patients to a primary care provider within the medical home. Understand practice supply and demand, and balance patient load accordingly.
b) Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
c) Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.
d) Assure that patients are able to see their provider or care team whenever possible.
e) Promote and expand access to the medical home by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits.
f) 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.

This Project addresses the following needs:
CN3: Inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions

CN4: Lack of Patient-Centered Care

Related Category 3 Outcome Measure.
IT-1.10 HbA1c poor control

The Category 3 goal for this project is to reduce the percentage of community clinic patients with Type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is greater than 9% (poor control) to 27%.

Providing a patient centered medical home where a diabetic patient has a direct relationship with a provider and care team has shown a relationship with decreased use of inpatient and emergency care (see Rationale above). Community clinics offer a variety of services in one location, including medical, dental, podiatry, nutrition counseling, social services, behavioral health, care management, and social services. Combining the power of the medical home model with the community oriented patient navigator services offered by the RAHC community health workers, we believe we can have a positive, early impact on helping diabetic patients control their HbA1c.

Through a host of national projects funded by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid, it has been shown that the implementation of a Health Information Exchange among hospitals, providers, and related healthcare providers can have a positive impact on health care coordination, patient satisfaction, and total healthcare costs. RHP5 is characterized by being home to a number of small communities and metropolitan areas strung along a 90 mile stretch of highway along the U.S. – Mexico border. The resident population is very mobile and often lives in one community, works in another, and gets their healthcare/hospital care in another. Having the ability to effectively share health information in a secure manner among providers will prove beneficial to all. The RAHC will assure the development of the connection between the PCMH and the Rio Grande Valley HIE.

Relationship to Other Projects.

This project reinforces the projects being proposed by UTHSCSA partnerships with RHP5 hospitals and other performing providers by strengthening the network of care, particularly those services aimed at the lowest income and highest uninsured groups in the region. This project will complement the chronic disease management project by providing an a long term home for patients with underlying chronic disease who have gone through an intense 180 day period of education and orientation to control their condition, but who need a long term PCMH for ongoing management. This project also meshes with other initiatives currently under way in the region such as the development of Accountable Care Organizations, development of a fully functioning medical school, and increased medical research on a variety of topics including obesity, nutrition, and diabetes among Hispanic populations.

Relationship to Other Performing Providers' Projects in the RHP.

A major aim of this project is to work with Su Clinica Familiar to create PCMH at each of the 5 Su Clinica clinic sites. In addition other clinics are likely to pursue this goal and the RAHC will work with those clinics along with Su Clinica to share progress, best practices, and lessons learned throughout the project period.

Plan for Learning Collaborative.

The UTHSCSA through the RAHC as the facilitator will develop the learning collaborative during the project period. The RAHC will also work with the HIE and Su

Clinica to create a seamless access to patient data to facilitate management of patients enrolled in the PCMH. All of the partners in the project have the capacity to host online and videoconference interactive meetings that will be organized and facilitated by the UTHSCSA RAHC. This will provide ample opportunity for a robust learning collaborative.

The RAHC SPH has an advanced data collection, data management and data analysis operation. Working with the Su Clinica Information Technology team and the Rio Grand HIE will create a robust system of data for evaluation, management and decision making. Furthermore it will provide the foundation to expand the IT interaction with hospitals and other clinics in the region.

Project Valuation:

The project will be valued based upon the successful attainment of the following expected results:

- Develop and implement action plans for a patient centered medical home.
- Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license.
- Management and coordination for shared, high-risk patients.
- This project will impact patients and health costs through addressing chronic conditions with a specific focus on diabetes. We estimate that a 7-10% reduction in uncontrolled to controlled A1c results on over 4000 patients with diabetes (out of the 31,000 Su Clinica patients) which is a potential long term savings of several million dollars based on data extrapolated from previous studies. Additional cost savings are found in our expected improvement of A1c results for another 50% of the PCMH diabetic population (<9.0% but still above 6.0%). We estimate those savings to be $1-2 million per year. Prevented hospitalizations is another area where we will reap cost savings since diabetics in RHP5 when hospitalized have at least one extra day in the hospital and an extra ½ day in the ICU (RHP 5 assessment data). We estimate savings that could reach $ 5-7 million / year from averted ICU and regular stay hospitalizations. Finally, our program will also likely improve hypertension and hypercholesterolemia because of its comprehensive approach as a PCMH. As we have shown with other chronic care management programs we will establish a program that achieves significant savings from preventing the onset of other chronic conditions and especially achieving control of diabetes.

Project Identifier 085144601.2.1	Project Option 2.1.3	Project Components 2.1.3.a-f	Implement medical homes in HPSA and other rural and impoverished areas
UTHSCSA			TPI 085144601
Related Category 3 Outcome Measure: IT-1.10	Reference Number IT-1.10	Reference Numbers: IT-1.10 a-d	Diabetes Care: HbA1c poor control (>9.0%) -NQF 0059 (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: Implement the medical home model in primary care clinics Metric P-1.1 Increase number of primary care clinics using medical home model a. Numerator: Number of primary care clinics in Su Clinica Familiar System using medical home model b. Denominator: Total number of primary care clinics in Su Clinica Familiar System. Data Source: UTHSCSA evaluation data and Su Clinica records. Goal: Place all clinics under the PCMH model. Milestone 1 Estimated Incentive Payment: $ 346,889 **Milestone 2**: P-2 Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling Metric P-2.1: Performing Provider policies on medical home	**Process Milestone 4**: P-4. Develop staffing plan to expand primary care team roles. Metric P-4.1 Expanded primary care team roles. Revised Job Descriptions. Data source: written, revised job descriptions. Goal: Create expanded PCMH teams. Milestone 4 Estimated Incentive Payment: $ 571,390 **Process Milestone 5**: P-5. Determine the appropriate panel size. Metric 1: Determine panel size. Panel size determination tool, patient registry, EMR, or needs assessment tool to determine panel size. Data Source: Actual Panel sizes from evaluation and clinic data and reports. Milestone 5 Estimated Incentive Payment: $571,391	**Improvement Milestone 6**: I-12. Based on baseline criteria, improve the number of eligible patients that are assigned to the medical homes. Goal: At least 50% of Su Clinica patients assigned to medical homes including at least 50% of those 4000+ with diabetes and related chronic conditions. Metric I-12.1: Number or percent of eligible patients assigned to medical homes (primary care provider team). Data Source: Clinic records, evaluation data, HIE data. Milestone 6 Estimated Incentive Payment: $ 1,154,592	**Improvement Milestone 7**: I-18. Obtain medical home recognition by a nationally recognized agency. Goal: 100% accreditation. At least 75% of Su Clinica patients assigned to medical home including 100% of those with diabetes and related chronic conditions. Metric: I-18.1 Medical Home recognition/accreditation. Data Source: Accreditation document. Milestone 7 Estimated Incentive Payment: $ 1,181,169

Data source: Performing Provider's "Policies and Procedures" documents Milestone 2 Estimated Incentive Payment: $ 346,889 **Milestone 3**: P-3. Reorganize staff into primary care teams. Metric 3. P-3.1. Primary Care Team. Number of staff organized into primary care teams. Baseline: No primary care teams. Goal: At least 50% of staff part of patient centered primary care teams. Data Source: Provider evaluation data and clinic records. Milestone 3 Estimated Incentive Payment: $ 346,889			
Year 2 Estimated Milestone Bundle Amount: $1,040,667	Year 3 Estimated Milestone Bundle Amount: $1,142,781	Year 4 Estimated Milestone Bundle Amount: $1,154,592	Year 5 Estimated Milestone Bundle Amount: $1,181,169
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $ **4,519,209**			

- ***Performing Provider Name: University of Texas Health Science Center San Antonio***
- ***Project Name:*** Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5
- ***Project Identifier Here:*** 085144601.2.2 (RHP 5)

Provider: A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure.	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas including RHP 5. It extends to campuses in the metropolitan border communities of Laredo (RHP 20) and the Rio Grande Valley (RHP 5). More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. Primary and specialty care if offered in RHP 5 by UTHSCSA residents and faculty.
Intervention(s): Clearly state the intervention(s).	This project is designed to expand proactive, ongoing chronic care management to keep patients with chronic diseases healthy. This project will include elements of the Chronic Care Model (CCM) for ambulatory care that have been shown to lead to the greatest improvements in health outcomes.
Need for the project: A brief description of the need for the project including data as appropriate.	The need for this project in RHP 5 is vital. Over 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. No chronic care management programs are provided currently among the proposed partners.
Target population:	The target population is adult diabetic patients. The project will reach at least 6000 patients over the life of project. Additionally, 1875 people will receive diabetes self-management education programs. Approximately 60% of those reached will be Medicaid eligible or indigent. They will benefit from the chronic care management services associated with this project through better control of HbA1c.
Category 1 or 2 expected patient benefits:	[I-17.1]: Our goal is to have 6000 patients receiving care under the chronic care management program
Category 3 outcomes:	IT-1.10 Our goal is to have a 5% decrease in percentage of patients with HbA1c control > 9.0% over baseline (at least 120 patients)

Project Title: Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5
Unique project ID: 085144601.2.2
Performing Provider Name/TPI: University of Texas Health Science Center San Antonio 085144601
Option 2.2.1 Will expand proactive, ongoing care to keep patients with chronic diseases healthy.

DESCRIPTION OF PROJECT This project is designed to expand proactive, ongoing chronic care management to keep patients with chronic diseases healthy. It will also empower them to self-manage their conditions. The ultimate goal is to prevent worsening health precipitating the need for Emergency Department or Inpatient care. Most chronic diseases fall into the category of non-communicable diseases (NCDs). NCDs are the pandemic of the 21st century, and the World Health Organisation reported in 2010 that they now account for more disability and death globally than all other causes combined.(World Health Organisation, 2011) In 2011 the World Economic Forum estimated that by 2030 they will cost $47 Trillion globally.(Bloom DE et al., 2011) Texas, particularly South Texas, is among the leaders in our nation in prevalence of NCDs. To meet this growing threat in RHP5, our chronic disease management initiative will use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms early, with the goal of preventing complications and managing utilization of acute and emergency care. Chronic disease management also enhances the ability to identify one or more chronic health conditions or co-occurring chronic conditions that merit intervention across a patient population. This ability is based on assessment of patients' risk of developing complications, comorbidities or likelihood of utilizing acute or emergency services. These chronic health conditions include, prominently, diabetes, congestive heart failure, chronic obstructive pulmonary disease, renal disease, non-alcoholic fatty liver disease (NAFLD), all of which are liable to progress to complicating health conditions and a range of severe or end-stage diseases. With this project we will begin by focusing on diabetes. Effective management of this chronic disease is imperative because it is more prevalent in our RHP than nationally.

This **project will include 6 elements** of the Chronic Care Model (CCM) for ambulatory care that have been shown to lead to the greatest improvements in health outcomes:

1) Delivery system redesign (changes in the organization of care delivery)
2) Self-management support strategies (increase patients involvement in their own care)
3) Decision support (guidelines, education, and expertise to inform care decisions)
4) Information systems (changes to facilitate use of information about patients, their care and their outcomes),
5) Community linkages (activities increasing community involvement)
6) Health system support (leadership, practitioner, and financial support).

The volume of services of this project consists of 6 service elements that will be integrated across the project partners to ensure patients receive high quality initial and follow-up care. We have a multidisciplinary, multi-institutional care team:

- UTHSCSA providing patient education and outreach, project coordination and data monitoring.
- Valley Baptist hospital providing clinical services and medication management.
- Tropical Texas, the local mental health authority, providing consultation on mental health issues with the CCM patients
- Proyecto Juan Diego, a community-based non-profit, providing lay health worker follow-up.

Potential CCM patients can be enrolled in the program by any of these partners and will be serviced by this team (element 1) through common management and support strategies for diabetics (element 3). The team will have timely access to patient progress through health information

exchange systems (element 4) including case management activities and referrals to community linkages (element 5) and support for diabetic patients to increase their confidence and involvement in their diabetes self-management (element 2). There will be system support for leaders and practitioners participating in the CCM team (element 6). Overall we will reach 6000 patients with this evidence based chronic disease care model (DY3 1500, DY4 2000 and DY 5 2500). The patient benefit will be controlled diabetes. During the life of the project a 5% decrease in patients (at least 120 patients) with uncontrolled diabetes whose A1cs $\leq$ 9.0% will be achieved.

We will implement an outcome evaluation and a 'plan, do, study, act' (PDSA) strategy. Quality improvement cycles will ensure long-term health benefits are achieved and that improvement processes are incorporated throughout the funding period. Based on meta-analysis findings for Chronic Care Management models, this approach does improve outcomes, but it can take years to see true improvements.(Coleman et al., 2009) However, we believe that by using CCM and the PDSA cycles we will see sustained improvements during the life of this project. All services implemented through this initiative will be monitored by two oversight entities that cut across the partners in anticipation of creating greater collaboration for clinical care in the RHP 5. These will be a clinical care and a clinical information management team. The clinical care team will be comprised of medical personnel appointed from participating providers, clinics and community partners. The clinical information management team will be comprised of health information exchange representatives and appointed health information representatives from clinical and community based partners. The University of Texas will be responsible for ensuring actions of these two entities are in line with project milestones and that PDSA and evaluation activities are continuous and reported to the two teams. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated.

Goals of the Project The goal of this project is to create multidisciplinary care teams coordinated by HIE to provide culturally appropriate and comprehensive chronic care management We will initially focus on persons with diabetes to achieve the following project goals:

- design and implement chronic care teams who efficiently respond to patient's health needs
- Ensure patients can access care teams in person, via phone or email
- Increase patient engagement in their health care treatment
- Implement projects that empower patients to make lifestyle choices
- Conduct quality improvement projects to continuously improve impact and efficiency.

Relationship of the project to regional goals This project substantially contributes to delivery system transformation in RHP 5 by furthering each one of the regions' goals:

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency

department use and duplicative services, and expands on the accomplishments of our existing health care system.

Challenges and issues facing this project The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

• Rushed practitioners not following established practice guidelines
• Lack of care coordination
• Lack of active follow-up to ensure the best outcomes
• Patients inadequately trained to manage their illnesses

In RHP 5, preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting. With the high prevalence of patients with chronic conditions, the demand for treatment is heavy and ongoing. There is a need for greater connectivity among hospital and primary care providers and community based chronic disease management resources so that patients are able to learn and have support for creating lifestyle changes. Additionally, multidisciplinary care teams are not established to focus on managing and supporting patients with chronic conditions outside the hospital setting.

Facing the Challenges 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, we will build an evidenced program based on the effectiveness of the Chronic Care Model We also have assembled a team of committed organizations that will contribute to the chronic care management team model: Valley Baptist Medical System (Harlingen and Brownsville), Tropical Texas Behavioral Health, Rio Grande Valley HIE, Proyecto Juan Diego, and UTHSCSA. We will also work closely with Project 2.1 in RHP 5 and its patient centered medical home.

5-year expected outcome for Performing Provider and patients of the Chronic Care Management (CCM) Program :

- Transformation of chronic care into an integrated management program conducted by all of the partner institutions.
- Institutionalization of health information exchange in the partner institutions that will facilitate integrated management
- Once process and implementation milestones are reached, 5% fewer type 2 diabetic patients enrolled in the CCM program will have HbA1c levels above 9.0% (poor control).

STARTING POINT/BASELINE No project of this kind is currently implemented in the RHP 5 area or with these partners. Patients are currently not receiving the CCM model services at any clinical care facility. As such, there is also no data to establish a baseline for number of patients with uncontrolled diabetes. This will be established in DY 2. Based on data from the Cameron County Hispanic Cohort approximately 38% of people with diabetes have A1cs over 9.0%. Data from a clinic the same region indicate nearly 35% of patients have uncontrolled diabetes (Su Clinica data, 2011). By Year 3 we will be serving 1300 patients with CCM services and over the life of the project reach 6000 patients.

RATIONALE

Reasons for Selecting the Project Option: Chronic diseases are the leading health threat to the RHP5 region. Seventy percent of the population has one or more chronic condition, with obesity being the underlying and exacerbating issue for most. While CDC data show lower rates, recent local data find that 31% of adults have diabetes in the region with over half unaware of their condition (Fisher-Hoch, et al, 2012). Creating a comprehensive chronic care model directly addresses the population management care needs of the population and creates more comprehensive and cost effective approaches to support self-management among the population.

The proposed project is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The project emphasizes enhanced chronic disease management through team-based care.

We will implement quality improvement activities for this proposed project. We will conduct a rapid cycle improvement (PDSA) process to identify problems, and study and implement solutions.

Project components: We will implement all the required core project components for this project option (listed below). We have assembled the partner institutions that are committed to working together to implement this project and redesign the outpatient delivery system to coordinate care for patients with chronic diseases. They will:

a) Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally appropriate education; and health coaches to navigate the health care system

b) Ensure that patients can access their care teams when needed in person or electronically

c) Increase patient engagement, through self-management education, group visits, self-management support, improved patient-provider communication, and community resources

d) Implement evidence-based educational methods known to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions

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

Unique community need identification number the project addresses.

CN.1 Shortage of primary and specialty care providers and inadequate access to primary or preventive care

CN.2 Shortage of behavioral health care professionals and inadequate access to behavioral health care

CN.3 Inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions

CN.4 Lack of Patient-Centered Care

How the project represents a new initiative: There is currently no coordinated approach to management of chronic disease in RHP5. With published rates of the uninsured as high as 70%, the community receives inadequate care even for diagnosed chronic disease. This project is therefore unique for this region which is one of the poorest and least served in our nation. It will therefore be developed for patients who currently have little or no care. The project is also unique is that it seeks to coordinate will other DSRIP proposals in a network of projects designed to reach those at need,

provide comprehensive management of chronic diseases, empower the patient and in the long term reducing the needs for Emergency Room or Inpatient care.

Data Driving this Project In RHP 5, 70% of the population has one or more chronic condition (Fisher-Hoch et al, 2012). A similar proportion has currently no health insurance. The whole population (88% Hispanic) of RHP 5 suffers from substantial health disparities including 1) 50% of the adult population is obese; 2) 31% of the adult population has diabetes; 3) Over 70% of adults have a chronic condition of diabetes, hypertension, hypercholesterolemia, heart disease, or other condition. Many people with diabetes (55.5%) and hypertension (50.0%) are untreated (Fisher-Hoch et al., 2012). Health along the entire US border with Mexico is among the worst in the nation.(Diaz-Apodaca et al., 2010) Obesity is the underlying and exacerbating issue. Data from our region shows that the prevalence of obesity in adults in the region is 48.5% and that 8.0% are morbidly obese.(Fisher-Hoch et al., 2012)

Related Category 3 Outcome Measure(s): The Category 3 goal for this project is to reduce the percentage of CCM patients with Type 2 diabetes whose most recent hemoglobin A1c (HbA1c) is greater than 9% (poor control). We will establish baseline values in year 2 and then our goal will be to decrease the percent of patients with poorly controlled diabetes by 5% in DY5. 2009 data from the CDC indicates that the Age-Adjusted Estimates of the Percentage of Adults Diagnosed with Diabetes in South Texas was (see table). Based on previously mentioned data where only 50% of the population with diabetes is aware of their diagnosis, the above mentioned rates are underestimations of actual disease in RHP 5. Providing patients with comprehensive care and support from a chronic care management team has shown a relationship with decreased use of inpatient and emergency care. We believe we can have a positive, early impact on helping diabetic patients control their HbA1c.

County	Percentage
Cameron	8.5%
Hidalgo	10.2%
Starr	8.5%
Willacy	8.8%

Through a host of national projects funded by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid, it has been shown that the implementation of a Health Information Exchange among hospitals, providers, and related healthcare providers can have a positive impact on health care coordination, patient satisfaction, and total healthcare costs. RHP5 is characterized by being home to a number of small communities and metropolitan areas strung along a 90 mile stretch of highway along the U.S. – Mexico border. Having the ability to effectively share health information in a secure manner among providers will prove beneficial to all.

Relationship to other Projects: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas including RHP 5. It extends to campuses in the metropolitan border communities of Laredo (RHP 20) and the Rio Grande Valley (RHP 5). More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. Primary and specialty care if offered in RHP 5 by UTHSCSA residents and faculty.

This project reinforces other RHP 5 projects by strengthening the network of care, particularly those services aimed at the lowest income and highest uninsured groups in the region. We will work closely with the projects building patient centered medical homes as they will increase care coordination and reduce unnecessary emergency department visits as well. Any project that strengthens the cooperative relationships among healthcare providers and reduces unnecessary delays and waste, will prove beneficial.

This project complements other initiatives in the region such as the community wide campaign (project 2.4), development of a medical school, and increased medical research on a variety of topics including obesity, nutrition, and diabetes among Hispanic populations. This project is related to project 2.1 and its proposed development of a patient centered medical home.

Relationship to Other Performing Providers' Projects in the RHP There are no other providers proposing this same project in pass 1 of the waiver. There are multiple organizations, some of which are performing providers on other projects, involved in the implementation of this project. Additionally, in future passes of the waiver a chronic care management project will be proposed by another institution. This future project however will work with another hospital system, another outreach organization, and will serve patients in another county. High rates of poverty in our population is a major barrier to traveling any distance for health care and thus these two projects are not overlapping in terms of patients served and geographic area served. We are fully committed to working with other performing providers to share progress, best practices and lessons learned.

Plan for Learning Collaborative We plan to work with the UT School of Public Health as the facilitator to encourage the development of a learning collaborative during the project period. Working together to develop and implement a Health Information Exchange will identify similarities among performing providers and will highlight those areas where challenges can be overcome.

Project Valuation The project will be valued on successful attainment of Development and implementation of action plans for a chronic care management model

- Collaboration with the RGV Health Information Exchange to develop and use EMR for effective patient management across the partner hospitals, PCMHs, community clinics in this project
- Improved data exchange between hospitals and affiliated partners and clinical sites
- Restructured staffing into multidisciplinary care teams that manage a panel of patients
- Management and coordination of high-risk patients

This project will save healthcare costs by addressing diabetes. We estimate that the 5% reduction in uncontrolled to controlled A1c results in $500,000 / year based on data extrapolated from previous studies (7). Additional cost savings are found in our expected improvement of A1c results for another 50% of the CCM population (<9.0% but > 6.0%). We estimate those savings to be $1.9 million / year. Prevented hospitalizations is another area where we will reap cost savings since diabetics when hospitalized have at least one extra day in the hospital and an extra ½ day in the ICU (RHP 5 assessment data). We estimate savings of nearly $9 million / year from averted ICU and regular stay hospitalizations. Finally, our program will also likely improve hypertension and hypercholesterolemia because of its comprehensive approach. As we have shown with other chronic care management programs (7) we will establish a program that achieves significant savings from preventing the onset of other chronic conditions and achieving control of diabetes. In summary, implementing a chronic care management model project in an area of the state with the highest uninsurance rates, high rates of diabetes, high percentage of Hispanic population, and lowest incomes in the nation will be challenging but will have a positive effect on health.

References:

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Project identifier: 085144601.2.2	*PROJECT OPTION:* *2.2.1*	*PROJECT COMPONENT(S):* *2.2.1 A-E*	Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5	
UTHSCSA				085144601
Related Category 3 Outcome Measure(s): OD-1- Primary Care and Chronic Disease Management	*085144601.3.6*	IT-1.10	Diabetes care HbA1c greater than 9% (poor control).	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1 [P-4.1]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Baseline/Goal: establish a formalized team with at least 5 members Data Source: Organizational chart, Job duties Milestone 1 Estimated Incentive Payment: $1,,500,962 **Milestone 2** [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program.	**Milestone 3** P-2: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 P-2.1: Increase percent of staff trained Baseline/Goal: train 50% of direct patient delivery CCM staff across performing provider and contractors in Chronic Care Model Data Source: HR, training program materials Milestone 3 Estimated Incentive Payment: **$**1,098,828 **Milestone 4** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [P-11.1]: Increase the number of patients enrolled in a self-management program Baseline/Goal: 400 patients enrolled in diabetes self-management programs Data Source: EHR, patient registry, class enrollment and attendance records	**Milestone 6** [P-10]: Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric 1 [P-10.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: 20% increase number of patients receiving interaction beyond one – to –one visits over year 2 Data Source: EHR, billing records, communication logs Milestone 6 Estimated Incentive Payment: $832,639 **Milestone 7** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [P-11.1]: Increase the number of patients enrolled in a self-management program Baseline/Goal: 650 patients enrolled in diabetes self-management programs	**Milestone 10** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [P-11.1]: Increase the number of patients enrolled in diabetes self-management education program Baseline/Goal: 825 patients enrolled in diabetes self-management programs Data Source: EHR, patient registry, class enrollment and attendance records Milestone 10 Estimated Incentive Payment: $1,703,609 **Milestone 11** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC Baseline/Goal: 2500 patients enrolled in the CCM for diabetes

Project identifier: 085144601.2.2	*PROJECT OPTION:* *2.2.1*	*PROJECT COMPONENT(S):* *2.2.1 A-E*	Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5	
UTHSCSA				085144601
Related Category 3 Outcome Measure(s): OD-1- Primary Care and Chronic Disease Management	*085144601.3.6*	IT-1.10	Diabetes care HbA1c greater than 9% (poor control).	
Year 2 (10/1/2012 – 9/30/2013)	**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: Care management program protocols and activities will be delineated across performing provider and contractors in Chronic Care Model Data Source: Program materials Milestone 2 Estimated Incentive Payment: $1,500,961	Milestone 4 Estimated Incentive Payment: $1,098,828 **Milestone 5** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally <u>Metric 2</u> [I-17.1]: Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC Baseline/Goal: 1500 patients enrolled in CCM for diabetes Data Source: Registry Milestone 5 Estimated Incentive Payment: $1,098,827		Data Source: EHR, patient registry, class enrollment and attendance records Milestone 7 Estimated Incentive Payment: $832,638 **Milestone 8** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally <u>Metric 1</u> [I-17.1]: Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC Baseline/Goal: 2000 patients enrolled in the CCM for diabetes Data Source: Registry Milestone 8 Estimated Incentive Payment: $832,639 **Milestone 9** [P-16]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to	Data Source: Registry Milestone 11 Estimated Incentive Payment: $1,703,608

Project identifier: 085144601.2.2	*PROJECT OPTION:* *2.2.1*	*PROJECT COMPONENT(S):* *2.2.1 A-E*	Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5	
UTHSCSA				085144601
Related Category 3 Outcome Measure(s): OD-1- Primary Care and Chronic Disease Management	*085144601.3.6*	IT-1.10	Diabetes care HbA1c greater than 9% (poor control).	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			"raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-16.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 30% of providers participating in a CCM DSRIP for RHP 5 will be present and identify "raise the floor" improvement. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-16.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: 20% of providers participating in the CCM DSRIP in RHP5 will document raise the floor implementation within 6 months of semi-annual meeting Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and	

Project identifier: 085144601.2.2	*PROJECT OPTION:* *2.2.1*	*PROJECT COMPONENT(s):* *2.2.1 A-E*	Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5	
UTHSCSA				085144601
Related Category 3 Outcome Measure(s): OD-1- Primary Care and Chronic Disease Management	*085144601.3.6*	IT-1.10	Diabetes care HbA1c greater than 9% (poor control).	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 9 Estimated Incentive Payment: $832,639	
Year 2 Estimated Milestone Bundle Amount: $3,001,923	Year 3 Estimated Milestone Bundle Amount: $3,296,483		Year 4 Estimated Milestone Bundle Amount: $3,330,555	Year 5 Estimated Milestone Bundle Amount: $3,407,217
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $13,036,178				

- ***Performing Provider Name: University of Texas Health Science Center San Antonio***
- ***Project Name:*** Establish/Expand a Patient Care Navigation Program based on a Mobile Clinic model
- ***Project Identifier:*** 085144601.2.3

Provider:	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas including RHP 5. It extends to campuses in the metropolitan border communities of Laredo (RHP 20) and the Rio Grande Valley (RHP 5). More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. Primary and specialty care is offered in RHP 5 by UTHSCSA residents and faculty.
Intervention(s):	This project expands the use of an existing Mobile Clinic in a customized van providing primary care in underserved rural areas by enhancing and expanding its impact with locally based patient navigators to support early screening and detection of chronic conditions and navigation for care coordination.
Need for the project:	The need for this project in RHP 5 is vital. Over 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. No patient navigation services are provided in these rural areas
Target population:	The target population is adults living in selected rural areas in RHP 5. We will provide education sessions for 3,000 people, 6,000 health screenings, and navigation services for 450 people during life of project. We will also refer patients to primary care providers. Approximately 60% of those reached will be Medicaid eligible or indigent. They will benefit from the self-management education, risk screenings and patient navigation services associated with this project to better address chronic diseases which are prevalent in our area.
Category 1 or 2 expected patient benefits:	[I-6]: Our goal is to reach 115 patients without a primary care provider who are given a scheduled primary care provider appointment
Category 3 outcomes:	IT-12.5 Our goal is to provide 6000 screenings for diabetes, hypertension and hypercholesterolemia over the life of the project (2000/condition).

Project Title: Establish/Expand a Patient Care Navigation Program based on a Mobile Clinic model
Unique Project ID: 085144601.2.3
Performing Provider/TPI: UTHSCSA / 085144601
Project Option 2.9.1 expands the use of an existing Mobile Clinic in a customized van providing primary care in underserved rural areas by enhancing and expanding its impact with Patient Navigators.

Description of Project

This project expands the use of an existing Mobile Clinic in a customized van providing primary care in underserved rural areas by enhancing and expanding its impact with locally based patient navigators. The Mobile Clinic is currently manned by one Physician's Assistant and one community health worker (CHW), and is equipped with interactive mobile consulting equipment connected to specialist centers for telemedicine activities. This Mobile Clinic will be used to establish this project and may add a second van later. The Mobile Clinic parks for up to 5 weeks at a time in 5 different secured sites (such as school grounds) but typically rural unincorporated areas each year throughout the county.

We will add patient navigators and a social worker to the staff of the mobile van clinic to help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. The staff will conduct a variety of services to enhance prevention, screening and treatment of people living in the rural areas served by the van including: conducting outreach, assisting with health screening services, and provide referrals to primary care offices. The patient benefits will be at least 3,000 people during the life of the project will partake in chronic disease patient education sessions (DY 3=800, DY 4=1,000, DY 5=1,200). The mobile clinic staff will conduct at least 2,000 screenings for diabetes, hypertension and hypercholesterolemia (6,000 total) over the life of the project. We will provide navigation services to 450 people (DY3=125, DY 4= 150, DY 5 = 175). The full scope of navigation services, including at least 115 people without a primary care physician (PCP) receiving assistance with setting appointments with a PCP, will include:

1. Identifying individuals in the community in need of medical care and directing them to the van for primary appointments.
2. Facilitating communication among patients, family members, survivors and healthcare providers.
3. Coordinating care among providers.
4. Arranging financial support and assisting with paperwork.
5. Arranging transportation and child care.
6. Ensuring that appropriate medical records are available at medical appointments.
7. Facilitating follow-up appointments.
8. Community outreach and building partnership with local agencies and groups.
9. Ensuring access to clinical trials.
10. Health education and self-management programs.

There is no one common definition of Patient Navigators and the profile varies widely by program. We will use trained Community Health Workers (CHWs). CHWs have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also possess the linguistic and cultural skills needed to connect with patients from

underserved communities. CHWs are also known as community health advisors, lay health advocates and *promotoras de salud*.

While there is no set education required for a patient navigator to be successful, we will ensure that our successful navigators are

1. Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
2. Knowledgeable about the environment and healthcare system.
3. Connected with critical decision makers inside the system, especially financial decision makers.

Relationship of the project to regional goals

This project addresses two major goals of RHP5.

- Increase access to primary care of those with Medicaid or without health insurance. This project addresses this goal by providing mobile health service to a poor and uninsured rural population.
- Improve control of chronic disease that afflicts 70% of our adult population. This project will connect those with chronic disease to an integrated chronic disease program either through a PCMH or an integrated chronic disease management program.

Project Goals

RHP 5 is a medically underserved area with a population that is 30 – 40% uninsured and that has no public hospital or hospital district. All of the hospitals are private for profit and are therefore limited in their ability to meet the needs of the population for primary and specialty care, based on current reimbursement/financing mechanisms and levels of insurance. Furthermore, the population suffers from very substantial health disparities:

- 50% of the adult population is obese
- 31% of the adult population has diabetes
- Over 75% of adults have a chronic condition of diabetes, hypertension, hypercholesterolemia, heart disease, or other condition.
- In addition, diabetes care and treatment is a major barrier to increasing access to care for the uninsured working poor. Also, the service area has an 88% Hispanic population.

The goal of this project is to utilize CHWs as Patient Navigators to seek out and then provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients, using the medical Van(s) as a mobile hub. Patient Navigators will help and support these patients to reach and then navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely health care services. Patient Navigators will assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. The Patient Navigators will engage with patients in a culturally and linguistically appropriate manner to guide the patients through integrated health care delivery systems and increase access to health promotion and disease prevention services.

This project meets the following regional goal

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, team-based model while also building a regional, coordinated model of care designed to reduce costs, lower duplicative work, and increase patient satisfaction.

Challenges and issues facing this project

In RHP 5, 70% of the population has one or more chronic conditions. A similar proportion has currently no health insurance, such that preventive care and intervention is neglected and patients often only present to clinics or emergency departments with advanced severe disease. Obesity is the underlying and exacerbating issue. Patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for these in those rural areas.

Facing the challenges

This project will build on a medically equipped mobile clinic in a van operated by the University of Texas in Deep South Texas, serving extremely rural and impoverished areas. We will hire, train, and monitor CHWs to be navigators in the locations visited by the UT Mobile Clinic, and perhaps adding at least one additional van (Mobile Clinic) as the project progresses. These patient navigators will identify people (of all age) in the community who are in need of care and support and guide them through the system. The patient navigators will also provide health promotion disease prevention services.

5-year expected outcome for Performing Provider and patients.

The goals for this project are

- Creation of a model of low cost primary care and patient navigation for the rural poor.
- Enrollment of people into the system and referral of integrated care, particularly those with chronic conditions.
- Establish training program for CHWs as patient navigators
- Streamlined referrals for care at PCMH and chronic care models in RHP5 clinics and hospitals.
- Improved education for patients on chronic disease prevention and self-management provided by clinic staff and the CHW/patient navigators.

Starting Point/Baseline:

The mobile van currently uses an electronic medical records system but is not connected to a health information exchange. The clinical staff is culturally competent and accepted by community members where the van visits. The administrative team is knowledgeable about public health outreach. Currently no patients receive patient navigation services so the baseline is zero in DY 2. With respect to our category 3 outcomes we will improve the screening of three essentially preventable and treatable conditions, which our RHP 5 have been shown to be at least half the time undiagnosed: diabetes, hypertension, hypercholesterolemia. Examining the patient records in 2011, we find that 139 patients were screened for diabetes, hypertension, hypercholesterolemia. These numbers will be examined against data collection planned for DY 3 to establish a solid baseline.

Rationale

Patient navigators provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators help and support these patients to navigate through the continuum of health care services. Patient Navigators ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators also assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting nonurgent care from the Emergency Department to site-appropriate locations. Our patient navigators will be community health workers who will receive additional training on navigation. They will be from the community and will be bilingual to engage with patients in a culturally and linguistically appropriate manner. They will provide an essential service of guiding patients through integrated health care delivery systems.

We will implement all the required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Reasons for Selecting the Project Option

The RHP5 needs assessment demonstrates the high prevalence of chronic diseases, such as type 2 diabetes, high cholesterol, hypertension, and chronic liver disease in this population. Furthermore published data demonstrate that poverty is high, and that the majority of people do not have access to health services through insurance. These problems are compounded in the rural areas. Therefore this project will serve a number of important purposes, increasing screening for chronic disease in a poor rural population that is medically underserved and is therefore at risk for presenting at ED or clinics with advanced manifestations of chronic disease. Those are the reasons for choosing this project.

Unique community need identification number the project addresses*.*

This project addresses several needs identified for RHP 5. These include:
CN.1 , Shortage of primary and specialty care providers and inadequate access to primary or preventive care
CN.3 Inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions
CN.4 Lack of Patient-Centered Care

How the project represents a new initiative

This project is a much expanded and revised form of an existing project. It reforms the existing system by training and engaging Community Health Workers as patient navigators who will contact people in the rural areas where the van is located and arrange for them to be seen and then for those with chronic disease conditions the navigators will help those individuals enter into an integrated care program to mitigate the progression of the condition and reduce the likelihood of appearing at an emergency department or clinic with advance complications.

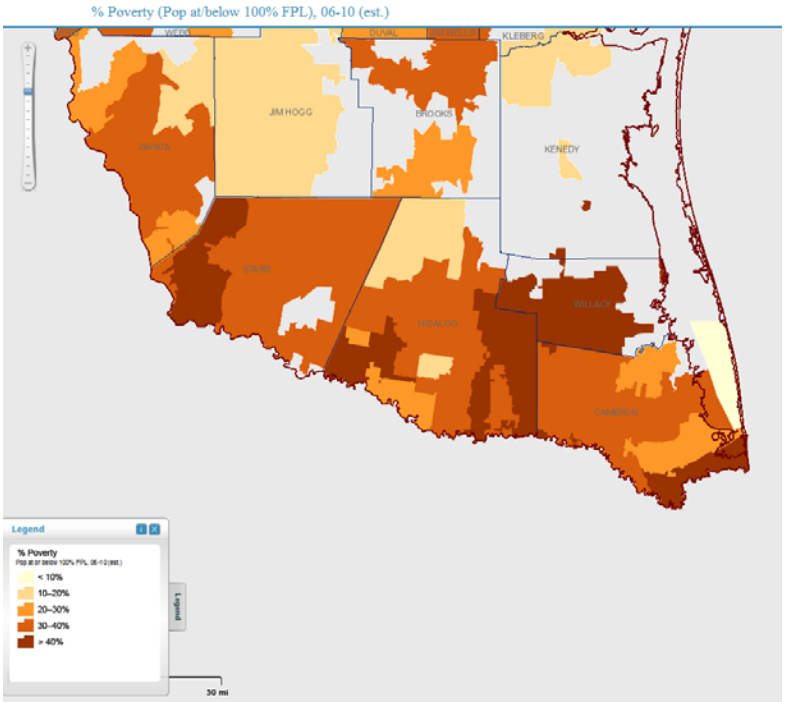
Furthermore this project is a new initiative because patients currently seen on the van are not identified as frequent ED users and are not followed to reduce preventable admissions. Innovative health care personnel are currently not employed to work with patients seen on the mobile van. Patients are referred to primary care facilities, but due to lack of staff are not specifically provided navigation services. Preventive care is not the focus of services provided. Chronic care management including education and self-management is not routinely provided. A PDSA cycle is not used to implement quality improvement activities.

Data Driving this Project.

Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas as a whole). Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Currently only 31.4% have insurance of any kind, more than half of which is Medicare or Medicaid. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer. We have unpublished data showing that prevalence of cancers associated with obesity and diabetes such as gut cancers is high. Some more unusual cancers are more common than elsewhere, particularly stomach, liver and ovarian cancers. The underlying conditions are essentially preventable or treatable. The long term cost of this neglect will be huge.

Related Category 3 Outcome Measure(s):

The overall goal of this project is improvement in the health of a health disparity population with high rates of essentially treatable and preventable diseases which are undiagnosed and untreated. 70% of people in RHP5 have one or more chronic conditions, diabetes, hypertension or elevated cholesterol. 50% are undiagnosed and of those diagnosed only about half are on treatment. This project will address this disparity in the rural poor part of RHP5.



The Category 3 goal for this project is to identify those with previously undiagnosed diabetes, hypertension or high cholesterol and to treat them comprehensively with medication, health education and self-management programs. The people from this project will be referred to the PCMH at Su Clinica, or to the chronic disease management program at Valley Baptist Hospital or to one of the Federally Qualified Health Clinics in the region. This project will identify those with chronic conditions and place them into integrated care programs in a PCMH or integrated care program or FQHC, depending on the location of the patient, their insurance status and their condition.

As stated above, RHP5 is among the highest poverty, and most medically underserved regions in the nation. The figure depicts the percentage of the population below poverty by Zip Code Tabulation Area (darker the color the higher the poverty).

OD- 12 Primary Care and Primary Prevention:

IT-12.5 Other USPSTF-endorsed screening outcome measures for Diabetes (HbA1c)
IT-12.5 Other USPSTF-endorsed screening outcome measures for Hypertension
IT-12.5 Other USPSTF-endorsed screening outcome measures for Hypercholesterolemia

Relationship to other Projects:

This project reinforces the projects being proposed by RHP5 hospitals and other performing providers by strengthening the network of care, particularly those services aimed at the lowest income and highest uninsured groups in the region. This project is related to project 2.2 through the option of referring patients from the van to the chronic care team for comprehensive follow-up care. This project is related to 2.1 through the option of referring patients from the van to the PCMH at Su Clinica for comprehensive follow-up. This project also meshes with other initiatives currently under way in the region such as the develop of Accountable Care Organizations, development of a fully functioning medical school, and increased medical research on a variety of topics including obesity, nutrition, and diabetes among Hispanic populations.

Relationship to Other Performing Providers' Projects in the RHP.

No other performing provider is implementing this same community wide campaign initiative. However, this project will work in coordination with all other performing providers in the region to refer patients who present with health risks for follow-up and comprehensive care. We are fully committed to working with the other performing providers to ensure the triple aims are achieved.

Plan for Learning Collaborative:

We plan to work with the UT School of Public Health as the facilitator to encourage the development of a learning collaborative during the project period. Working together to develop and implement the mobile van navigation project and with other projects implementing health information exchange initiatives will bring to light many similarities among performing providers and will also highlight those areas where challenges can be overcome. Our experience with preventive and screening care, health communication, and text message support for lifestyle changes will be resources we plan to bring to the learning collaborative. We anticipate a strong working relationship among universities, hospitals, and private performing providers.

Project Valuation:

The project will be valued based upon the successful attainment of the following expected results:

- Develop and implement action plans for mobile clinic navigation services
- Improved early screening of health risks among low income, low health insurance populations
- Prevention and early intervention among high-risk patients
- Restructure staffing into community outreach teams to screen more patients.
- Collaborate with other performing providers to efficiently refer at risk patients into care.

This project will save healthcare costs by providing screenings for common chronic conditions in RHP 5 with the goal of identifying problems earlier in the disease process or averting disease completely. From previous studies, we have shown that this type of screening, education and outreach project can avert cases of diabetes. For **each** diabetes case averted there are lifetime medical costs and indirect

labor costs saved of $1,010,659. We also will prevent hospitalizations with this project as we will identify problems earlier. Based on the number of patients reached, we anticipate reducing hospitalizations by 20% among the 3,000 patients saving nearly $3.2 million during life of project from averted hospitalizations. Finally, our program will also likely improve hypertension and hypercholesterolemia because of its comprehensive approach. Based on a very conservative estimate of lifetime costs saved just from strokes avoided (Taylor et al. 1996) we estimate $5.4 million in savings. This program is a particularly important cost savings initiative in our area where chronic conditions are rampant.

UNIQUE IDENTIFIER: ***085144601.2.3***	***PROJECT OPTION: 2.9.1***	***PROJECT COMPONENT*** 2.9.1 [a-e]	Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
UTHSCSA				*TPI* 085144601
Related Category 3 Outcome Measure(s): *OD 12*	*[unique Category 3 IT identifier(s)]* 085144601.3.7	IT-12.5 diabetes IT-12.5 hypertension IT-12.5 hypercholesterolemia	**Other USPSTF**-endorsed screening outcome measures diabetes hypertension hypercholesterolemia	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*P-1*]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program Metric 1 [*P-1.1*]: Provide report identifying the following: o Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). o Gaps in services and service needs, o How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). Baseline/Goal: there has not been such assessment conducted. Produce a comprehensive report documenting all points above Data Source: Program documentation, EMR, claims, needs assessment survey Milestone 1 Estimated Incentive Payment: $800,513	**Milestone 2** [P-2]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. a. Workforce development plan for patient navigator recruitment, training and education Baseline/Goal: No one has been trained as navigators or done navigation procedures. To train 3 people as navigators, identify a minimum of 3 navigation procedures and have 2 continuing education sessions each year Data Source: Patient navigation program materials and database, EMR Milestone 2 Estimated Incentive Payment: $ 219,766	**Milestone 6** [P-3]: Provide care management/navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Goal: 150 patients needing navigation services would receive them in DY 4 Data Source: Enrollment reports Milestone 6 Estimated Incentive Payment: $ 222,037 **Milestone 7** [P-4]: Milestone: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources Metric 1 [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program Goal: 1000 people will be offered	**Milestone 10** [P-3]: Provide care management/navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Goal: 175 patients needing navigation services would receive them in DY 5 Data Source: Enrollment reports Milestone 10 Estimated Incentive Payment: $ 227,147 **Milestone 11** [P-4]: Milestone: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources Metric 1 [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program

Unique Identifier: ***085144601.2.3***	***Project Option: 2.9.1***	***Project Component*** 2.9.1 [a-e]	Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
UTHSCSA				*TPI* 085144601
Related Category 3 Outcome Measure(s): *OD 12*	*[unique Category 3 IT identifier(s)]* 085144601.3.7	IT-12.5 diabetes IT-12.5 hypertension IT-12.5 hypercholesterolemia	**Other USPSTF**-endorsed screening outcome measures diabetes hypertension hypercholesterolemia	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 3 [P-3]: Provide care management/navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Goal: 125 patients needing navigation services would receive them in DY 3 Data Source: Enrollment Payment: Milestone 3 Estimated Incentive $ 219,766 **Milestone 4** [P-4]: Milestone: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources Metric 1 [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program Goal: 800 people will be offered patient education Data Source: Class offering records	patient education Data Source: Class offering records and class participation lists Milestone 7 Estimated Incentive Payment: $ 222,037 **Milestone 8** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: 50 people will be provided a primary care provider appointment in DY 4 Data Source: Performing Provider administrative data on patient Milestone 8 Estimated Incentive Payment: $ 222,037 **Milestone 9** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At	Goal: 1200 people will be offered patient education Data Source: Class offering records and class participation lists Milestone 11 Estimated Incentive Payment: $ 227,147 **Milestone 12** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 2 [I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: 65 people will be provided a primary care provider appointment in DY 4 Data Source: Performing Provider administrative data on patient Milestone 12 Estimated Incentive Payment: $ 227,148 **Milestone 13 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to

Unique Identifier: ***085144601.2.3***	***Project Option: 2.9.1***	***Project Component*** 2.9.1 [a-e]	Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
UTHSCSA				*TPI* 085144601
Related Category 3 Outcome Measure(s): *OD 12*	*[unique Category 3 IT identifier(s)]* 085144601.3.7	IT-12.5 diabetes IT-12.5 hypertension IT-12.5 hypercholesterolemia	**Other USPSTF**-endorsed screening outcome measures diabetes hypertension hypercholesterolemia	

Year 2 (10/1/2012 – 9/30/2013)	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 class participation lists Milestone 4 Estimated Incentive Payment: $ 219,765 **Milestone 5 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive	each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: at least two staff members will participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 9 Estimated Incentive Payment: $222,037	promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 13 Estimated Incentive Payment: $227,149

UNIQUE IDENTIFIER: ***085144601.2.3***	***PROJECT OPTION: 2.9.1***	***PROJECT COMPONENT*** 2.9.1 [a-e]	Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
UTHSCSA				*TPI* 085144601
Related Category 3 Outcome Measure(s): *OD 12*	*[unique Category 3 IT identifier(s)]* 085144601.3.7	IT-12.5 diabetes IT-12.5 hypertension IT-12.5 hypercholesterolemia	**Other USPSTF**-endorsed screening outcome measures diabetes hypertension hypercholesterolemia	
Year 2 (10/1/2012 – 9/30/2013)	**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: $219,765			
Year 2 Estimated Milestone Bundle Amount: $800,513	Year 3 Estimated Milestone Bundle Amount: $879,062		Year 4 Estimated Milestone Bundle Amount: $888,148	Year 5 Estimated Milestone Bundle Amount: $908,591
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $3,476,314				

- ***Performing Provider Name: University of Texas Health Science Center San Antonio***
- ***Project Name:*** **Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**
- ***Project Identifier:*** 085144601.2.4

Provider:	The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas including RHP 5. It extends to campuses in the metropolitan border communities of Laredo (RHP 20) and the Rio Grande Valley (RHP 5). More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas. Primary and specialty care is offered in RHP 5 by UTHSCSA residents and faculty.
Intervention(s):	This project will implement an evidenced based community wide campaign to support lifestyle changes to prevent and control chronic disease. The campaign includes mass media, social media, text message support, educational sessions, environmental changes, and enhanced community-based chronic disease screenings to increase physical activity and improve healthy food choices.
Need for the project:	The need for this project in RHP 5 is vital. Only 30% of the RHP 5 population meet physical activity guidelines and only 16% meet dietary guideline. Over 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care.
Target population:	The target population is adults living in selected municipalities in RHP 5. During the life of the project we will reach 6000 people. Approximately 60% of those reached will be Medicaid eligible or indigent. They will benefit from the social support, education, chronic care screening associated with this project.
Category 1 or 2 expected patient benefits:	The project will reach 6,000 people with at least two components of the Community Wide Campaign (of the 5 components) to support healthy lifestyle behavior changes.
Category 3 outcomes:	IT-1-7 Our goal is 86 patients will achieve controlled blood pressure during life of project

Project Title: Implement Evidence-based Health Promotion Programs
Unique project ID: 085144601.2.4

Performing Provider/TPI: The University of Texas Health Science Center San Antonio (UTHSCSA) / 085144601

Project Option 2.6.1 - Implement Evidence the evidenced-based Community Wide Campaign (CWC) which will include community health worker outreach, self-management education, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health.

PROJECT DESCRIPTION

UTHSCSA proposes to implement an evidenced-based Community Wide Campaign (CWC) that will include text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of healthy lifestyles. The CWC will address lack of physical activity and healthful food choices in our population leading to multiple chronic conditions which were noted in the RHP needs assessment including hypertension, obesity, diabetes and cardiovascular diseases. This project option will focus on implementation of the population-based campaign to promote healthy lifestyles in several municipalities within RHP 5. The CWC project ties to CN.1 by addressing shortages of primary care / preventive services in RHP 5 by making preventive information and lifestyle changes easily accessible and actionable through mass media venues, social media and text messaging.

In RHP 5, approximately 70% of the population has at least one chronic condition, particularly driven by the high rates of obesity and overweight.(Fisher-Hoch et al., 2012) The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting. The current prevention and treatment system is an unconnected, silo-based approach, which reduces effectiveness and increases the cost of health care. As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. With the high prevalence of patients with chronic conditions, the longer-term cost savings will come from moving up stream and implementing health promotion interventions that prevent and control chronic conditions. The proposed project will support health by following CDC recommendations for a proven-effective intervention. The Guide to Community Preventive Services (Guide) recommends multi-component community-wide campaigns as a strategy to increase physical activity and nutrition, the underlying causes of many chronic conditions.(Community Preventive Services Task Force, 2012) The Guide defined community-wide campaigns as:
"…large-scale campaigns deliver(ing) messages that promote physical activity by using television, radio, newspaper columns and inserts, and trailers in movie theaters. They use many components and include individually focused efforts such as support and self-help groups; physical activity counseling; risk factor screening and education at worksites, schools, and community health fairs; and environmental activities such as community events and the creation of walking trails."
The meta-analysis reported in the Guide provided evidence that community-wide campaigns increase energy expenditure by increasing the proportion of people who report being physically active. The Guide also indicates other health issues including nutrition can be addressed.

CWCs have the following core components to achieve physical activity and healthy eating.

1) Mass media providing communication about lifestyle changes

2) Social support including self-help groups, exercise groups, community health worker home visits, text messages, and social media
3) Screening for risk factors and chronic disease including diabetes, high blood pressure, high BMI
4) Education about physical activity and nutrition in community locations
5) Environmental or policy changes to support healthy lifestyles

Through this project people will be exposed to targeted and scientifically accurate information about healthy lifestyles via mass media and social media. Text messages based on a bank of hundreds of text messages in Spanish and English will be sent. Patients will be referred to self-help and exercise groups in their local area. Within their cities, increased opportunities for health risk screenings will occur in easily accessible community locations with referrals to medical homes. Increased physical activity and nutrition education opportunities will be offered in community centers including parks and recreation facilities and schools. Changes to the environment to support physical activity and healthy food choices will also be implemented including protected paths for cycling and walking. Results will include controlled blood pressure and management of chronic diseases.

The CWC implementation team will consist of healthcare professionals, prevention experts, health communication experts and municipality-based leadership. People living in several municipalities will be targeted with the community wide campaign required core components listed above. Given the low income levels, high uninsured rates, and high percentage of Hispanics living in RHP 5, we expect to target the following municipalities: San Benito, Los Indios, Los Fresnos, Harlingen, Brownsville, Rancho Viejo, Combes, Rio Hondo, Laguna Vista, Port Isabel. These municipalities fall within one of the poorest regions in the nation. The patient benefit will include reaching at least 6,000 unique people (DY 3=1,700, DY 4=2,000, DY 5=2,300) during life of project with at least two CWC components indicating a more intensive exposure to the CWC leading to the control of blood pressure (DY 4 at least 35, DY 5 at least 45 patients).

PROJECT GOAL:

The whole population (88% Hispanic) of RHP 5 suffers from substantial health disparities:

- 50% of the adult population is obese
- 31% of the adult population has diabetes
- Over 70% of adults have a chronic condition of diabetes, hypertension, hypercholesterolemia, heart disease, or other condition.

The goals of this project are to

1) Implement innovative evidence-based community-wide campaign activities with fidelity to the recommended core components in selected municipalities of RHP 5:

2) Address the lack of physical activity and healthful food choices in RHP 5 so as to reduce risks for chronic disease, particularly hypertension.

This project meets the following regional goals:

- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges and issues facing this project: Transforming the health care delivery system to include a demonstrable focus on prevention and primary care is essential, but not without challenges. It

involves redirecting training, staff time and resources to prevention initiatives such as a CWC. In RHP 5 this is vital because 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. Obesity is the underlying and exacerbating issue, but patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for those in these rural areas.

Addressing the challenges: We will implement the evidenced-based CWC (CWC) which will include its core components including media messages, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health. The CWC will address lack of physical activity and healthful food choices which is prevalent in our community.

STARTING POINT/BASELINE

How the project represents a new initiative: This project will expand and innovate health care service delivery by creating an expansive base of preventive behavior change in the region. Mexican Americans have been documented in our area to have low participation in physical activity and consumption of fruits and vegetables. It is also common for our population not to consumer appropriate portions of food. The combination of these three factors leads to energy imbalance which is driving the obesity epidemic and explosion of chronic conditions in the community, even among the very young. The high obesity rate was noted in the RHP 5 needs assessment. The CWC has been selected because it is evidenced based for addressing these behaviors.

Our baseline data indicates that adults living in RHP 5 are substantially less likely to meeting physical activity (PA) guidelines or consume sufficient number of fruits and vegetables each day.

Comparing Two Samples on Meeting Health Guidelines (%)

	RHP5	Hispanic BRFSS (national)
Meet PA Guideline	30.59	41.00
Meet Dietary Guideline	16.29	22.68

The proposed CWC activities have only been implemented in one of the partnering communities involved with this project. The federal funding that supported this implementation ended February 28, 2013. Therefore, no federal funding supports CWC activities in these communities. Results from the initial implementation of the CWC show 31% of the Spanish and non-Spanish speaking population indicated they were aware of the campaign. People reporting more intensive exposure to the campaign also were more likely to meet physical activity guidelines and more likely to consume fruits and vegetables. (Table 1) These results provide us additional evidence of the need for this CWC, not only more expansively in this one community, but now more broadly disseminated. The limitations of this early iteration of the CWC include its primary focus on those who spoke Spanish. We will now expand the campaign to be fully in English and Spanish. Another limitation was its focus on one community. We will now expand the campaign to reach communities across RHP 5. Additionally, the earlier iteration of the campaign did not fully rely on text messaging support or social media. These elements will be added to the campaign to expand its reach and intensity.

RATIONALE

The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals.

Table 1: Odds ratios for Physical Activities, **Spanish Speakers (n=1187)**

Exposures	all n=1187	[a]Meet Physical Activities guidelines, n (%)		[b]OR (95% CI)	P value	[c]OR (95% CI)	P value
		No n=854 (72.37%)	Yes n=326 (27.63%)				
Have you regularly read, seen, or heard any health messages from the TSSC campaign? (yes)	733(62.65)	506(60.02)	227(70.28)	**1.39(1.04,1.87)**	**0.0275**	**1.34(1.01,1.86)**	**0.0403**
Newsletter	635(55.51)	428(52.07)	207(65.09)	**1.53(1.14,2.04)**	**0.0042**	**1.51(1.12,2.04)**	**0.0075**
Discussion	418(36.35)	271(32.69)	147(46.37)	**1.62(1.22,2.13)**	**0.0007**	**1.59(1.20,2.11)**	**0.0135**
TV	332(29.12)	217(26.43)	115(36.51)	**1.49(1.13,1.98)**	**0.0055**	**1.49(1.12,1.99)**	**0.0066**
Radio	114(9.90)	67(8.05)	47 (14.87)	**1.88(1.26,2.81)**	**0.002**	**1.86(1.23,2.79)**	**0.0030**
Web	30(2.63)	20(2.43)	10(3.19)	1.22(0.56,2.64)	0.6152	1.14(0.52,2.5)	0.7489
Newsletter &Discussion & TV& Radio	47(4.01)	26(3.08)	21(6.50)	**2.00(1.11,3.63)**	**0.0218**	**1.86(1.02,3.41)**	**0.0434**

[a]Meet physical activity guidelines of 150 moderate and vigorous minutes per week
[b]Odds Ratios from Mixed Logistic Regression Models accounting for version differences of questionnaire
[c]Odds Ratios from Mixed Logistic Regression Models accounting for version differences of questionnaire adjusted for age, diabetic, gender, marital status, school years, language, insurance

The implementation of evidenced based health promotion development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing preventive care to large, at risk populations in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction.

This initiative aims to eliminate fragmented, uncoordinated preventive care by creating health promotion information regarding two health behaviors that underlie countless chronic conditions. The projects establish a foundation of transformation in RHP 5 and support the prevention and control of chronic disease at a population level.

We will implement quality improvement activities for this proposed project. We will conduct a rapid cycle improvement (PDSA) process to identify problems, and study and implement solutions.

5-year expected outcome for Performing Provider and patients

The expected outcome in five years is a fully implemented CWC in multiple municipalities across RHP 5. Once process and implementation milestones are reached, we expect an increase in the percentage of patients with controlled blood pressure. We also expect an increase in percentage of people meeting guidelines for minutes of physical activity reported and servings of fruits and vegetables consumed each day. These changes will lead result in several positive health outcomes. For persons with hypertension, engagement in CWC activities will result in controlled blood pressure.

RELATED CATEGORY 3 OUTCOME MEASURES

Because low levels of physical activity and food choices are related to hypertension, the category 3 goal for this project is to increase the percentage of patients enrolled in the evidenced based CWC services who report controlled blood pressure. In RHP 5 based on BRFSS data from 2009

27.7% of respondents indicate they have been diagnosed with high blood pressure. These rates are lower than the state as a whole, which demonstrates our population does not access health care in a preventive fashion. In another study (Fisher-Hoch et al, 2012) the weighted prevalence of hypertension is 30.7% and 50% of those with the condition were unaware they had it, Implementing the CWC activities will increase screening for health risk factors such as high blood pressure, opportunities for physical activity and healthful food choices, and social support and social media support for long-term lifestyle changes to sustain controlled blood pressure readings.

Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure.

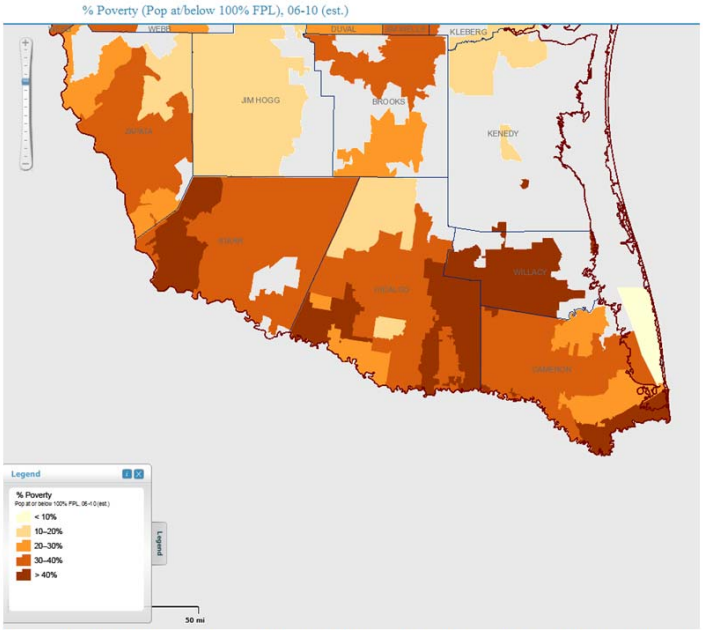


Figure 1. RHP 5 Percentage of Families living at or below 100% of Poverty Level

As stated above, RHP5 is among the highest poverty regions in the nation. The communities served by the community-wide campaign have over 20% of their population at or below 100% of poverty. The figure below depicts the percentage of the population below poverty by Zip Code Tabulation Area.

Relationship to Other Projects.

This project reinforces the projects being proposed by RHP5 hospitals and other performing providers by strengthening the focus on preventive care, conducting early screening and referrals, and working in population centers with low income and high uninsurance rates. This project will connect populations with scientifically proven strategies for improving healthy lifestyles, provide them with access to environmental and social support to initiate and sustain the lifestyle changes. The hospitals and clinics will find unprecedented media and environmental support for their recommendations to exercise more and consume a healthy diet. We will work to increase the coordination of care and reduce the burden on hospitals caused by unnecessary emergency department visits. Any project that strengthens the cooperative relationships among healthcare providers and reduces unnecessary delays and waste, can only prove beneficial to the region.

Relationship to Other Performing Providers' Projects in the RHP.

No other performing provider is implementing this same CWC initiative. However, this project will work in coordination with all other performing providers in the region to refer patients who present with health risks for follow-up and comprehensive care. We are fully committed to working with the other performing providers to ensure the triple aims are achieved.

Plan for Learning Collaborative

We plan to work with the UT School of Public Health as the facilitator to encourage the development of a learning collaborative during the project period. Working together to develop and implement a CWC and with other projects implementing health information exchange initiatives will bring to light many similarities among performing providers and will also highlight those areas where challenges can be overcome. Our experience with preventive care, health communication, and text message support for lifestyle changes will be resources we plan to bring to the learning collaborative. We anticipate a strong working relationship among universities, hospitals, and private performing providers.

Project Valuation:

The project will be valued based upon the successful attainment of the following:

- Develop and implement action plans for a CWC
- Improved early screening of health risks among low income, low health insurance populations
- Prevention and early intervention among high-risk patients
- Restructure staffing into community outreach teams that conduct proven effective CWC activities to patients.
- Collaborate with other performing providers to efficiently refer at risk patients into care.

Based on our previous implementation of the CWC we expect to reach 6,000 people with any combination of at least two components of the CWC (e.g. media, health screening or environmental change and text message support). At least 86 patients with initially uncontrolled blood pressure will achieve controlled blood pressure. Based on a very conservative estimate of lifetime costs saved just from strokes avoided in the population of 6,000 people (Taylor et al. 1996) better controlled blood pressure will result in $5.4 million in savings. Additional substantial cost savings will come from other avoided hospitalizations, chronic conditions including heart diseases, diabetes, and obesity since the CWC focuses on enhancing healthy lifestyles. Based on calculations from past economic evaluations of our CWC, we estimate additional substantial cost savings from this project from cases of diabetes avoided of another $7.9 million in lifetime savings. This project will have a high cost effectiveness ratio.

References

- *Bodenheimer,T., Lorig,K., Holman,H., and Grumbach,K. (2002). Patient self-management of chronic disease in primary care. JAMA 288, 2469-2475.*
- *Community Preventive Services Task Force. The Guide to Community Preventive Services. 2012. Centers for Disease Control and Prevention.*
- *Fisher-Hoch,S.P., Vatcheva,K.P., Laing,S.T., Hossain,M.M., Rahbar,M.H., Hanis,C.L., Brown,H.S., III, Rentfro,A.R., Reininger,B.M., and McCormick,J.B. (2012). Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a mexican american population, cameron county Hispanic cohort, 2003-2008. Prev. Chronic. Dis. 9, E135.*
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- *Witmer,A., Seifer,S.D., Finocchio,L., Leslie,J., and O'Neil,E.H. (1995). Community health workers: integral members of the health care work force. Am. J. Public Health 85, 1055-1058.*

085144601.2.4	*2.6.1*	*PROJECT COMPONENT(S)* *2.6.1*	**Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**
UTHSCSA			TPI - 085144601
Related Category 3 Outcome Measure(s): OD-1 Primary Care and Chronic Disease Management	*Unique Cat 3 ID: 085144601.3.8*	Category 3 outcome measure: IT-1.7	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)228** ***(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)
Process Milestone 1 [P-1]: Conduct an assessment of health promotion programs that involve community health workers at local and regional level. Metric 1 [P-1.1]: Document regional assessment Data Source: Performing Provider assessment and summary of findings Milestone 1 Estimated Incentive Payment: $1,716,089	**Process Milestone** 2: [P-3]. Implement, document and test an evidence-based innovative project for targeted population Metric 1 : P-3.1. Metric: Document implementation strategy and testing outcomes. Data Source: Evaluation report Milestone 2 Estimated Incentive Payment: $628,159 **Process Milestone 3** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 50% of staff participating in	**Process Milestone 5** [P-4]: Execution of a learning and diffusion strategy for testing spread and sustainability of best practices and lessons learned. Metric 1 [P-4.1]: Document learning and diffusion strategic plan Data Source: Performing provider report summarizing challenge faced and learning, testing and spread of best practice. Data Source: Evaluation report Milestone 5 Estimated Incentive Payment: $634,652 **Process Milestone 6** [P-5]: Execution of evaluation process for project innovation. P-5.1. Metric: Document evaluative process, tools and analytics. Data Source: Performing Provider contract or other documentation of evaluation Milestone 6 Estimated Incentive Payment: $634,652 **Improvement Milestone 7 [I-8]** Increase access to health promotion	**Process Milestone 8** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 50% of staff participating in patient navigation project will be present and identify "raise the floor" improvement. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-8.2]: Implement the "raise the floor" improvement

085144601.2.4	*2.6.1*	*PROJECT COMPONENT(S)* *2.6.1*	**Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**
UTHSCSA			TPI - 085144601
Related Category 3 Outcome Measure(s): OD-1 Primary Care and Chronic Disease Management	*Unique Cat 3 ID: 085144601.3.8*	Category 3 outcome measure: IT-1.7	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)228** ***(Standalone measure)***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	patient navigation project will be present and identify "raise the floor" improvement. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment: $628,159 **Improvement Milestone 4 [I-8]** Increase access to health promotion programs and activities using innovative project option. <u>Metric 1</u> [I-8.1]: Increase percentage of target population reached. Goal:: reach at least 1700 people in the target populations with at least two components of the CWC in DY 4 Data Source: population awareness surveys and CWC registry data Milestone 4 Estimated Incentive Payment: $628,160	programs and activities using innovative project option. <u>Metric 1</u> [I-8.1]: Increase percentage of target population reached. Goal:: reach at least 2000 people in the target populations with at least two components of the CWC in DY 4 Data Source: population awareness surveys and CWC registry data Milestone 7 Estimated Incentive Payment: $634,652	initiatives established at the semiannual meeting Goal: one raise the floor improvement will be documented within 6 months of semi-annual meeting 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 8 Estimated Incentive Payment: $973,891 **Improvement Milestone 9** [I-8]: Increase access to health promotion programs and activities using innovative project option. <u>Metric 1</u> [I-8.1]: Increase percentage of target population reached. Goal: reach at least 2300 people in the target populations with at least two components of the CWC in DY 5

085144601.2.4	*2.6.1*	*PROJECT COMPONENT(S)* *2.6.1*	**Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**	
		UTHSCSA		TPI - 085144601
Related Category 3 Outcome Measure(s): OD-1 Primary Care and Chronic Disease Management	*Unique Cat 3 ID: 085144601.3.8*	Category 3 outcome measure: IT-1.7	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)228** ***(Standalone measure)***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
				Data Source: population awareness surveys and CWC registry data Milestone 9 Estimated Incentive Payment: $973,890
Year 2 Estimated Milestone Bundle Amount: $1,716,089	Year 3 Estimated Milestone Bundle Amount: $1,884,478		Year 4 Estimated Milestone Bundle Amount: $1,903,956	Year 5 Estimated Milestone Bundle Amount: $1,947,781
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $7,452,304				

E. Category 3: Quality Improvements

The following narratives and accompanying tables describe each of the Pass 1 Category 3 improvement target outcomes selected for each Category 1 and Category 2 project by Performing Provider, in alphabetical order of provider.

***Title of Outcome Measure (Improvement Target)**: IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone Measure)*

Unique RHP Outcome Id Number 121989102.3.1
Performing Provider/TPI: Border Region Behavioral Health Center/121989102
Related Category 1 or Category 2 Projects: 121989102.1.1

Outcome Measure Description:
The Category 3 project chosen is IT-2.4 reduce preventable admissions for behavioral health/substance abuse.
Process Milestones and Metrics:

- DY2: P-1
- DY3: P-4

Outcome Improvement Target:

- DY4: IT-2.4
- DY5: IT-2.4

Rationale:
The three projects requested in Pass 1 of Region 5 are designed to support the goal of preventing hospital admissions. Specifically this goal refers to State Hospital, private psychiatric hospital and acute medical/surgical hospital admissions.
Outcome measure 2.4 was chosen as it serves as the overarching goal for the project. Other benefits are realized for the population served, but all these ultimately serve the purpose of reducing possible admissions. Inpatient admission represents interruptions in the client's life and work, and represents the most financially intensive intervention from the providers' perspective.
Process measures chosen represent management initiates currently under-practiced. Stakeholders generally do not focus on inpatient admissions and QI activities such as Plan Do Study are traditionally absent form the management culture but need to be implemented.
The Process milestones directly service the Region 5 goal of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

Outcome Measure Valuation:
The <u>population included</u> in these projects (1.11.2 or 1.14.1) is the entire adult and child/adolescent client population of Border Region Behavioral Health Center clinic in Starr County. The clinic has an active enrollment of approximately 325 adult and 175 child/adolescent clients.
The Pass 1 infrastructure projects 1.11.2 and 1.14.1 both support the Program Innovation and Redesign project 2.15.2. The impetus of the infrastructure projects is to make more licensed personnel available in the region. Needed licensed personnel such as LPHAs, nurses and psychiatrists are historically underrepresented in this region. Telecommunication infrastructure will permit contracting services for behavioral health, and in the case of 2.15.1, medical services that cannot be hired or contracted locally.

The expected impact of this project a decrease in inpatient admissions from 70 per year in DY1 to 63 per year by DY4 and 54 per year in DY5. This decrease will occur despite a 6% increase in general population projected for Starr County by DY5.

Specific description of Adult population served

a) - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

b) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

c) Initial Eligibility:
   (1) An individual age 18 or older who has a diagnosis of:
      (a) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes: 295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90.
      (b) bi-polar disorder as defined in the following DSM-IV TR diagnostic codes: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89.
      (c) major depression as defined in the following DSM-IV TR diagnostic codes : 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, and 296.36; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
   (2) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
   (3) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.
d) Individuals with only the following diagnoses are excluded from this provision:
   (1) Substance Abuse as defined in the following DSM-IV TR diagnostic codes: 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.89, 291.9, 292.0, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 303.00, 303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 305.00, 305.1, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90.
   (2) IDD as defined in the following DSM-IV TR diagnostic codes: 317, 318.0, 318.1, 318.2, 319.
   (3) Pervasive Developmental Disorder as defined in the following DSM-IV TR diagnostic codes: 299.00, 299.10, 299.80.

Persons with mental conditions referred by primary care or other providers but not meeting the above criteria may be eligible for services funded under transformation waiver 1115 projects.

Specific description of Child/Adolescent population:

a) – Children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:
   (1) Have a serious functional impairment; or
   (2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
   (3) Are enrolled in a school system's special education program because of serious emotional disturbance.
b) Age Limitations:
   (1) Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and
   (2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and
   (3) Youth receiving Children's MH Services who are approaching their 18th birthday and continue to be in need of services shall either be transferred to Adult MH Services on his/her 18th birthday or referred to another community provider, dependent upon the individual's needs. Youth reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult priority population criteria and served for up to one additional year.
   (4) For purposes of this contract definitions of "child" and "youth" are as follows:
      (a) Child: An individual who is at least three years of age, but younger than 13 years of age.
      (b) Youth: An individual who is at least 13 years of age, but younger than 18 years of age.

121989102.3.1	IT 2.4	Potentially Preventable Admissions	
Border Region Behavioral Health Center			121989102.3.1
Related Category 1 or 2 Projects:	121989102.1.1 & 121989102.1.2 & 121989102.2.1		
Starting Point/Baseline:	No telemedicine services exist in Starr 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 NA Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Facility minutes, documented reports. Process Milestone 2 Estimated Incentive Payment: $1,219	**Outcome Improvement Target 1** IT- 2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate *(Standalone measure)* 1. One for BH/SA as the principal diagnosis; 2. Second category in which a significant BH/SA secondary diagnosis is present Improvement Target: 10% decrease in admission rate from DY2 **Data Source:** Admissions data from CARE system, Anasazi Continuity of Care records Outcome Improvement Target 2 Estimated Incentive Payment*:* $ $~~2,181~~ 1,304	**Outcome Improvement Target 2 -** IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate *(Standalone measure)* 1. One for BH/SA as the principal diagnosis; 2. Second category in which a significant BH/SA secondary diagnosis is present Improvement Target:15 % decrease in admission rate from DY4 **Data Source:** Admissions data from CARE system, Anasazi Continuity of Care records Estimated Incentive Payment*:* $ $2,835
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):0	Year 3 Estimated Outcome Amount: $1,219	Year 4 Estimated Outcome Amount: $1,304	Year 5 Estimated Outcome Amount: $2,835
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $5,358			

Title of Outcome Measure Improvement Target: OD-2 Potentially Preventable Admissions IT-2.4 Behavioral Health/Substance Abuse Admission Rate
Unique Outcome Measure ID: 121989102.3.2
Performing Provider/TPI: Border Region Behavioral Health Center/121989102
Related Category 1 or 2 Projects: 121989102.1.2

Outcome Measure Description
The Category 3 project template describes various processes milestones and metrics for measuring the both the progress in acquiring and implementing the infrastructure plans and their effect on the implementation of the 1.14.1
The Quality Assurance activities defined in this Category 3 project address an approach to Quality Assurance which can be applied to each project. Included are
Process Milestones:
DY2: NA

DY3:

- P-4 Ongoing Plan-Do-Study-Act sessions in which activities such as data collection are evaluated, and initiatives conceived and reviewed.

Outcome Improvement Target:
DY4:

- IT-2.4 Behavioral Health/Substance Abuse admission rate – One for BH/SA as the principal diagnosis; Second in which a significant BH/SA secondary diagnosis is present

DY5:

- IT-2.4 Behavioral Health/Substance Abuse admission rate – One for BH/SA as the principal diagnosis; Second in which a significant BH/SA secondary diagnosis is present

Rationale:
The three projects requested in Pass 1 of Region 5 are designed to support the goal of preventing hospital admissions. Specifically this refers to State Hospital, private psychiatric hospital and acute medical/surgical hospital admissions.
Outcome measure 2.4 was chosen as it serves as the overarching goal for the project. Other benefits are realized for the population served, but all these ultimately serve the purpose of reducing possible admissions. Inpatient admission represents interruptions in the client's life and work, and represents the most financially intensive intervention from the providers' perspective.

Outcome Measure Valuation:
The population included in this (1.11.2 or 2.15.1) project is the entire adult and child/adolescent client population of Border Region Behavioral Health Center clinic in Starr County. The clinic has an active enrollment of approximately 325 adult and 175 child/adolescent clients.
The Pass 1 infrastructure projects (1.11.2 and 1.14.1) both support the Program Innovation and Redesign project 2.15.2. The impetus of the infrastructure projects is to make more licensed personnel available in the region. Needed licensed personnel such as LPHAs, nurses and psychiatrists are historically underrepresented in this region. Telecommunication infrastructure will permit contracting services for behavioral health, and in the case of 2.15.1, medical services that cannot be hired or contracted locally.

The expected impact of this project a decrease in inpatient admissions from 70 per year in DY1 to 63 per year by DY4 and 54 per year in DY5. This decrease will occur despite a 6% increase in general population projected for Starr County by DY5.

Specific description of Adult population served

d) - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

e) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

f) Initial Eligibility:
   (4) An individual age 18 or older who has a diagnosis of:
      (d) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes: 295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90.
      (e) bi-polar disorder as defined in the following DSM-IV TR diagnostic codes: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89.
      (f) major depression as defined in the following DSM-IV TR diagnostic codes : 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, and 296.36; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
   (5) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
   (6) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.

e) Individuals with only the following diagnoses are excluded from this provision:
   (4) Substance Abuse as defined in the following DSM-IV TR diagnostic codes: 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.89, 291.9, 292.0, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 303.00, 303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 305.00, 305.1, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90.
   (5) IDD as defined in the following DSM-IV TR diagnostic codes: 317, 318.0, 318.1, 318.2, 319.
   (6) Pervasive Developmental Disorder as defined in the following DSM-IV TR diagnostic codes: 299.00, 299.10, 299.80.

Persons with mental conditions referred by primary care or other providers but not meeting the above criteria may be eligible for services funded under transformation waiver 1115 projects.

Specific description of Child/Adolescent population:

c) – Children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:
   (4) Have a serious functional impairment; or
   (5) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
   (6) Are enrolled in a school system's special education program because of serious emotional disturbance.
d) Age Limitations:
   (1) Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and
   (2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and
   (3) Youth receiving Children's MH Services who are approaching their 18th birthday and continue to be in need of services shall either be transferred to Adult MH Services on his/her 18th birthday or referred to another community provider, dependent upon the individual's needs. Youth reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult priority population criteria and served for up to one additional year.
   (4) For purposes of this contract definitions of "child" and "youth" are as follows:
      (c) Child: An individual who is at least three years of age, but younger than 13 years of age.
      (d) Youth: An individual who is at least 13 years of age, but younger than 18 years of age.

121989102.3.2	IT-2.4	OD-2 Potentially Preventable Admissions	
Border Region Behavioral Health Center			121989102
Related Category 1 or 2 Projects:	121989102.1.2 & 121989102.1.1 &121989102.2.1		
Starting Point/Baseline:	*Admission rates available only for State Hospitals*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 **NA** Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Facility minutes, documented reports. Process Milestone 2 Estimated Incentive Payment: $28,646	**Outcome Improvement Target 1** IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate *(Standalone measure)* 1. One for BH/SA as the principal diagnosis; 2. Significant BH/SA secondary diagnosis is present. Improvement Target: 10% decrease in admission rate from DY2. **Data Source:** Admissions data from CARE system, Anasazi Continuity of Care records Outcome Improvement Target 1 Estimated Incentive Payment*:* $ $30,645	**Outcome Improvement Target 2** IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate *(Standalone measure)* 1. One for BH/SA as the principal diagnosis; 2. Significant BH/SA secondary diagnosis is present. Improvement Target:15% decrease in admission rate from DY4 **Data Source:** Admissions data from CARE system, Anasazi Continuity of Care records Outcome Improvement Target 2 Estimated Incentive Payment*:* $ $66,619
Year 2 Estimated Outcome Amount:(add incentive payment amounts from each milestone/outcome improvement target **0**	Year 3 Estimated Outcome Amount: $28,646	Year 4 Estimated Outcome Amount: $30,645	Year 5 Estimated Outcome Amount: $66,619
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $125,909			

Title of Outcome Measure Improvement Target: *OD-2 Potentially Preventable Admissions, IT-2.4 Behavioral Health/Substance Abuse Admission Rate*

Unique Outcome Measure Identification Number: 121989102.3.3
Performing Provider/TPI: Border Region Behavioral Health Center TPI: 121989102
Related Category 1 or 2 Projects: 121989102.2.1

Outcome Measure Description
The Category 3 project template describes various processes milestones and metrics for measuring the both the progress in acquiring and implementing the infrastructure plans and their effect on the implementation of the 2.15.1

The Quality Assurance activities defined in this Category 3 project address an approach to Quality Assurance, which can be applied to each project. Included are:

- Ongoing Plan-Do-Study-Act sessions in which activities such as data collection are evaluated, baselines established and initiatives conceived and reviewed.

Combined with process milestones and metrics from QA project and its related project 1.14.1, it is expected an accurate assessment of integrated health care's role and ability to reduce preventable admissions may be established.

Process Milestones:

- DY2: NA
- DY3: P-4

Outcome Improvement Target(s):

- DY4: IT-2.4
- DY5: IT-2.4

Rationale:
The three projects requested in Pass 1 of Region 5 are designed to support the goal of preventing hospital admissions. Specifically this refers to State Hospital, private psychiatric hospital and acute medical/surgical hospital admissions. Outcome measure 2.4 was chosen as it serves as the overarching goal for the project. Other benefits are realized for the population served, but all these ultimately serve the purpose of reducing possible admissions. Inpatient admission represents interruptions in the client's life and work, and represents the most financially intensive intervention from the providers' perspective.

Appropriate staffing is key the success of any program design. The overarching goal of these waiver proposals is to shift utilization patterns away from expense and often less effective public services and toward more cost effective community services. Understaffed programs also experience access issues, creating delays in services during which clients may decompensate further. The documented lack of credentialed staff in Region 20 makes workforce expansion a key component of these initiates.

Outcome Measure Valuation:
The <u>population included</u> in this project will be the patient panel selected to receive integrated primary and behavioral health services through the Region 5 Starr County clinic of Border Region

Behavioral Health Center. As a subset of the numerator for the improvement target (the number of admissions from the entire adult and child/adolescent client), specific data reporting will highlight these individuals. The clinic has an active enrollment of approximately 325 adult and 175 child/adolescent clients. Currently, no data has been gathered in Starr County on co-morbid diagnoses within the client population.
The Pass 1 infrastructure projects 1.11.2 and 1.14.1 both support the Program Innovation and Redesign project 2.15.2. The impetus of the infrastructure projects is to make more licensed personnel available in the region. Needed licensed personnel such as LPHAs, nurses and psychiatrists are historically underrepresented in this region. Telecommunication infrastructure will permit contracting services for behavioral health, and in the case of 2.15.1, medical services that cannot be hired or contracted locally.

The expected impact of this project a decrease in inpatient admissions from 70 per year in DY1 to 63 per year by DY4 and 54 per year in DY5. This decrease will occur despite a 6% increase in general population projected for Starr County by DY5.

Specific description of Adult population served

g) - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

h) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

i) Initial Eligibility:
   (7) An individual age 18 or older who has a diagnosis of:
      (g) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes: 295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90.
      (h) bi-polar disorder as defined in the following DSM-IV TR diagnostic codes: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89.
      (i) major depression as defined in the following DSM-IV TR diagnostic codes : 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, and 296.36; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
   (8) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
   (9) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.

f) Individuals with only the following diagnoses are excluded from this provision:
   (7) Substance Abuse as defined in the following DSM-IV TR diagnostic codes: 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.89, 291.9, 292.0, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 303.00, 303.90, 304.00, 304.10, 304.20, 304.30, 304.40,

304.50, 304.60, 304.80, 305.00, 305.1, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90.

(8) IDD as defined in the following DSM-IV TR diagnostic codes: 317, 318.0, 318.1, 318.2, 319.

(9) Pervasive Developmental Disorder as defined in the following DSM-IV TR diagnostic codes: 299.00, 299.10, 299.80.

Persons with mental conditions referred by primary care or other providers but not meeting the above criteria may be eligible for services funded under transformation waiver 1115 projects.

Specific description of Child/Adolescent population:

e) – Children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:

(7) Have a serious functional impairment; or

(8) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or

(9) Are enrolled in a school system's special education program because of serious emotional disturbance.

f) Age Limitations:

(1) Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and

(2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and

(3) Youth receiving Children's MH Services who are approaching their 18th birthday and continue to be in need of services shall either be transferred to Adult MH Services on his/her 18th birthday or referred to another community provider, dependent upon the individual's needs. Youth reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult priority population criteria and served for up to one additional year.

(4) For purposes of this contract definitions of "child" and "youth" are as follows:

(e) Child: An individual who is at least three years of age, but younger than 13 years of age.

(f) Youth: An individual who is at least 13 years of age, but younger than 18 years of age.

121989102.3.3	IT 2.4	OD-2 Potentially Preventable Admissions	
Border Region Behavioral Health Center			121989102
Related Category 1 or 2 Projects:	121989102.2.1 & 121989102.1.2 & 121989102.1.1		
Starting Point/Baseline:	No integrated health services exist, Admission data available only for State Hospitals		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 NA Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Facility minutes, documented reports. Process Milestone 2 Estimated Incentive Payment: $31,084	**Outcome Improvement Target 1** IT 2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate *(Standalone measure)* 1. One for BH/SA as the principal diagnosis; 2. Second category in which a significant BH/SA secondary diagnosis is present Improvement Target:10% decrease in admission rate from DY2 **Data Source**: Admissions data from CARE system, Anasazi Continuity of Care records Outcome Improvement Target 1 Estimated Incentive Payment*:* $ $33,253	**Outcome Improvement Target 2** IT -2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate *(Standalone measure)* 1. One for BH/SA as the principal diagnosis; 2. Second category in which a significant BH/SA secondary diagnosis is present Improvement Target:15% decrease in admission rate from DY4. **Data Source:** Admissions data from CARE system, Anasazi Continuity of Care records Outcome Improvement Target 2 Estimated Incentive Payment*:* $ $72,288
Year 2 Estimated Outcome Amount: (add incentive payment amounts from each milestone/outcome improvement target): 0	Year 3 Estimated Outcome Amount: $31,084	Year 4 Estimated Outcome Amount: $ $33,253	Year 5 Estimated Outcome Amount: $72,288
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5* $136,625			

Title of Outcome Measure (Improvement Target): *OD- 9 IT-9.2 ED appropriate utilization (Standalone Measure)*

Unique RHP Outcome Id Number 1219891-02.3.4
Performing Provider/TPI: Border Region Behavioral Health Center/1219891-02

Outcome Measure Description:
The Category 3 project chosen is IT 9.2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

Process Milestones:

- DY2: P-1 Project Planning. Engage Stakeholders, identify capacity, needed resources, establish timelines and document plan implementation
- DY3: P-4 Plan, Do, Study Act cycles to improve data collection, implementation

Outcome Improvement Target:

- DY4: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse
- DY5: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse

Rationale:
The Emergency Department plays a central role is the current crisis treatment systems. Being the second public resource is the progression of crisis intervention activities; it usually means the police (the first public resource) have already been utilized. The third public resource (Community mental health) is then utilized to determine if inpatient services are warranted and should be authorized. As an indicator of the effectiveness of outpatient program to reduce crisis events, the use of Emergency room visits and reduction in hospitalization is an important parameter of the effectiveness of outpatient interventions.

This Category 3 Quality Improvement project will provide additional input to conduct the on-going evaluation of the gap analysis and resultant improvement plan form the corresponding Category 1 project, 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

The Process milestones directly service the Region 5 goal of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

Outcome Measure Valuation:
The population included in these projects is the entire adult and child/adolescent population of Border Region Behavioral Health Center clinic in Starr County. The clinic has an active enrollment of approximately 325 adult and 175 child/adolescent clients and the county has a population of 29,000.

This allows both evaluation of new crisis planning on the enrolled population, plus permits the evaluation of non-enrolled persons as consumers of public resources in a behavioral crisis situation.

As each Border Region intervention at the emergency represents three public resources (police, hospital and Border Region) and costs per intervention can be reasonably determined for each, then any reduction in ER use from baseline represents a combined savings for these three resources. Any inpatient costs reductions following reduction Emegency Department use also represents a value attributed the interventions of these projects.

ER preventable admissions are expected to decrease 10% by DY4 from DY2 and decrease 15% from DY4 to DY5.

1219891-02.3.4	***OD-9***	***IT-9.2***	**Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.**
Border Region Behavioral Health Center			1219891-02.3.4
Related Category 1 or 2 Projects:	1219891-02.2.2 & 1219891-02.1.3		
Starting Point/Baseline:	No GAP analysis of Crisis Services has been implemented. Starr County provides over 1000 crisis interventions per year.		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans. Data Source: Attendance rosters, summary of meetings. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,742	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Facility minutes, documented reports. Process Milestone 2 Estimated Incentive Payment $29,851	**Outcome Improvement Target 1** 1. IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse Improvement Target: 10% decrease in number of ED visits from DY2 baseline Data Source: Admissions data from CARE system, Anasazi client record system encounter data Outcome Improvement Target 2 Estimated Incentive Payment*:* $ $29,851	**Outcome Improvement Target 2** 1. IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse Improvement Target: 30% decrease in number of ED visits from DY4 Data Source: Admissions data from CARE system, Anasazi client record system Encounter Estimated Incentive Payment*:* $ $59,701
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $14,742	Year 3 Estimated Outcome Amount: $29,851	Year 4 Estimated Outcome Amount: $ $29,851	Year 5 Estimated Outcome Amount: $59,701
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $134,145			

Title of Outcome Measure (Improvement Target): *OD- 9 IT-9.2 ED appropriate utilization (Standalone Measure)*

Unique RHP Outcome Id Number 121989102.3.5
Performing Provider/TPI: Border Region Behavioral Health Center/121989102

Outcome Measure Description:
The Category 3 project chosen is IT 9.2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

Process Milestones:

- DY2: P-1 Project Planning. Engage Stakeholders, identify capacity, needed resources, establish timelines and document plan implementation
- DY3: P-4 Plan, Do, Study Act cycles to improve data collection, implementation

Outcome Improvement Target:

- DY4: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse
- DY5: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse

Rationale:
The Emergency Department plays a central role is the current crisis treatment systems. Being the second public resource is the progression of crisis intervention activities; it usually means the police (the first public resource) have already been utilized. The third public resource (Community mental health) is then utilized to determine if inpatient services are warranted and should be authorized. As an indicator of the effectiveness of outpatient program to reduce crisis events, the use of Emergency room visits and reduction in hospitalization is an important parameter of the effectiveness of outpatient interventions.

This Category 3 Quality Improvement project will provide additional input to conduct the on-going evaluation of the gap analysis and resultant improvement plan form the corresponding Category 1 project, 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

The Process milestones directly service the Region 5 goal of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

Outcome Measure Valuation:
The population included in these projects is the entire adult and child/adolescent population of Border Region Behavioral Health Center clinic in Starr County. The clinic has an active enrollment of approximately 325 adult and 175 child/adolescent clients and the county has a population of 29,000. This allows both evaluation of new crisis planning on the enrolled population, plus permits the evaluation of non-enrolled persons as consumers of public resources in a behavioral crisis situation.

As each Border Region intervention at the emergency represents three public resources (police, hospital and Border Region) and costs per intervention can be reasonably determined for each, then any reduction in ER use from baseline represents a combined savings for these three resources. Any inpatient costs reductions following reduction Emergency Department use also represents a value attributed the interventions of these projects

ER preventable admissions are expected to decrease 10% by DY4 from DY2 and decrease 15% from DY4 to DY5.

Border Region Behavioral Health Center			1219891-02.3.5
Related Category 1 or 2 Projects:	121989102.2.2		
Starting Point/Baseline:	No GAP analysis of Crisis Services has been implemented. Starr County provides over 1000 crisis interventions per year.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans. Data Source: Attendance rosters, summary of meetings Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $22,113	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Facility minutes, documented reports. Process Milestone 2 Estimated Incentive Payment $44,776	**Outcome Improvement Target 1** 1. IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse. Improvement Target: Reduction of DY2 baseline of 10% Data Source: Admissions data from CARE system, Anasazi client record system encounter data Outcome Improvement Target 2 Estimated Incentive Payment*:* $44,776	**Outcome Improvement Target 2** 2. IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse Improvement Target: Reduction of DY4 # ED visits of 30% Data Source: Admissions data from CARE system, Anasazi client record system Encounter Estimated Incentive Payment*:* $89,552
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $22,113	Year 3 Estimated Outcome Amount: $44,776	Year 4 Estimated Outcome Amount: $44,776	Year 5 Estimated Outcome Amount: $89,552
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $201,217			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 160709501.3.1

Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Outcome Measure Description

OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

DY 5: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:
The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:
The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

160709501.3.1	3.IT-14.1	Number of practicing primary care physicians per 100,000 individuals	
Doctors Hospital at Renaissance			TPI 160709501
Related Category 1 or 2 Projects:	160709501.1.1		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $158,102 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $158,102	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,891 **Process Milestone 4 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,892	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $684,186	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,365,470
Year 2 Estimated Outcome Amount: $316,204	Year 3 Estimated Outcome Amount: $449,783	Year 4 Estimated Outcome Amount: $684,186	Year 5 Estimated Outcome Amount: $1,365,470
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,815,643			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 160709501.3.2

Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Outcome Measure Description
OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4:	IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline
DY 5:	IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:

The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

160709501.3.2	3.IT-14.1	Number of practicing primary care physicians per 100,000 individuals	
Doctors Hospital at Renaissance			TPI 160709501
Related Category 1 or 2 Projects:	160709501.1.2		
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 – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $158,102 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $158,102	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,891 **Process Milestone 4 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,892	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $684,186	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,365,470
Year 2 Estimated Outcome Amount: $316,204	Year 3 Estimated Outcome Amount: $449,783	Year 4 Estimated Outcome Amount: $684,186	Year 5 Estimated Outcome Amount: $1,365,470
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,815,643			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 160709501.3.3

Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Outcome Measure Description

OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

DY 5: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:

The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

160709501.3.3	3.IT-14.1	Number of practicing primary care physicians per 100,000 individuals	
Doctors Hospital at Renaissance			TPI 160709501
Related Category 1 or 2 Projects:	160709501.1.3		
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: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $158,102 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $158,102	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,891 **Process Milestone 4 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,892	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $684,186	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,365,470
Year 2 Estimated Outcome Amount: $316,204	Year 3 Estimated Outcome Amount: $449,783	Year 4 Estimated Outcome Amount: $684,186	Year 5 Estimated Outcome Amount: $1,365,470
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,815,643			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing specialty care practitioners per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 160709501.3.4

Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Outcome Measure Description

OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing specialty care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

DY 5: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:

The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

160709501.3.4	3.IT-14.1	Number of practicing specialty care physicians per 100,000 individuals in HPSA or MUA	
Doctors Hospital at Renaissance			TPI 160709501
Related Category 1 or 2 Projects:	160709501.1.4		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $158,102 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $158,102	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,891 **Process Milestone 4 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $224,892	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $684,186	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,365,470
Year 2 Estimated Outcome Amount: $316,204	Year 3 Estimated Outcome Amount: $449,783	Year 4 Estimated Outcome Amount: $684,186	Year 5 Estimated Outcome Amount: $1,365,470
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,815,643			

Title of Outcome Measure (Improvement Target): IT- 14.2 Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs (Stand-alone measure)

Unique RHP outcome identification number: 160709501.3.5
Outcome Measure Description:
IT- 14.2 Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs (Stand-alone measure)

Process Milestones:
DY2:

P-1: Project Expansion Planning: Engage stakeholders; define needed resources, document implementation plans

DY3:

P-2: Establish baseline rates for the improvement target. The cohort of 30 students (total of 80 in the program) will be accepted in DY2 and able to begin clinical rotations in August of 2014 (end of DY3)

-Baseline rates will be established from historical data derived from the latest class to complete the PA program which is the very beginning of DY2 in December.

Outcome Improvement Target:
DY4

IT-14.4: Increase the amount of PA students advancing through the program with their clinical rounds within RHP5. This will be an indicator for success in the long-term goal of producing an increased amount of PA's for RHP5.

DY5

IT-14.4: Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs. – December of 2015 (beginning of DY5) will be when the first cohort of 30 will be graduating the PA program increasing the amount of PA's within RHP5.

Rationale:

The long-term goal of this project is to train more physician assistants that will be available to provide healthcare services for the RHP5 community. This project will be an expansion of the current PA program that is available at UTPA, and will effectively collaborate with the resources of DHR to help provide the clinical rotations that are necessary to complete the program. In the near term, UTPA will have to heavily invest in the necessary recourses that are needed to properly support the newly expanded class of 80 then 100. The first cohort of 30 will be doing their clinical rounds as soon as DY4, and will finish the program by the beginning of DY5.

Improvement Targets – Improvement targets for this category 3 measure will be to increase the percentage of PA students admitted into the program and are graduating will be practicing in a HPSA by an increase of 20% in DY5. The baseline for the improvement target will be obtained from the historical numbers that were chosen in DY3 when the class of 2012 finishes in December of DY2.

Outcome Measure Valuation:

The project as a whole addresses a lack of primary care providers throughout the region. The first increase of students will be seen in the very first year (DY2) and reach full maturity of program acceptance in the second year (DY3). Seeing that a PA student only needs 2 ½ years to be accepted and graduate from the PASP program, and at less cost than traditional medical school, PAs will be available to go into the workforce and provide services for a community in need much faster than physicians will.

The PAs will be have been trained locally, and have a historically high percentage staying within the community to provide their services. Throughout their training, they will have completed their practicums at local hospitals, and with indigent care through the county clinics further increasing their awareness of the community needs. Their training and experience will be a valuable asset to the patients that will have increased access to healthcare due to an increased availability of provider.

160709501.3.5	OD1-IT.14.2	Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs (Stand-alone measure)	
Doctors Hospital at Renaissance		160709501	
Related Category 1 or 2 Projects:	Category 1 project: 160709501.1.5		
Starting Point/Baseline:	Baseline based off of class of 2012 (beginning of DY2)		
DY2 (10/1/12-9/30/13)	DY3 (10/1/13-9/30/14)	DY4 (10/1/14-9/30/15)	DY5 (10/1/15-9/30/16)
Process Milestone 1 (P-1): Project Expansion Planning: Engage stakeholders, define needed resources, document implementation plans **Data Source:** Local health department statistics, accreditation requirements for full program expansion **Goal/Baseline:** Complete implementation plan to ensure long-term success *Process Milestone 1 Estimated Incentive Payment:* ***$105,330.00***	**Process Milestone 2 (P-2)** Establish baseline rates for the improvement target basing information off of prior years data – Starting in August 2014, PA students in the first cohort of 30 will begin their clinical rotations. Baseline: Baseline will be set from graduating class of 2012 which is the beginning of DY2 to determine how many are staying within RHP5 and establishing the PA per 1000 individual ratio for that year. **Data Source:** Proprietary Information developed to keep track of PA students that complete the program. *Process Milestone 2 Estimated Incentive Payment:* ***$183,137.00***	**Process Milestone 3 (P-3)** IT-14.4: Percentage of graduates working in a MUA --- The first cohort of 30 will be in the middle of their clinical rounds for the entirety of DY4 providing additional healthcare services in the offices they are working. Starting in August 2015, PA students in the second cohort of 20 will begin their clinical rotations. *Process Milestone 3 Estimated Incentive Payment:* ***$261,220.00***	**Outcome Improvement Target 3 (IT-14.7):** IT-14.4: Percentage of graduates working in a MUA. --- December of 2015 is when the first cohort of 30 will be graduating expanding the class size from 50 to 80. **Goal:** Increase the percentage of graduates that practice in a HPSA or MUA by 3% over DY4 baseline **Metrics:** • Numerator: Number of graduates practicing in a HPSA • Denominator: Number of graduates from the PASP program at UTPA *Outcome Improvement Target 1 Estimated Incentive Payment:* ***$393,638.00***

Year 2 Outcome Amount: $105,330.00	Year 3 Outcome Amount: $183,137.00	Year 4 Outcome Amount: $261,220.00	Year 5 Outcome Amount: $393,638.00
Total Estimated Incentive Payments for 4-year period: $943,325.00			

Title of Outcome Measure (Improvement Target): IT-14.7: Percent of trainees who report that they plan to practice in HPSA or MUA based on systematic survey

Unique RHP outcome identification number: Doctors Hospital at Renaissance: 160709501.3.6

Outcome Measure Description:

IT-14.7: Percent of trainees who report that they plan to practice in HPSA or MUA based on systematic survey

Process Milestones:

DY2:

- P-1: Put into place a systematic survey for keeping track of percentages of students that report they will practice in a HPSAor MUA.
- P-2: Create a baseline for percentage of students that will practice in a HPSA
    - Numerator: Number of trainees who report that they will practice in a HPSA
    - Denominator: Number of trainees in the PASP program

DY3:

- P-3: Increase the numbers of trainees that are participating in clinical rounds throughout RHP5 and the performing provider's facilities.

Outcome Improvement Targets for Each Year:

DY4:

- IT-14.7: Increase the percentage of students that report they will practice in a HPSAor MUA by 6% over DY2 baseline.

DY5

- IT-14.7: Increase the percentage of students that report they will practice in a HPSA or MUAby 9% over DY2 baseline.

Rationale:

Process milestones –

P-1: Process milestone 1 simply sets up how the university will keep track of the students according to a set metrics to ensure an increase of those graduating will practice in a HPSA

P-2: Process milestone 2 uses the survey created by milestone 1 to gather the information of the PA class that year to create as the baseline for comparison in the rest of the demonstration years. (DY3-DY5)

P-3: Process milestone 3 demonstrates that the PA's will start clinical rounds at the end of DY3 and be in the middle of their program throughout DY4 and will be asked to complete the survey towards the end when they have more knowledge of what they would like to do.

Improvement Targets – Improvement targets for this category 3 measure will be to increase the percentage of PA students admitted into the program and are graduating will be practicing in a HPSAor MUA by 3% each consecutive year over the DY2 baseline which is derived from prior year's program data. The percentage amount may seem relatively low, but that is because historically the percentage of those going into primary

care is already high (65%). These improvement targets will be sought after in DY4 after the first cohort will have completed 14 months of clinical rounds and will have a better idea of where they want to practice.

Outcome Measure Valuation:

The project as a whole addresses a lack of primary care providers throughout the region. The first increase of students will be seen in the very first year (DY2) and reach full maturity of program acceptance in the second year (DY3). Seeing that a PA student only needs 2 ½ years to be accepted and graduate from the PASP program, and at less cost than traditional medical school, PAs will be available to go into the workforce and provide services for a community in need much faster than physicians will.

The PAs will be have been trained locally, and have a historically high percentage of staying within the community to provide their services. Throughout their training, they will have completed their practicum at local hospitals, and with indigent care through the county clinics further increasing their awareness of the community needs. Their training and experience will be a valuable asset to the patients that will have increased access to healthcare due to an increase of availability.

160709501.3.6	OD1-IT.14.7	Percent of trainees who report that they plan to practice in HPSA or MUA based on a systematic survey	
Doctors Hospital at Renaissance		160709501	
Related Category 1 or 2 Projects:	Category 1 project: 160709501.1.5		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Put into place a systematic survey for keeping track of percentages of students that report they will practice in a HPSA. **Data Source:** Documentation of the survey to be used for the incoming classes *Process Milestone 1 Estimated Incentive Payment: $52,665.00* **Process Milestone 2 (P-2):** Create a baseline for percentage of students that will practice in a HPSA **Metrics:** • Numerator: Number of trainees who report that they will practice in a HPSA • Denominator: Number of trainees in the PASP program *Process Milestone 2 Estimated Incentive Payment: $52,665.00*	**Process Milestone 2 (P-3)** : Increase the numbers of trainees that are participating in clinical rounds throughout RHP5 and the performing provider's facilities. --The first cohort of students will begin their clinical rotations come August of 2014. The surveys cannot be implemented yet at this point, but the PAs will start to experience what it is like to provide healthcare for patients within a MUA setting throughout the course of 48 weeks. **Data Source:** Rotation Schedule *Process Milestone 3 Estimated Incentive Payment : $183,137.00*	**Outcome Improvement Target 2 (IT-14.7):** IT-14.7: Increase the percentage of students that report they will practice in a HPSA or MUA by3% over DY2 baseline. **Metrics:** • Numerator: Number of trainees who report that they will practice in a HPSA or MUA • Denominator: Number of trainees in the PASP program *Outcome Improvement Target 2 Estimated Incentive Payment: $261,220.00*	**Outcome Improvement Target 3 (IT-14.7):** IT-14.7: Increase the percentage of students that report they will practice in a HPSA or MUA by6% over DY2 baseline. **Metrics:** • Numerator: Number of trainees who report that they will practice in a HPSA or MUA • Denominator: Number of trainees in the PASP program *Outcome Improvement Target 3 Estimated Incentive Payment: $393,638.00*

DY2 Estimated Incentive Payment: $105,330.00	DY3 Estimated Incentive Payment: $183,137.00	DY4 Estimated Incentive Payment: $261,220.00	DY5 Estimated Incentive Payment: $393,638.00

Title of Outcome Measure (Improvement Target): IT-14.8– percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey.
Unique RHP outcome identification number: Doctors Hospital at Renaissance: 160709501.3.7
Outcome Measure Description:
IT-14.8– percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey.

The majority of RHP5 providers serve a large percentage of Medicaid populations as they compile a large proportion of the population in the region. This measure will help demonstrate the increase of availability of healthcare that will be available for this particular segment of population within RHP5.

The survey that will be created for the students will educate them on the percentage of Medicaid populations, their area of highest concentrations, and what it means to keep this population healthy.

Process Milestones:
DY2:

- P-1: Put into place a systematic survey for keeping track of percentages of students that report they will serve Medicaid populations based on a systematic survey.
- P-2: Create a baseline for percentage of students that will serve Medicaid populations
    - Numerator: Number of trainees who report that they will serve Medicaid populations
    - Denominator: Number of trainees in the PASP program

DY3:

- P-3: Process milestone 3 demonstrates that the PA's will start clinical rounds at the end of DY3 and be in the middle of their program throughout DY4 and will be asked to complete the survey towards the end when they have more knowledge of what they would like to do.

Outcome Improvement Targets for Each Year:
DY4:

- IT-14.8: Increase the percentage of students that report they will serve Medicaid populations by 3% over DY2 baseline assuming that thresholds have not already been met for the class.

DY5

- IT-14.8: Increase the percentage of students that report they will serve Medicaid populations by 6% over DY2 baseline assuming that thresholds have not already been met for the class.

Rationale:

Process milestones –

P-1: Process milestone 1 simply sets up how the university will keep track of the students according to a set metrics to ensure an increase of those serving the Medicaid population throughout the region.

P-2: Process milestone 2 uses the survey created by milestone 1 to gather the information of the PA class that year to create as the baseline for comparison in the rest of the demonstration years. (DY3-DY5)

Improvement Targets – Improvement targets for this category 3 measure will be to increase the percentage of PA students admitted into the program and are graduating will be practicing in Medicaid population areas. The percentage amount may seem relatively low, but that is because historically the percentage of the Medicaid population density is already high throughout the entire region.

Outcome Measure Valuation:

The project as a whole addresses a lack of primary care providers throughout the region. The first increase of students will be seen in the very first year (DY2) and reach full maturity of program acceptance in the second year (DY3). Seeing that a PA student only needs 2 ½ years to be accepted and graduate from the PASP program, and at less cost than traditional medical school, PAs will be available to go into the workforce and provide services for a community in need much faster than physicians will.

The PAs will be have been trained locally, and have a historically high percentage of staying within the community to provide their services. Throughout their training, they will have completed their practicum at local hospitals, and with indigent care through the county clinics further increasing their awareness of the community needs. Their training and experience will be a valuable asset to the patients that will have increased access to healthcare due to an increase of availability.

160709501.3.7	OD1-IT.14.8	Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey.	
Doctors Hospital at Renaissance		160709501	
Related Category 1 or 2 Projects:	Category 1 project: 160709501.1.5		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Put into place a systematic survey for keeping track of percentages of students that report they will serve Medicaid populations based on a systematic survey. **Data Source:** Documentation of the survey to be used for the incoming classes *Process Milestone 1 Estimated Incentive Payment: $52,665.00* **Process Milestone 2 (P-2):** Create a baseline for percentage of students that will serve Medicaid populations. **Metrics:** • Numerator: Number of trainees who report that they will serve Medicaid populations • Denominator: Number of trainees in the PASP program	**Process Milestone (P-3)**: Process milestone 3 demonstrates that the PA's will start clinical rounds at the end of DY3 and be in the middle of their program throughout DY4 and will be asked to complete the survey towards the end when they have more knowledge of what they would like to do. **Metrics:** • Numerator: Number of trainees who report that they will serve Medicaid populations • Denominator: Number of trainees in the PASP program *Process Milestone 3 Estimated Incentive Payment : $183,137.00*	**Outcome Improvement Target 2 (IT-14.8):** IT-14.8: Increase the percentage of students that report they will serve Medicaid populations by 3% over DY2 baseline assuming that thresholds have not already been met for the class. **Metrics:** • Numerator: Number of trainees who report that they will serve Medicaid populations Denominator: Number of trainees in the PASP program *Outcome Improvement Target 1 Estimated Incentive Payment: $261,220.00*	**Outcome Improvement Target 3 (IT-14.8):** IT-14.8: Increase the percentage of students that report they will serve Medicaid populations by 6% over DY2 baseline assuming that thresholds have not already been met for the class. **Metrics:** • Numerator: Number of trainees who report that they will serve Medicaid populations Denominator: Number of trainees in the PASP program *Outcome Improvement Target 1 Estimated Incentive Payment: $393,638.00*

Process Milestone 2 Estimated Incentive Payment: $52,665.00			
DY2 Estimated Incentive Payment: $105,330.00	DY3 Estimated Incentive Payment: $183,137.00	DY4 Estimated Incentive Payment: $261,220.00	DY5 Estimated Incentive Payment: $393,638.00
Total Estimated Incentive Payments for 4-year period: $943,325.00			

Driscoll Children's Hospital – Category 3: Quality Improvements
Identifying Outcome Measure:
OD-7 Oral Health –IT-7.10, Other Outcome Improvement Target
Unique ID: 132812205.3.1 Identifying project and Provider Information: Driscoll Children's Hospital [TPI: 132812205]
Related Category 1 or 2 Project: 132812205.1.1

Outcome Measure Description:
The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in reducing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30 percent of all cases performed in the operating room for Calendar Year 2011 in other markets. Application of dental education and fluoride varnish treatments will reduce dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

IT-7.10 Other Outcome Improvement Target will be to decrease severe dental caries that result in operative interventions for targeted population in the Driscoll Service area by 5%.

Process Milestones:
- DY2
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3
  - P-2- Establish baseline of pediatric patients who receive treatment for severe dental caries in the operating room(s) for Driscoll service area.

Outcome Improvement Target(s) for each year:
- DY4
  - IT-7.10 - Decrease by 5% the number of severe dental caries that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments
- DY5
  - IT-7.10-Decrease by 10% the number of severe dental caries that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments

Rationale:
Data suggest a high utilization of dental procedures in the operating room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expansion of pediatric primary care oral health services is one key to improving overall health care delivery and health outcomes in the region. The outcome improvement target is by increasing access to dental education and fluoride varnish treatments we would then decrease carries that would result in operative intervention in our service delivery area.

Outcome Measure Valuation:
Application of dental fluoride varnish treatments coupled with education will reduce dental operating room procedures. Dental cases comprised of approximately 30 percent of all cases performed in the operating room for Calendar Year 2011 in other markets. The preventive treatment of dental education and fluoride varnish treatment versus dental operating room procedures creates significant value to our community.

Unique Cat 3 ID: 132812205.3.1	***Ref. Number from RHP PP:*** *3. IT-7.10*	*Other Outcome Improvement Target: Operative Dental Care Needs in Children*	
Performing Provider Name: Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	**Unique Category 1 Identifier -** 132812205.1.1		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Hospital/Health plan records. **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $150,000	**Process Milestone 2:** [P-2] Establish baseline of pediatric patients who receive treatment for severe dental caries in the operating room(s) for Driscoll service area. Numerator: Total number of Driscoll's Health plan children with severe dental caries requiring operative intervention during CY 2011. Denominator: Total number of Driscoll's Health plan participants who received dental education and fluoride varnish treatment for prevention of severe dental caries during CY 2011. **Data Source**: Documentation of claims data in RHP 4 market. **Process Milestone(s):** Estimated Incentive Payment: $150,000	**Outcome Improvement Target 1** [IT-7.10]: **Improvement Target**: Decrease by 5% the number of severe dental caries that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments **Data Source**: Documentation of claims data. **Outcome Improvement Target 2:** Estimated Incentive Payment*:* $225,000	**Outcome Improvement Target 2** [IT-7.10]: **Improvement Target**: Decrease of 10% the number of severe dental caries that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments **Data Source**: Documentation of claims data. **Outcome Improvement Target 2:** Estimated Incentive Payment*:* $495,000
Year 2 Estimated Outcome Amount: $150,000	Year 3 Estimated Outcome Amount: $150,000	Year 4 Estimated Outcome Amount: $225,000	Year 5 Estimated Outcome Amount: $495,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,020,000			

Identifying Outcome Measure and Provider Information:
Unique ID: 132812205.3.2
Identifying Project and Provider Information: Driscoll Children's Hospital [TPI: 132812205]

OD-8 Perinatal Outcome: IT-8.9 NICU Average Days per Delivery, TPI 2.6– Implement Evidence-based Health Promotion Programs

Outcome Measure Description:
The Project focuses on the current lack of informative and structured maternity social and healthcare supports available to indigent women during pregnancy as potential risk factors for these outcomes. Low-income pregnant women are prone to pre-term births for a variety of known as well as unknown reasons. Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in NICU inpatient days and pre-term/low-weight births are keys to improving overall health care delivery and health outcomes in the region.

IT-8.9 Reduce the Neonatal ICU days per delivery for the targeted population by 5 percent for DY4-5. The targeted population is defined within Category 3 Outcome table.

Process Milestones:

- DY2
  - P-1- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

- DY3
  - P-2- Undertake steps and actions to establish baselines to Reduce Average NICU days per delivery for the targeted population

Outcome Improvement Target(s) for each year:

- DY4
  - IT-8.9: Improvement Target: Average NICU days per Cadena member delivery will be at least 5% less than a Non-Cadena member (using CY2011 baseline information).
- DY5
  - IT-8.9: Improvement Target: Average NICU days per Cadena member delivery will be at least 10% less than a Non-Cadena member (using CY2011 baseline information).

Rationale:
Since the beginning of the Cadena de Madres Program, the number of Premature Infant Admissions less than 37 weeks has decreased significantly and as a result has reduced NICU costs for Managed Medicaid patients. Reduction in preterm births with a corresponding

reduction in NICU utilization are keys to improving overall health care delivery and health outcomes in the region. This outcome will be implemented in DY3 with improvement targets starting in DY4. Driscoll provides educational sessions and consulting visits to the public for multiple reasons, one of which is to help reduce ALOS for NICU patients.

Outcome Measure Valuation:
Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Neonatal ICU use is a high cost service line. Decreasing the number of premature infant admissions less than 37 weeks with a resulting decrease in the average NICU days per delivery is a more efficient use of resources as well as significantly decreasing complications for the infant. Expanding health education to high risk pregnant patients as well as increasing the number of women provided counseling sessions on tobacco and alcohol will create significant savings and value

Unique Cat 3 ID: 132812205.3.2	***Ref Number from RHP PP:*** **3.IT-8.9**	*Other Outcome Improvement Target: Reduce the Average Neonatal ICU days per delivery for the targeted population*	
Performing Provider Name: Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	**Unique Category 2 identifier –** 132812205.2.1		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of Meeting minutes/plans **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $250,000	**Process Milestone 2[P-2]:** Undertake steps and actions to establish baselines for the NICU days per delivery for the targeted population. **Numerator:** Total Days for Non-Cadena members during CY2011 **Denominator:** Total number of Non-Cadena member deliveries during CY2011 **Data Source**: Claims data/Hospital documentation (utilizing Region 4 data) **Process Milestone 2** Estimated Incentive Payment: $250,000	**Outcome Improvement Target 1** [IT-8.9]: Improvement Target: NICU days per delivery for Cadena members will be at least 5% less than Non-Cadena members (using CY2011 baseline information). **Numerator:** Total NICU Days for Cadena members in DY4 **Denominator**: Total number of Cadena member deliveries in DY4 **Data Source**: Claims data/Hospital documentation **Outcome Improvement Target 1** Estimated Incentive Payment*:* $375,000	**Outcome Improvement Target 2** [IT-8.9]: Improvement Target: NICU days per delivery for Cadena members will be at least ~~5%~~ 10% less than Non-Cadena members (using CY2011 baseline information). **Numerator:** Total NICU Days for Cadena members in DY5 **Denominator**: Total number of Cadena member deliveries in DY5 **Data Source**: Claims Data/Hospital documentation **Outcome Improvement Target 2** Estimated Incentive Payment*:* $825,000
Year 2 Estimated Outcome Amount: $250,000	Year 3 Estimated Outcome Amount: $250,000	Year 4 Estimated Outcome Amount: $375,000	Year 5 Estimated Outcome Amount: $825,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,700,000			

Identifying Outcome Measure:
OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies
Unique ID: 132812205.3.3
Identifying Project and Provider Information: *Driscoll Children's Hospital [TPI: 132812205]*
Related Category 1 or 2 Projects: 132812205.2.2

Outcome Measure Description:
IT-8.9 Other Outcome Improvement Target will be to increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.
Process Milestones:

- DY2
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3
  - P-2- Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients

Outcome Improvement Target(s) for each year:

- DY4
  - IT-8.9 Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.
- DY5
  - IT-8.9- Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.

Rationale:
The early detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. This potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

Outcome Measure Valuation:
The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities.

Unique Cat 3 ID: 132812205.3.3	Ref Number from RHP PP: 3.IT-8.9	Other Outcome Improvement Target: Early Detection of Maternal Fetal Anomalies	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier -132812205.2.2*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Documentation of meeting minutes. **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $ 400,000	**Process Milestone 2:** [P-2] Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients. Numerator: Total number of early detected maternal fetal anomalies over a 12-month period less total number of early detected maternal fetal anomalies over the prior 12-month period. Denominator: Total number of early detected maternal fetal anomalies over the prior 12-month period. **Data Source**: Hospital Record **Process Milestone 2:** Estimated Incentive Payment $400,000	**Outcome Improvement Target 2** [IT-8.9]: Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from prior demonstration year. **Data Source**: Hospital records Outcome Improvement Target 1 Estimated Incentive Payment*:* $600,000	**Outcome Improvement Target 3** [IT 8.9]: Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from baseline year. **Data Source**: Hospital records Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,320,000
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $400,000	Year 3 Estimated Outcome Amount: $400,000	Year 4 Estimated Outcome Amount: $600,000	Year 5 Estimated Outcome Amount: $1,320,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,720,000			

Title of Outcome Measure (Improvement Target): IT-1.10– HbA1c Poor Control
Unique RHP outcome identification number: 136332705.3.1
RHP Performing Provider: Starr County Memorial Hospital
Outcome Measure Description:

a. *Numerator:* Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
b. *Denominator:* Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

Process Milestones:
DY2:

- P-1: Documentation of project plan for documenting diabetic patients, creating follow-ups, and creating case management for high-risk diabetics (HbA1c > 9.0%).
- P-2: Create baseline by the end of DY2 for comparison bi-annually in DY3.

Outcome Improvement Targets for Each Year:
DY3:

- IT-1.10 Diabetes Care: HbA1c Poor Control
  - *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)
  - Goal: Decrease in HbA1c levels for those registered with a level above 9.0%

DY4:

- IT-1.10 Diabetes Care: HbA1c Poor Control
  - *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)
  - Goal: Decrease in HbA1c levels for those registered with a level above 9.0%

DY5

- IT-1.10 Diabetes Care: HbA1c Poor Control
  - *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)
  - Goal: Decrease in HbA1c levels for those registered with a level above 9.0%

Rationale:

Process milestones – Milestone 1 [P-1] was chosen so that the clinic will have a clear project plan that the staff can implement throughout the year. As the rest of the demonstration years pass, continuous quality improvements can be taken to ensure that new approaches are adopted to further the improve IT-1.10. A key feature will be the utilization of the EMR system to keep track of the diabetic discharges to help create follow-

ups and case management for diabetic patients that are considered to be "high-risk". Process milestone 2 will be geared towards gathering the data from the demonstration year to create the baseline that will be used through DY3 – DY5.

Improvement Targets – Improvement Target 1.10 (IT-1.10) will be assessed for improvement biannually in DY3. As processes are streamlined and more data becomes available, Star County Memorial Hospital's rural clinic will continue to decrease the number of patients that have an HbA1c level over 9.0%. With the baseline being set in DY2, there will be a 5% of the patients with decreased HbA1c levels in DY3. This goal will carry over through DY4 and DY5. As the data is compiled, procedures are implemented for efficiencies, and accessibility is increased throughout the clinic, the goals will be readjusted at the end of DY3.

Outcome Measure Valuation:

Improvement Target 1.10 is considered a standalone measure. This project's focus is expanding family care and obstetrical services in the Starr County's rural health clinic. In combination with Starr County Memorial Hospital, the rural health clinic serves as a major provider of healthcare in the county, SCMH emergency department is a vital access point to that healthcare. It becomes imperative that this service line is optimized to create greater access to services so that new initiatives can be put into place such as follow-up plans, high-risk user case management, referral patterns to the rural health clinic, all geared towards creating less readmissions and improving on preventable conditions.

136332705.3.1	OD1-IT.1.10	HbA1c Poor Control (<9.0%)	
Starr County Memorial Hospital		*136332705*	
Related Category 1 or 2 Projects:	Category 1 project: 136332705.1.1		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Documentation of project plan for documenting diabetic patients, creating follow-ups, and creating case management for high-risk diabetics (HbA1c > 9.0%). **Data Source:** Documentation of project plan and procedures ***Process Milestone 1 Estimated Incentive Payment: $$$*** **Process Milestone 2 (P-2):** Create baseline by the end of DY2 for comparison bi-annually in DY3. **Metrics:** • *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) ***Process Milestone Estimated Incentive Payment: $63,831.00***	**Outcome Improvement Target 1 (IT-1.10):** • *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) • *Goal:* Decrease in HbA1c levels for those registered with a level above 9.0% ***Outcome Improvement Target 1 Estimated Incentive Payment: $35,599.00***	**Outcome Improvement Target 2 (IT-1.10):** • *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) • *Goal:* Decrease in HbA1c levels for those registered with a level above 9.0% ***Outcome Improvement Target 2 Estimated Incentive Payment: $76,437.00***	**Outcome Improvement Target 3 (IT-1.10):** • *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) • *Goal:* Decrease in HbA1c levels for those registered with a level above 9.0% ***Outcome Improvement Target 3 Estimated Incentive Payment: $171,563.00***

Total Estimated Incentive Payments for 4-year period: **$347,430.00**

Title of Outcome Measure (Improvement Target): IT-1.13 – Diabetes Care Foot Exam
Unique RHP outcome identification number:136332705.3.2
Outcome Measure Description:
IT-1.13 – Diabetes care Foot Exam

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.

b. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2)

Process Milestones:
DY2:

- P-1: Put into place documentation metrics for diabetic patients & results of their individual foot exam;
- P-2: Create baseline for patients receiving foot exam for comparison in DY3

Outcome Improvement Targets for Each Year:
DY3:

- IT-1.13: Increase the number of adult patients receiving foot exam by 10% over DY2 baseline unless this procedure is already at maximum utilization within 10% deviation.

DY4:

- IT-1.13: Increase the number of adult patients receiving foot exam by 15% over DY2 baseline unless this procedure is already at maximum utilization within 10% deviation.

DY5

- IT-1.13: Increase the number of adult patients receiving foot exam by 18% over DY2 baseline unless this procedure is already at maximum utilization within 10% deviation.

Rationale:

Process milestones - P-1 & P-2 were chosen due to an effort to create procedures through the clinic to check the patients' feet in efforts to prevent conditions and admissions. Incorporating foot exams for every patient will be a new customary procedure, for this reason, P-1 was created so that proper documentation will be created throughout the process. Results of the foot exam, such as any possible conditions, will be documented and kept track of to build data through DY5 and onward. In order to create a baseline for comparison in DY3-DY5, P-2 was put into place to assess how many patients are able to be seen with-in the time frame given in DY2. It will be calculated as a percentage of patients as opposed to a general number to ensure that the most patients possible are receiving this service regardless of an increase or decrease in patient flux. IT-1.13 specifies that diabetic patients are to be kept track, but in best interest of the community as a whole, this service will be extended to every patient that is serviced within SMCH and at the rural health clinic.

Improvement Targets –Improvement targets for this category 3 measure are simply to increase the percentage amount of foot exams that are provided to the patients through DY3-DY5. If the thresholds have already been met, as in the percentages of patients being given a foot exam cannot go higher already, then the SCMH will strive to maintain that percentage.

Outcome Measure Valuation:

Improvement Target 1.13 is a non-standalone measure, and is relatively easy to do yet has high cost-saving potential. This measure targets the diabetic population, but to keep the communities interest in focus at large, the scope of the target population is extended to every patient that is able to receive surgical services within SCMH. Screens done on the feet can address open wounds, poor circulation, and developing conditions which can be documented and treatment plan created.

136332705.3.2	OD1-IT.1.13	Patient Foot Exam	
Starr County Memorial Hospital		*136332705*	
Related Category 1 or 2 Projects:	Category 1 project: 136332705.1.2		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Project Planning; creating metrics for documentation for exam and all occurring results. **Data Source:** Documentation of foot exam; EMR records; billing *Process Milestone 1 Estimated Incentive Payment:* ***$13,344.00*** **Process Milestone 2 (P-2):** Create baseline for percentages of patients receiving foot exam. **Metrics:** a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year. b. Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2) *Process Milestone 2 Estimated Incentive Payment:* ***$13,344.00***	**Outcome Improvement Target 1 (IT-1.13):** Increase the number of adult patients receiving foot exam by 10% over DY2 baseline unless this procedure is already at maximum utilization within 10% deviation. *Outcome Improvement Target 1 Estimated Incentive Payment: $51,267.00*	**Outcome Improvement Target 2 (IT-1.13):** Increase the number of adult patients receiving foot exam by 15% over DY2 baseline unless this procedure is already at maximum utilization within 10% deviation. *Outcome Improvement Target 2 Estimated Incentive Payment: $75,876.00*	**Outcome Improvement Target 3 (IT-1.13):** Increase the number of adult patients receiving foot exam by 18% over DY2 baseline unless this procedure is already at maximum utilization within 10% deviation. *Outcome Improvement Target 3 Estimated Incentive Payment: $185,732.00*

DY 2 Estimated Incentive Payment: $26,688.00	DY 3 Estimated Incentive Payment: $51,267.00	DY 4 Estimated Incentive Payment: $75,876.00	DY 5 Estimated Incentive Payment: $185,732.00

Title of Outcome Measure (Improvement Target): IT-4.4– Surgical Site Infections (SSI)
Unique RHP outcome identification number:136332705.3.3
Outcome Measure Description:
IT-4.4 Surgical site infections (SSI) rates

IT-4.4 will focus on decreasing SSI rates that are designated by IQR criteria.[76]

Process Milestones:
DY2:

- P-1: Create plan for implementing constant quality improvement procedures for general surgery including all staff and surgical site.
- P-2: Create baseline by the end of DY2 for the number of complications addressed and/or prevented. It will be reported by a ratio of complications/procedures.

Outcome Improvement Targets for Each Year:
DY3:

- IT-4.4: Improvement in SSIs
    - As general surgery volumes increase, a 5% improvement over DY2 baseline on SSI will be the achievement goal.

DY4:

- IT-4.1: Improvement in SSIs
    - As general surgery volumes increase, a 3% improvement over DY3 on SSI will be the achievement goal.

DY5

- IT-4.1: Improvement in SSIs
    - As general surgery volumes increase, a 3% improvement over DY4 on SSI will be the achievement goal.

Rationale:

Process milestones - P-1 & P-2 are implemented throughout DY2 to have documentation in place for the general surgery staff, and all other support staff so everyone understands the focus of the quality improvement measures & mindset. This project increases the accessibility of general surgery accessibility from the current two days a week, to a full five days a week. As volumes are expected to increase, milestone 1 (P-1) will create plan documents that will implement constant quality improvement and focus on the SSI requirements that are stipulated according to the CDC[6]. The data will be collected at the end of DY2 (Milestone 2 [P-2]) for comparison in DY3 allowing enough time for adequate results creating the baseline.

Improvement Targets – Improvement Target 4.4 (IT-4.4) will be assessed for improvement biannually in DY3. As processes are streamlined and more data becomes available, Star County Memorial Hospital will

[76]http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf?agree=yes&next=Accept

generate at least 5% increases of improvements over the SSI developed through general surgery in DY3. With the recent expansion of availability, creating optimal utilization rates are still underway, so the amount of preventable SSI will taper down slightly through DY5 until the rates reach their thresholds allowing a greater volume of preventable SSIs with the implementation of continuous quality improvements.

Outcome Measure Valuation:

Improvement Target 4.4 is considered a standalone measure. This project's focus is expanding accessibility to general surgery creating efficient utilization of staff and current facility resources. IT-4.4 is a measure that is centered on preventing surgical site infections, and as a result developing constant quality improvement measures with increasing surgical volumes. Amongst the most common complications include: surgical site infections and postoperative sepsis, cardiovascular complications, respiratory complications (including postoperative pneumonia), and thromboembolic complications, each of which increase the hospital length of stay[77]. Baselines will have to be created using the time allowed by DY2 to gather enough data. Through the country, the average SSI rate is between 1%-3%, so a national standard[78] will set the standard for SCMH to meet and further improve on.

[77]http://cid.oxfordjournals.org/content/43/3/322.full

[78]http://www.cdc.gov/hai/pdfs/ssi/ssi_tagged.pdf

136332705.3.3	OD1-IT.4.4	Improvement of SSI rates	
Starr County Memorial Hospital		*136332705*	
Related Category 1 or 2 Projects:	Category 1 project: 136332705.1.2		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Create plan for implementing constant quality improvement procedures for general surgery including all staff and surgical site. **Data Source:** Documentation of project plan and procedures *Process Milestone 1 Estimated Incentive Payment: $13,344.00* **Process Milestone 2 (P-2):** Create baseline by the end of DY2 for the number of complications addressed and/or prevented. It will be reported by a ratio of complications/procedures. **Metrics:** • Numerator: Number of site infections for general surgery • Denominator: Number of general surgery procedures	**Outcome Improvement Target 1 (IT-4.4):** As general surgery volumes increase, a 5% improvement on SSI's over DY2baseline will be the achievement goal. **Metrics:** • Numerator: Number of site infections for general surgery • Denominator: Number of general surgery procedures *Outcome Improvement Target 1 Estimated Incentive Payment: $51,267.00*	**Outcome Improvement Target 2 (IT-4.4):** As general surgery volumes increase, a 3% DY3 outcome improvement on SSI's will be the achievement goal. **Metrics:** • Numerator: Number of site infections for general surgery • Denominator: Number of general surgery procedures *Outcome Improvement Target 2 Estimated Incentive Payment: $75,876.00*	**Outcome Improvement Target 3 (IT-4.4):** As general surgery volumes increase, a 3% over DY4 outcome improvement on SSI's will be the achievement goal. **Metrics:** • Numerator: Number of site infections for general surgery • Denominator: Number of general surgery procedures *Outcome Improvement Target 3 Estimated Incentive Payment: $185,731.00*

Process Milestone 2 Estimated Incentive Payment: $13,344.00			
Total Estimated Incentive Payments for 4-year period: $339,562.00			

Title of Outcome Measure (Improvement Target): IT-3.3– Diabetes 30 day readmission rate
Unique RHP outcome identification number: 136332705.3.4
Outcome Measure Description:

A. Numerator: The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
B. Denominator: The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Process Milestones:
DY2:

- P-1: Documentation of project plan for documenting diabetic patients, creating follow-ups, and creating case management for high-risk emergency department users.
- P-2: Create baseline by the end of DY2 for comparison bi-annually in DY3.

Outcome Improvement Targets for Each Year:
DY3:

- IT-3.3: Diabetes 30 day readmission rate:
    - Numerator: The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
    - Denominator: The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.
    - Goal: Decrease readmission rate by 5%

DY4:

- IT-3.3: Diabetes 30 day readmission rate:
    - Numerator: The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
    - Denominator: The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.
    - Goal: Decrease readmission rate by 5%

DY5

- IT-3.3: Diabetes 30 day readmission rate:
    - Numerator: The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

- Denominator: The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.
- Goal: Decrease readmission rate by 5%

Rationale:

Process milestones - P-1 & P-2 are implemented throughout DY2 to have project documentation in place to ensure that the whole staff is on track ensuring a top-down approach of buy-in for this improvement target. A key feature will be the utilization of the EMR system to keep track of the diabetic discharges to help create follow-ups with the rural health clinic, and some case management for the high-risk frequent emergency department users. Process milestone 2 will be geared towards gathering the data from the demonstration year to create the baseline that will be used through DY3 – DY5.

Improvement Targets – Improvement Target 3.7(IT-3.3) will be assessed for improvement biannually in DY3. As processes are streamlined and more data becomes available, Star County Memorial Hospital will generate at least 5% increases of improvements over the SSI developed through general surgery in DY3. With the recent expansion of availability, creating optimal utilization rates are still underway, so the amount of preventable SSI will taper down slightly through DY5 until the rates reach their thresholds allowing a greater volume of preventable SSIs with the implementation of continuous quality improvements.

Outcome Measure Valuation:

Improvement Target 3.3 is considered a standalone measure. This project's focus is creating efficiencies of throughput in the Starr County Memorial Hospital emergency department (ED). Serving as a major provider of healthcare in the county, SCMH emergency department is a vital access point to that healthcare. It becomes imperative that this service line is optimized to create greater access to services so that new initiatives can be put into place such as follow-up plans, high-risk user case management, referral patterns to the rural health clinic, all geared towards creating less readmissions and improving on preventable conditions.

136332705.3.4	OD3-IT.3.3	Diabetic 30 day readmissions	
Starr County Memorial Hospital		*136332705*	
Related Category 1 or 2 Projects:	Category 2 project: 136332705.2.1		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Documentation of project plan for documenting diabetic patients, creating follow-ups, and creating case management for high-risk emergency department users. **Data Source:** Documentation of project plan and procedures *Process Milestone 1 Estimated Incentive Payment: $9,375.00* **Process Milestone 2 (P-2):** Create baseline by the end of DY2 for comparison bi-annually in DY3. **Metrics:** • *Numerator:* The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.	**Outcome Improvement Target 1 (IT-3.3):** • *Numerator:* The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. • *Denominator:* The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. • *Goal:* Decrease readmissions rate by 5% over baseline	**Outcome Improvement Target 2 (IT-3.3):** • *Numerator:* The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. • *Denominator:* The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. • *Goal:* Decrease readmissions rate by 7% over baseline	**Outcome Improvement Target 3 (IT-3.3):** • *Numerator:* The number of readmissions (ages 18 and over), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. • *Denominator:* The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. • *Goal:* Decrease readmissions rate by 11% over baseline

• *Denominator:* The number of admissions (ages 18 and over), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. ***Data Source:*** EMR records & Claims *Process Milestone 2 Estimated Incentive Payment: $9,375.00* DY2 Annual Incentive Amount: ***$18,750.00***	**Data Source:** EMR; Claims History *Outcome Improvement Target 1 Estimated Incentive Payment: $18,750.00* DY3 Annual Incentive Amount: ***$18,750.00***	**Data Source:** EMR; Claims History *Outcome Improvement Target 2 Estimated Incentive Payment: $28,125.00* DY4 Annual Incentive Amount: ***$28,125.00***	**Data Source:** EMR; Claims History *Outcome Improvement Target 3 Estimated Incentive Payment: $61,875.00* DY5 Annual Incentive Amount: ***$61,875.00***
Total Estimated Incentive Payments for 4-year period: $127,500.00			

Title of Outcome Measure (Improvement Target): IT-6.1– Patient Satisfaction
Unique RHP outcome identification number: 136332705.3.5
Outcome Measure Description:
IT-6.1 Percent Improvement over baseline of patient satisfaction scores

Percent improvement over baseline of patient satisfaction scores for one or more of patient satisfaction domains that the provider target for improvement in a specific tool.

a. Numerator: Percent improvement in targeted patient satisfaction domain
b. Data Source: Patient survey
c. Denominator: Number of patients who were administered the survey

Process Milestones:
DY2:

- P-1: Assess which tools want to be focused on for patient satisfaction
- P-2: Create baseline for patients receiving the survey

Outcome Improvement Targets for Each Year:
DY3:

- IT-6.1: Patient Satisfaction Survey
    - Increase the amount of patients completing the survey by 10%; insuring that patient literacy levels are catered to and adjusted accordingly.

DY4:

- IT-6.1: Patient Satisfaction Survey
    - Increase the amount of patients completing the survey by 10%; insuring that patient literacy levels are catered to and adjusted accordingly.

DY5

- IT-6.1: Patient Satisfaction Survey
    - Increase the amount of patients completing the survey by 10%; insuring that patient literacy levels are catered to and adjusted accordingly.

Rationale:

Process milestones - P-1 & P-2 were chosen as an initiative to implement continuous quality improvement of care from the patient's perspective. Milestone 1 (P-1), for improvement target 6.1, will allow the clinic to assess which tools would fit their criteria of care the best. Milestone 2 (P-2) will create the baseline as surveys are distributed to the patients and results are returned. The data will be collected at the end of DY2 for comparison in DY3 allowing enough time for adequate results. Pending the results is how the clinic will adjust its outreach to the patients for the surveys to help ensure they are comfortable and completing the surveys and an adjusted literacy level.

Improvement Targets – Improvement Target 6.1 will be assessed for improvement biannually in DY3. There will be a 10% increase in survey completion for the year assuming that there isn't a 100% completion rate within the clinic. Adjustments can be made to help ensure that the patients

are receiving and returning the surveys complete. These surveys will introduce a new point of view in efforts of continuous quality improvement and innovation towards access, safety, and efficiency.

Outcome Measure Valuation:
Improvement Target 6.1 is considered a standalone measure. This measure was implemented to create incentives for this clinic to improve their quality of care. As surveys are completed, and the process is streamlined to help gather a high percentage of completion, continuous quality improvement will be heavily focused upon. Such improvements will focus on accessibility, safety, and efficiencies of service, increasing its value to the community as major health provider.

136332705.3.5	OD6-IT.6.1	Increasing Patient Satisfaction	
Starr County Memorial Hospital		*136332705*	
Related Category 1 or 2 Projects:	Category 2 project: 136332705.2.1		
Starting Point/Baseline:	Established at the end of DY2		
DY2(10/1/12-9/30/13)	DY3(10/1/13-9/30/14)	DY4(10/1/14-9/30/15)	DY5(10/1/15-9/30/16)
Process Milestone 1 (P-1): Assess which survey tools need to be focused upon for patient satisfaction. **Data Source:** Creation/adoption of acceptable survey such as CG-CAHPS. *Process Milestone 1 Estimated Incentive Payment: $9,375.00* **Process Milestone 2 (P-2):** Create baseline foroutcome (satisfaction) percentages of patients receiving &completing the assessment survey. **Metrics:** • Numerator: Percent improvement in targeted patient satisfaction domain • Denominator: Number of patients who were administered the survey **Data Source:** Collection of surveys *Process Milestone 2 Estimated Incentive Payment: $9,375.00*	**Outcome Improvement Target 1 (IT-6.1):** Increase the amount of patients completing the survey by 10% over DY2 baseline, increase patient satisfaction scores by 5% over DY2 baseline; insuring that patient literacy levels are catered to and adjusted accordingly. **Metrics:** • Numerator: Percent improvement in targeted patient satisfaction domain • Denominator: Number of patients who were administered the survey **Data Source:** Collection of surveys *Outcome Improvement Target 1 Estimated Incentive Payment: $18,750.00*	**Outcome Improvement Target 2 (IT-6.1):** Increase the amount of patients completing the survey by 12% over DY2 baseline; increase patient satisfaction scores by 7% over DY2 baselineinsuring that patient literacy levels are catered to and adjusted accordingly. **Metrics:** • Numerator: Percent improvement in targeted patient satisfaction domain • Denominator: Number of patients who were administered the survey **Data Source:** Collection of surveys *Outcome Improvement Target 2 Estimated Incentive Payment: $28,125.00*	**Outcome Improvement Target 3 (IT-6.1):** Increase the amount of patients completing the survey by 15% over DY2 baseline; increase patient satisfaction scores by 10% over DY2 baselineinsuring that patient literacy levels are catered to and adjusted accordingly. **Metrics:** • Numerator: Percent improvement in targeted patient satisfaction domain • Denominator: Number of patients who were administered the survey **Data Source:** Collection of surveys *Outcome Improvement Target 3 Estimated Incentive Payment: $61,875.00*
DY2 Estimated Outcome Amount: ***$18,750.00***	DY3 Estimated Outcome Amount: ***$18,750.00***	DY4 Estimated Outcome Amount: ***$28,125.00***	DY5 Estimated Outcome Amount: ***$61,875.00***

Total Estimated Incentive Payments for 4-year period: ***$127,500.00***

Tropical Texas Behavioral Health – Category 3

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure Identification Number: 138708601.3.1
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.
Related Category 1 or 2 Project: 138708601.1.1

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Expand Primary Care Capacity project by the DY indicated:

- DY2-DY3:
  - Process Milestone: P-4
- DY4-DY5:
  - Outcome Domain: OD-6
  - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction

was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.1	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.1.1*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $269,728	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $337,129	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $355,518	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $601,817
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $269,728	Year 3 Estimated Outcome Amount: $337,129	Year 4 Estimated Outcome Amount: $355,518	Year 5 Estimated Outcome Amount: $601,817
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,564,192			

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure Identification number: 138708601.3.2
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.
Related Category 1 or 2 Project: 138708601.1.2

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Expand Primary Care Capacity project by the DY indicated:

- DY2-DY3:
  - Process Milestone: P-4
- DY4-DY5:
  - Outcome Domain: OD-6
  - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has

demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.2	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.1.2*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $73,440	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $140,124	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $147,767	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $250,139
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,440	Year 3 Estimated Outcome Amount: $140,124	Year 4 Estimated Outcome Amount: $147,767	Year 5 Estimated Outcome Amount: $250,139
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $611,470			

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure identification number: 138708601.3.3
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Related Category 1 or 2 Project: 138708601.1.3

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Expand Primary Care Capacity project by the DY indicated:

- DY2-DY3:
  - Process Milestone: P-4
- DY4-DY5:
  - Outcome Domain: OD-6
  - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has

demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.3	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.1.3*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $15,055	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $84,224	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $88,818	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $150,350
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $15,055	Year 3 Estimated Outcome Amount: $84,224	Year 4 Estimated Outcome Amount: $88,818	Year 5 Estimated Outcome Amount: $150,350
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $338,447			

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure identification number: 138708601.3.4
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Related Category 1 or 2 Project: 138708601.2.1

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Integrate Primary and Behavioral Health Care Services project by the DY indicated:

- DY2-DY3:
  - Process Milestone: P-4
- DY4-DY5:
  - Outcome Domain: OD-6
  - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has

demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.4	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.1*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $202,605	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $457,426	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $482,377	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,125,683
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $202,605	Year 3 Estimated Outcome Amount: $457,426	Year 4 Estimated Outcome Amount: $482,377	Year 5 Estimated Outcome Amount: $1,125,683
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,268,091			

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure identification number: 138708601.3.5
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Related Category 1 or 2 Project: 138708601.2.2

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting project by the DY indicated:

- DY2-DY3:
    - Process Milestone: P-4
- DY4-DY5:
    - Outcome Domain: OD-6
    - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports

the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.5	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.2*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $195,919	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $379,266	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $399,953	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $677,036
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $195,919	Year 3 Estimated Outcome Amount: $379,266	Year 4 Estimated Outcome Amount: $399,953	Year 5 Estimated Outcome Amount: $677,036
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,652,174			

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure identification number: 138708601.3.6
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Related Category 1 or 2 Project: 138708601.2.3

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Integrate Primary and Behavioral Health Care Services project by the DY indicated:

- DY2-DY3:
  - Process Milestone: P-4
- DY4-DY5:
  - Outcome Domain: OD-6
  - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has

demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.6	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.3*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $918	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3,474	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $3,664	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $6,202
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $918	Year 3 Estimated Outcome Amount: $3,474	Year 4 Estimated Outcome Amount: $3,664	Year 5 Estimated Outcome Amount: $6,202
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $14,258			

Identifying Outcome Measure:
OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores
RHP Outcome Measure identification number: 138708601.3.7
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601
Related Category 1 or 2 Project: 138708601.2.4

Outcome Measure Description:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Expand Chronic Care Management Models project by the DY indicated:

- DY2-DY3:
    - Process Milestone: P-4
- DY4-DY5:
    - Outcome Domain: OD-6
    - Improvement Target: IT-6.1(5)

Rationale:
The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has

demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.7	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.4*		
Starting Point/Baseline:	*To Be Determined (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-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $6,005	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $367,400	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $415,351	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. Improvement Target: [TBD] Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,300,487
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,005	Year 3 Estimated Outcome Amount: $367,400	Year 4 Estimated Outcome Amount: $415,351	Year 5 Estimated Outcome Amount: $1,300,487
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,089,243			

Identifying Outcome Measure and Provider Information:

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

RHP Outcome Measure Identification Number: 138708601.3.8

Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.

Related Category 1 or 2 Project: 138708601.1.4

Outcome Measure Description:

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Expand Telemedicine/Telehealth project by the DY indicated:

- DY2-DY3:
  - Process Milestone: P-4
- DY4-DY5:
  - Outcome Domain: OD-6

- Improvement Target: IT-6.1(5)

Rationale:

The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:

The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.8	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $66,984	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $10,096	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. • Improvement Target: [TBD] • Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $23,203	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. • Improvement Target: [TBD] • Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment: $96,655
Year 2 Estimated Outcome Amount: *(add incentive payments amounts from each milestone/outcome improvement target)*: $66,984	Year 3 Estimated Outcome Amount: $10,096	Year 4 Estimated Outcome Amount: $23,203	Year 5 Estimated Outcome Amount: $96,655
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $196,938			

Identifying Outcome Measure and Provider Information:

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

RHP Outcome Measure Identification Number: 138708601.3.9

Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.

Related Category 1 or 2 Project: 138708601.2.5

Outcome Measure Description:

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting project by the DY indicated:

- DY2-DY3:
    - Process Milestone: P-4
- DY4-DY5:

- Outcome Domain: OD-6
- Improvement Target: IT-6.1(5)

Rationale:

The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:

The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.9	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $45,886	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $105,712	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. • Improvement Target: [TBD] • Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $202,989	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. • Improvement Target: [TBD] • Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $886,248
Year 2 Estimated Outcome Amount: *(add incentive payments amounts from each milestone/outcome improvement target)*: $45,886	Year 3 Estimated Outcome Amount: $105,712	Year 4 Estimated Outcome Amount: $202,989	Year 5 Estimated Outcome Amount: $886,248
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,240,835			

Identifying Outcome Measure and Provider Information:

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

RHP Outcome Measure Identification Number: 138708601.3.10

Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.

Related Category 1 or 2 Project: 138708601.2.6

Outcome Measure Description:

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Pending approval of the instrument from HHSC, TTBH will administer the Mental Health Corporations of America, Inc. (MHCA) Customer Satisfaction Survey as a measure of patient satisfaction. The survey contains 49 satisfaction questions that are scored in clusters according to four satisfaction domains: Personal Therapy, Physical Environment, Client/Staff Interaction and Overall, Outcome and Reputation. The instrument also includes questions pertaining to client demographics, healthcare insurance coverage and voluntary vs. non-voluntary treatment status. The survey is available in English and Spanish, gives our clients the opportunity to comment on an array of service related topics, provides TTBH with a detailed analysis of patient satisfaction and gives the Center the ability to compare our results with those of other community behavioral health centers across the country. To assess patient satisfaction specifically with services delivered through our project to integrate primary and behavioral health care, TTBH will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey with supplemental Patient-Centered Medical Home (PCMH) Item Set. The CG-CAHPS survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives on care and the PCMH supplement allows for the assessment of satisfaction with care provided by medical homes and include items applicable to adults and children. The process milestone to be implemented is P-4: Conduct, Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. The patient satisfaction outcome improvement targets will be determined in DY2 for implementation in DY3.

The following process milestone, outcome domain and improvement target were chosen for the Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting project by the DY indicated:

- DY2-DY3:
    - Process Milestone: P-4
- DY4-DY5:

- Outcome Domain: OD-6
- Improvement Target: IT-6.1(5)

Rationale:

The PDSA process milestone was selected to be consistent with TTBH's existing quality management process, which utilizes PDSA for performance improvement. Patient satisfaction was selected as the outcome domain because we have the ability to produce that data at this time, and given the evidence to support its use as a valid measure of treatment outcomes and its applicability to each of the projects. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well. Outcome improvement targets will be determined in DY2 for implementation in DY3.

Outcome Measure Valuation:

The category 3 outcome measures were valued by determining the percent of the project value necessary to implement the Plan, Do, Study, Act cycles to improve data collection and intervention activities. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.10	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $27,515	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. • Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $117,197	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. • Improvement Target: [TBD] • Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $212,815	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement over baseline of patient satisfaction scores. • Improvement Target: [TBD] • Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $682,922
Year 2 Estimated Outcome Amount: *(add incentive payments amounts from each milestone/outcome improvement target)*: $27,515	Year 3 Estimated Outcome Amount: $117,197	Year 4 Estimated Outcome Amount: $212,815	Year 5 Estimated Outcome Amount: $682,922
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,040,449			

Identifying Outcome Measure and Provider Information:
OD-10 Quality of Life/Functional Status, IT-10.7 Children with Special Health Care Needs mental health risk rate
RHP Outcome Measure Identification Number: 138708601.3.11
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.
Related Category 1 or 2 Project: 138708601.2.7

Outcome Measure Description:
The mental health care risk rate is defined as the percentage of identified children with special health care needs and their family members with high risk mental health conditions. The Child Behavior Checklist (CBCL) will be used to determine the baseline of mental health risk of children with special health care needs. It was first developed by Thomas M. Achenbach and has been one of the most widely-used standardized measures in child psychology for evaluating maladaptive behavioral and emotional problems in preschool subjects aged 2 to 3 and in subjects between the ages of 4 and 18. The CBCL can be self-administered or administered by an interviewer. It consists of 118 items related to behavior problems which are scored on a 3-point scale ranging from not true to often true of the child. There are also 20 social competency items used to obtain parents' reports of the amount and quality of their child's participation in sports, hobbies, games, activities, organizations, jobs and chores, friendships, how well the child gets along with others and plays and works by him/herself, and school functioning.

Several studies have supported the construct validity of the instrument. Tests of criterion-related validity using clinical status as the criterion (referred/non-referred) also support the validity of the instrument. Importantly, demographic variables such as race and SES accounted for a relatively small proportion of score variance. The CBCL has been translated into 85 languages and developed into different formats for many age groups, including a variation for adults called the ABCL which will also be used in this project as needed. Many studies agree that the CBCL is the most accurate tool available for analyzing children with potential behavioral issues. Because studies showed that demographic statistics of children (age, race, and so on) caused very little variance in test results, this further proved the reliability of the test as an empirical tool. The process milestone to be implemented is described below to determine the mental health risk rate. The risk rate outcome improvement targets will be determined in DY2 for implementation for improvement in DYs 3-5.

The following process milestones, outcome domain and improvement targets were chosen for the Mental Health Navigation Program for Children with Special Health Care Needs project by the DY indicated:

Process Milestones:
- DY2: Process Milestones: P-I, P-2, P-3

Outcome Improvement Targets for each year:
- DY3:
    - Outcome Domain: OD-10
    - Improvement Target: IT-10.7: Rate 1: To Be Determined (TBD)
    - Improvement Target: IT-10.7: Rate 2: TBD

- DY4:
    - Outcome Domain: OD-10
    - Improvement Target: IT-10.7: Rate 1: TBD
    - Improvement Target: IT-10.7: Rate 2: TBD
- DY5:
    - Outcome Domain: OD-10
    - Improvement Target: IT-10.7: Rate 1: TBD
    - Improvement Target: IT-10.7: Rate 2: TBD

Rationale:
Process milestones P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the risk of mental health conditions in children with special health care needs. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY2 we will establish baselines for Rate 1 and Rate 2 using the indicated process milestone. Improvement targets will be determined for Rate 1 and Rate 2 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a mental health care navigation program. The outcome measures being addressed are largely affected by social determinants other than encounters with care navigators. For instance, psychosocial and mental health issues, transportation issues, cultural and behavioral issues, and childcare issues will affect a patient's show rate for appointments.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the identified individuals at risk for mental health conditions per DY. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.11	*3.IT-10.7*	*Children with Special Health Care Needs Mental Health Risk Rate*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects:	*138708601.2.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. • Data Source: Timeline, Project plan and reports. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,450 **Process Milestone 2** [P-2]: Establish baseline rates for Rate 1 and Rate 2. • Data Source: CBCL data. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $8,450 **Process Milestone 3** [P-3]: Develop and test data systems • Data Source: CBCL data. Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $8,450	**Outcome Improvement Target 1** [IT-10.7]: Rate 1: Decrease in percentage of Children with Special Health Care Needs and their family members who were assessed and identified to be at high risk for mental health conditions during DY2. • Improvement Target: [TBD] • Data Source: CBCL results. Rate 2: Increase in the number of Children with Special Health Care Needs and their family members to be evaluated for risk of mental health conditions during DY2. • Improvement Target: [TBD] • Data Source: CBCL administration results. Outcome Improvement Target 1 Estimated Incentive Payment*:* $167,310	**Outcome Improvement Target 2** [IT-10.7]: Rate 1: Decrease in percentage of Children with Special Health Care Needs and their family members who were assessed and identified to be at high risk for mental health conditions during DY3. • Improvement Target: [TBD] • Data Source: CBCL results. Rate 2: Increase in the number of Children with Special Health Care Needs and their family members to be evaluated for risk of mental health conditions during DY3. • Improvement Target: [TBD] • Data Source: CBCL administration results. Outcome Improvement Target 2 Estimated Incentive Payment*:* $167,310	**Outcome Improvement Target 3** [IT-10.7]: Rate 1: Decrease in percentage of Children with Special Health Care Needs and their family members who were assessed and identified to be at high risk for mental health conditions during DY4. • Improvement Target: [TBD] • Data Source: CBCL results. Rate 2: Increase in the number of Children with Special Health Care Needs and their family members to be evaluated for risk of mental health conditions during DY4. • Improvement Target: [TBD] • Data Source: CBCL administration results. Outcome Improvement Target 3 Estimated Incentive Payment*:* $384,620
Year 2 Estimated Outcome Amount: *(add incentive payments amounts from each milestone/outcome improvement target)*: $25,350	Year 3 Estimated Outcome Amount: $167,310	Year 4 Estimated Outcome Amount: $167,310	Year 5 Estimated Outcome Amount: $384,620
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $744,590			

Identifying Outcome Measure and Provider Information:
OD-8 Perinatal Outcomes, IT-8.9 Postpartum depression risk rate
RHP Outcome Measure Identification Number: 138708601.3.12
Performing Provider/TPI: Tropical Texas Behavioral Health/138708601.
Related Category 1 or 2 Project: 138708601.2.8

Outcome Measure Description:
The mental health care risk rate is defined as the percentage of identified high risk postpartum women and their family members with high risk mental health conditions. The Public Health Questionnaire-9 (PHQ-9) will be used to determine the baseline of postpartum depression risk of the maternity clients within the CCDHHS clinics. The tool is a 9-item depression scale that is used to assist clinicians with diagnosing criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). It will be used to track a patient's overall depression severity as well as the specific symptoms that are improving or not with the treatment. The clinical staff will be able discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it will be scored by the primary care clinician, which will be the Navigators. The PHQ-9 has two components: Assessing symptoms and functional impairment to make a tentative depression and diagnosis, and deriving a severity score to help select and monitor treatment. Once the scoring has been completed, the Navigator will be able to make the appropriate referral for the client. The survey is currently available in English; however, it will be redeveloped internally to be in Spanish to assist the large number of Spanish speaking clients within the clinics. The process milestone to be implemented is described below to determine the postpartum depression risk rate. The risk rate outcome improvement targets will be determined in DY3 for implementation for improvement in DYs 4 and 5.

The following process milestones, outcome domain and improvement targets were chosen for the Postpartum Intervention Care Navigation Program by the DY indicated:

Process Milestones:
- DY2: Process Milestones: P-1, P-3
- DY3: Process Milestone: P-2, P-3

Outcome Improvement Targets for each year:
- DY4:
  - Outcome Domain: OD-8
  - Improvement Target: IT-8.9 Rate 1: To be Determined (TBD)
  - Improvement Target: IT-8.9 Rate 2: TBD
- DY5:
  - Outcome Domain: OD-8
  - Improvement Target: IT-8.9 Rate 1: TDB
  - Improvement Target: IT-8.9 Rate 2: TBD

Rationale:
Process milestones – P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the risk of mental health conditions in high risk

postpartum women and their families. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baselines for Rate 1 and Rate 2 with P-2. Improvement targets will be determined for Rate 1 and Rate 2 based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a postpartum depression intervention mental health care navigation program. These outcome measures being addressed are largely affected by social determinants other than encounters with navigators. For instance, psychosocial and mental health issues, transportation issues, cultural and behavioral issues, and childcare issues will affect a patient's show rate for appointments.

The Public Health Questionnaire-9 (PHQ-9) is a nine-question scale that asks respondents to answer how often they experience the cluster of symptoms that defines depression, which is based on the nine diagnostic criteria for major depressive disorder in the DSM-IV (Diagnostic and Statistical Manual Fourth Edition). The PHQ-9 can be used as a tool for diagnosing depression (as it is during recruitment and screening) as well as for tracking a client's overall depression severity and the specific symptoms that are or are not improving with treatment. In comparison to other depression scales, the PHQ-9 scale is shorter that many other depressing rating scales; can be administered in person, over the telephone or a as self-report; facilitate the diagnosis of major and minor depression; assesses depression symptom severity; research has show that it is effective in a variety of patients, including adolescent, adult and geriatric populations; and is available in multiple languages including English and Spanish which are most prevalent among the target population.

Outcome Measure Valuation:
The category 3 outcome measures were valued by determining the percent of the identified individuals at risk for mental health conditions per DY. Consideration was given to the recommended percentages across the DYs of 5%, 10%, 10%, and 20%. Where our determination was lower than the prescribed percentage, we increased to the minimum required.

138708601.3.12	*3.IT-8.9*	*Postpartum Depression Risk Rate*	
Tropical Texas Behavioral Health			*138708601*
Related Category 1 or 2 Projects::	*138708601.2.8*		
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: Timeline, Project plan and reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,675 **Process Milestone 2** [P-3]: Develop and test data systems • Data Source: Survey and Data Tool Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,675	**Process Milestone 3** [P-2]: Establish baseline rates for Rate 1 and Rate 2. • Data Source: Survey and Data Tool Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $56,333.50 **Process Milestone 4** [P-3]: Develop and test data systems • Data Source: Survey and Data Tool Results Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $56,333.50	**Outcome Improvement Target 1** [IT-8.9]: Rate 1: Decrease percentage of Postpartum women and their family members who were assessed and identified to be at high risk for mental health conditions during DY3. • Improvement Target: [TBD] • Data Source: PHQ-9 results. Rate 2: Increase the number of Postpartum women and their family members to be evaluated for risk of mental health conditions during DY3. • Improvement Target: [TBD] • Data Source: PHQ-9 administration results. Outcome Improvement Target 1 Estimated Incentive Payment*:* $112,667	**Outcome Improvement Target 2** [IT-8.9]: Rate 1: Decrease percentage of Postpartum women and their family members who were assessed and identified to be at high risk for mental health conditions during DY4. • Improvement Target: [TBD] • Data Source: PHQ-9 results. Rate 2: Increase the number of Postpartum women and their family members to be evaluated for risk of mental health conditions during DY4. • Improvement Target: [TBD] • Data Source: PHQ-9 administration results. Outcome Improvement Target 2 Estimated Incentive Payment*:* $253,500
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $25,350	Year 3 Estimated Outcome Amount: $112,667	Year 4 Estimated Outcome Amount: $112,667	Year 5 Estimated Outcome Amount: $253,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $504,184			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 085144601.3.1

Performing Provider/TPI: University of Texas Health Science Center San Antonio / 085144601

Outcome Measure Description

OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

DY 5: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:

The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

085144601.3.1	3.IT-14.1	Number of practicing primary care physicians per 100,000 individuals in HPSA/MUA	
UT Health Science Center San Antonio			TPI 085144601
Related Category 1 or 2 Projects:	085144601.1.1		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $71,978 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $71,979	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $166,865 **Process Milestone 3 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $166,865	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $535,520	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $776,116
Year 2 Estimated Outcome Amount: $143,957	Year 3 Estimated Outcome Amount: $333,730	Year 4 Estimated Outcome Amount: $535,520	Year 5 Estimated Outcome Amount: $776,116
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,789,323			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 085144601.3.2

Performing Provider/TPI: University of Texas Health Science Center San Antonio / 085144601

Outcome Measure Description

OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

DY 5: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:

The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

085144601.3.2	*3.IT-14.1*	*Number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA*	
UT Health Science Center San Antonio			*TPI 085144601*
Related Category 1 or 2 Projects:	*085144601.1.2*		
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 – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment*:* $71,978 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $71,979	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $166,865 **Process Milestone 3 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $166,865	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $535,520	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing behavioral health physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $776,116
Year 2 Estimated Outcome Amount: $143,957	Year 3 Estimated Outcome Amount: $333,730	Year 4 Estimated Outcome Amount: $535,520	Year 5 Estimated Outcome Amount: $776,116
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,789,323			

Category 3: Quality Improvements

Title of Outcome Measure: IT 14.1 Number of practicing primary care practitioners per 100,000 individuals in HPSA or MUA

Unique RHP outcome ID: 085144601.3.3

Performing Provider/TPI: University of Texas Health Science Center San Antonio / 085144601

Outcome Measure Description

OD-14 Primary Care Workforce

Stand-alone: IT - 14.1 Number of practicing primary care physicians per 100,000 individuals in HPSA or MUA

Non-stand-alone but related: (for internal tracking only)

IT - 14.6 percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)

IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems. Currently, various data sources present various data points that are close but not definitively aligned. We will research data definitions and sources and seek the most accurate. Sources include Texas Medical Association, Texas Institute of Health Care Quality and Efficiency, Texas Department of State Health Services' Health Professions Resource Center, US Department of Health and Human Services' Health Resources and Services Administration, and county medical societies.

DY 3: P-2 Establish baseline rates. Please see note above.

P-3 Develop and test data systems. Continuation and further improvement from DY2 efforts.

Outcome Improvement Targets for each year:

DY 4: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

DY 5: IT-14.1 Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA by TBD above baseline

Rationale:

The long-term goal of this project is to train more primary care physicians for practice in the RHP 5 community. In the near-term and within the scope of the Demonstration period, the addition of practicing faculty physicians will improve access to primary care for the underserved.

Outcome Measure Valuation:

The project is valued based upon achieving waiver goals, meeting community needs, depth of scope, and resources deployed. The Category 3 valuation is consistent with the Category 1 valuation as indicated by the Program Funding and Mechanics Protocol. Although the outcome domain chosen targets number of practicing primary care physicians per 100,000 individuals in HPSA or MUA, we are cautiously optimistic that implementation of this project will also generate improved experience of care for individuals, improved health for the population, and lower the cost of care while improving quality.

085144601.3.3	3.IT-14.1	Number of practicing primary care physicians per 1,000 individuals in HPSA or MUA	
UT Health Science Center San Antonio			TPI 085144601
Related Category 1 or 2 Projects:	085144601.1.3		
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: Dept of State Health Services and local health department statistics Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $71,978 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 2 Estimated Incentive Payment: $71,979	**Process Milestone 3 [P-2]** Establish baseline rate Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $166,865 **Process Milestone 3 [P-3]** Develop and test data systems Data Source: Public health and workforce statistics Process Milestone 3 Estimated Incentive Payment: $166,865	**Outcome Improvement Target 1** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $535,520	**Outcome Improvement Target 2** [IT-14.1]: Increase the number of practicing primary care physicians per 100,000 individuals in HPSA or MUA above baseline Improvement Target: TBD Data Source: Public health and workforce statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $776,116
Year 2 Estimated Outcome Amount: $143,957	Year 3 Estimated Outcome Amount: $333,730	Year 4 Estimated Outcome Amount: $535,520	Year 5 Estimated Outcome Amount: $776,116
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,789,323			

Category 3: Quality Improvements

Outcome Measure:
IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059) Standalone Measure

Measure Description:
The clinic proposes to measure outcomes resultant from Process and Improvement milestones by trending improvements in the percentage of patients diagnosed with diabetes whose HbA1c is above 9.0%, otherwise known as poor control. As our clinic moves along the path toward certification as a patient centered medical home, the benefits of focusing on population management will manifest themselves within the patient population diagnosed with diabetes. Establishing a care team which may include physicians, nurses, nutritionists, care managers, lab, and outreach is expected to yield a lower percentage of the targeted patient population whose HbA1c is in poor control.

The clinic expects that the use of electronic medical records, health information exchange, and the patient centered medical home will lead to a percentage reduction in the number of adult patients with Type 1 or 2 diabetes whose HbA1c is in poor control to a level of 27% at the end of the project period. The established baseline is 34.27% based upon calendar year 2011 data taken from the clinic's electronic medical records system.

Rationale:RHP5 has 31%(388,000) of adults with diabetes, over half (197,000) undiagnosed, and 56% (216,500) untreated. Diabetes is responsible for 56% of hospital admissions for CVD and 54% of sepsis. Diabetes and obesity are at the root of many of the chronic conditions dominating RHP5 and therefore top of the list of needs. Self-reported obesity approaches 35% but measured obesity is 49% (see needs assessment). Though self-reported diabetes is 13.7% objectively measured diabetes in adults over 18 years is more than twice at 30.7%. Thus half of those with diabetes are undiagnosed, and among those reporting diabetes half are untreated, leaving a very large pool of undiagnosed as well as untreated people. The cost for these two conditions alone runs into the hundreds of millions of dollars for RHP5. Underlying diabetes is present in over 50% of hospital admissions for serious and therefore costly conditions in RHP5.[1] The RHP5 cost in lost wages alone from diabetes is $227 million a year. This is the basis for choosing diabetes control as our major outcome measure. However, many with diabetes also have other conditions and these will also be improved with improved control.

Outcome Measure Valuation:
Numerator: Perentage of patients 18 – 75 years of age with diabetes (type 1 or 2) who had hemoglobin A1c (HbA1c) in poor control (>9.0%).
Denominator: Members 18 – 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).
The HgA1c measure was selected because it is currently the best measure of diabetes control. The disease has contributed to enormous disparities in health and to significant health care costs within our region as described above. In 2011, Su Clinica Familiar provided services to 31,415 patients, 4,373 of whom carry a diagnosis of Diabetes. This accounts for 23% of the Adult patient population at the Health Center and 17,309 clinic visits.
Thirty four per cent of those with diabetes (about 1400 patients) currently have HbA1c > 9%. The evidence suggests that putting these people into a more comprehensive program

such as the PCMH will enhance the likelihood of improving diabetes control through better patient management, education, prevention, and care coordination, the clinic's goal is to improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care.

Outcome data will be obtained through the clinic's electronic medical records system. As the project progresses, it will be possible to share clinical information with hospitals and others through the Health Information Exchange. Through this model, the clinic will be in a better position to identify problems early on, coordinate with others to develop an effective care plan, and work with the patient and family to achieve the outcome measure.

Category 3 outcome measure: IT-1.10	Reference Number 085144601.3.5	Project Components 2.1.3.a-f	Diabetes Care HbA1c poor control (>9.0%)
UTHSCSA			UTHSCSA 085144601.2.1
Related Category 1 or 2 Projects: 2.1.3			Identifier TPI# 085144601
Starting Point/Baseline		37.14%	

Year 2 (10/1/2012 – 9/30/2013	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P- 1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric- Complete PCMH Implementation Plan. Process Milestone 1 Estimated Incentive Payment: $27,386 **Process Milestone 2** [P-3] Develop and test data systems Metric: be able to provide data on proportion of patients under the PCMH program and to measure their HbA1c levels at any time. Data Source: Su Clinica records and data system Process Milestone 2 Estimated Incentive Payment: $27,386	**Outcome Improvement Target 1: IT-1.10** Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059) Improvement Target: Reduce proportion over 9% from baseline by 3%. Metric: Numerator: Percentage of patients 18-75 years of age with diabetes with hemoglobin A1c (HbA1c) control >= 9.0%. b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes c Data Source: EHR, Registry, Claims, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment: $126,976	**Improvement Milestone 2: IT-1.10** Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059) Improvement Target: Reduce proportion over 9% by 5% of baseline. Metric: Numerator: Percentage of patients 18-75 years of age with diabetes with hemoglobin A1c (HbA1c) control >= 9.0%. b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Claims, Administrative clinical data. Outcome Improvement Target 2 Estimated Incentive Payment: $203,752	**Outcome Improvement Target 3: IT-1.10** Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059) Improvement Target: Reduce proportion over 9% from baseline by 10% of baseline. Metric: Numerator: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) control > =9.0%. b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: EHR, Registry, Claims, Administrative clinical data. Outcome Improvement Target 3 Estimated Incentive Payment: $295,292
Year 2 Estimated Outcome Amount: $54,772	Year 3 Estimated Outcome Amount: $126,976	Year 4 Estimated Outcome Amount: $203,752	Year 5 Estimated Outcome Amount: $295,292
TOTAL ESTIMATED INCENTIVE PAYMENTS FO 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $680,792			

Identifying Outcome Measure: IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059) Standalone Measure
Unique project ID: 085144601.3.6
Performing Provider Name/TPI: University of Texas Health Science Center San Antonio 085144601
Related Category 1 or 2 Projects: 085144601.2.2

Measure Description:
UTHSCSA proposes to measure outcomes resultant from Process and Improvement milestones by trending improvements in the percentage of patients diagnosed with diabetes whose HbA1c is above 9.0%, otherwise known as poor control. As the project fully implements the chronic care management model the benefits of focusing on care management will result in patients diagnosed with diabetes, following a more controlled regimen of medication and lifestyle changes. Establishing a care team including professionals from multiple disciplines is expected to yield a lower percentage of the targeted patient population whose HbA1c is in poor control.

UTHSCSA expects that a 5% reduction in the number of adult patients with Type 2 diabetes whose HbA1c is in poor control (>9.0%). The baseline value will be established in DY 2.

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

Outcome Measure Valuation:
Numerator: Percentage of patients 18 – 75 years of age with diabetes (type 2) who had hemoglobin A1c (HbA1c) in poor control (>9.0%).
Denominator: Members 18 – 75 years of age as of December 31 of the measurement year with diabetes (type 2).

The HbA1c measure was selected due to the prevalence of this disease within the local population and its related impact on healthcare costs. Recent data from RHP 5 indicates that 31% of the population has type 2 diabetes, with 50% unaware of their diagnosis. Through chronic care management these patients will improve their health and reduce the per capita cost of health care.

Outcome data will be obtained through the CCM program's electronic medical records system. As the project progresses, it will be possible to share clinical information with clinics, other hospitals and others HIPPA protected entities through the Health Information Exchange. We

will be in a better position to identify problems early on, coordinate with others to develop an effective care plan, and work with the patient and family to achieve the outcome measure.

The project is also valued based on the cost savings that will be realized as we implement the chronic care management model. The cost savings will come from 6000 individuals being exposed to the CCM project, and 1875 patients receiving self-management education leading to A1c levels under better control at <9.0%. We will see patients with diabetes with A1c over 9.0% and patients with diabetes with A1c between 9.0% and 7.0% have improved values. Moreover, because the chronic care management model supports the prevention and control of other chronic diseases we will realize costs savings there too. Finally, significant cost savings will be realized from avoided hospitalizations. This program is a particularly important cost savings initiative in our area where chronic conditions are rampant.

085144601.3.6	Reference Number IT-1.10	Project Components 2.2.1	Diabetes Care HbA1c poor control (>9.0%)
UTHSCSA			TPI# UTHSCSA - #085144601
Related Category 1 or 2 Projects:			085144601.2.2
Starting Point/Baseline		To be developed in DY 2	

Year 2 (10/1/2012 – 9/30/2013	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P- 2 Establish baseline rates Metric 1. P-2.1. Determine baseline of population with uncontrolled diabetes (HbA1c >9.0%) among patients enrolled in Chronic Care Management (CCM) program Data Source: Registry Estimated Incentive Payment: $157,996	**Process Milestone 2**: P-3. Develop and test data system Metric 1: P-3.1 Establish data system for tracking CCM patients. Enter data and conduct test of system. Data Source: Data summary report Estimated Incentive Payment: $366,276	**Process Milestone 3: P-4.** Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services Metric 1: implement PDSA cycle on issue identified by stakeholders and staff, jointly study and implement solution Data Source: PDSA summary report **Improvement Target 1:IT-1.10** Diabetes care: *HbA1c poor control (>9.0%)233 - NQF 0059 (Standalone measure)* Metric: 1-10. Percentage of CCM patients with HbA1c control >9.0% Improvement Target: 40 CCM patients move from uncontrolled diabetes to controlled diabetes Data Source: Registry Estimated Incentive Payment: $587,745	**Process Milestone 5: P-4.** Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services Metric 1: implement PDSA cycle on issue identified by stakeholders and staff, jointly study and implement solution Data Source: PDSA summary report **Improvement Target 2:IT-1.10** Diabetes care: *HbA1c poor control (>9.0%)233 - NQF 0059 (Standalone measure)* Metric: 1-10. Percentage of CCM patients with HbA1c control >9.0% Improvement Target: 60 CCM patients move from uncontrolled diabetes to controlled diabetes Data Source: Registry Estimated Incentive Payment: $851,804
Year 2 Estimated Outcome Amount: $157,996	Year 3 Estimated Outcome Amount: $366,276	Year 4 Estimated Outcome Amount: $587,745	Year 5 Estimated Outcome Amount: $851,804
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $ 1,963,821			

Identifying Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measures for diabetes
IT-12.5 Other USPSTF-endorsed screening outcome measures for hypertension
IT-12.5 Other USPSTF-endorsed screening outcome measures for hypercholesterolemia
Unique RHP outcome identification number(s): 085144601.3.7
Performing Provider/TPI: UTHSCSA / 085144601
Related Category 1 or 2 Projects: 085144601.2.3

Measure Description:

We propose to measure outcomes resultant for Process and Improvement milestones by trending improvements in the percentage of patients screened for diabetes, hypertension and hypercholesterolemia. As the van project is implemented we will screen an increased number of people for these conditions. Those patients diagnosed with one of these conditions will be brought into the full array of patient navigation services so that these conditions are treated and self-managed. Implementing the core components of the patient navigation services will identify more individuals who are at risk for diabetes, hypertension and hypercholesterolemia, provide them support as they make behavior changes, and provide referrals to medical homes. All of these programmatic elements will results in their diabetes, hypertension and hypercholesterolemia brought under control.

We expect to use EMR data to measure these three non standalone measures. Patients of the mobile van who are enrolled patient navigation services will receive a range of services that lead to a percentage increase in the number of adult patients screened for diabetes, hypertension and hypercholesterolemia. We expect to see a 10% increase among the population who are screened for each of the three conditions: diabetes, hypertension and hypercholesterolemia. Currently 50% are unaware of their diagnosis and are therefore untreated (Fisher-Hoch et al, 2012).

OD- 12 Primary Care and Primary Prevention
IT-12.5 Other USPSTF-endorsed screening outcome measures (diabetes, hypertension and hypercholesterolemia)

Process Milestones:

DY2: P-1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3: P-3 Develop and test data systems
P-2 – Establish baseline rates for rate
DY4: P-4. Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services
DY5: P-4. Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services

Outcome Improvement Targets:

DY4: IT-12.5: increase USPSTF-endorsed screening outcome measures for diabetes, hypertension and hypercholesterolemia
DY5: IT-12.5: increase USPSTF-endorsed screening outcome measures for diabetes, hypertension and hypercholesterolemia

Rationale:

Identifying any one of the target conditions individually is important and cost savings. Identifying individuals with multiple conditions is exponentially important, particularly among individuals with low or no insurance coverage.

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

Hypertension: Approximately $76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure.

Hypercholesterolemia: Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Outcome Measure Valuation:

a Numerators: Number of people screened for blood glucose or HbA1c consistent with diabetes. Number of people screened for hypertension. Number of people screened for elevated cholesterol.

b Denominators: Number of adults aged 18 to 85 years of age as of December 31 of the measurement year in the patient or target population.

Data Source: EMR

These outcome measures were selected because in RHP 5, 70% of the population has one or more chronic conditions. A similar proportion has currently no health insurance, such that preventive care and intervention is neglected and patients often only present to clinics or emergency departments with advanced severe disease. Patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for these in those rural areas. Approximately 60% of those reached will be Medicaid eligible or indigent.

Outcome data will be obtained through the mobile van's electronic medical records system. Through this model, the van will be in a better position to identify problems early on, coordinate with others to develop an effective care plan, and work with the patient and family to achieve the outcome measure.

This project will save healthcare costs by providing screenings for common chronic conditions in RHP 5 with the goal of identifying problems earlier in the disease process or averting disease completely. From previous studies, we have shown that this type of screening, education and outreach project can avert cases of diabetes. For **each** diabetes case averted there are lifetime medical costs and indirect labor costs saved of $1,010,659. We also will prevent hospitalizations with this project as we will identify problems earlier. Based on the number of patients reached, we anticipate reducing hospitalizations by 20% among the 3000 patients saving nearly $3.2 million during life of project from averted hospitalizations. Finally, our program will also likely improve hypertension and hypercholesterolemia because of its comprehensive approach. Based on a very conservative estimate of lifetime costs saved just from strokes avoided (Taylor et al. 1996) we estimate $5.4 million in savings. This program is a particularly important cost savings initiative in our area where chronic conditions are rampant.

Category 3 outcome measure: 085144601.3.7	Reference Number IT 12.5	Project Components 2.9.1 [a-e]	**Other USPSTF**-endorsed screening outcome measures (diabetes, hypertension and hypercholesterolemia)
UTHSCSA			TPI# UTHSCSA 085144601
Related Category 1 or 2 Projects: 085144601.2.3			
Starting Point/Baseline		To be developed 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 Metric 1. P-1.1. Create a project plan for expanding mobile van services including screening, establish agreements with stakeholders, and identify resources and timelines. Data Source: Planning summary report Estimated Incentive Payment: $42,132	**Process Milestone 2**: P-3. Develop and test data system Metric 1: P-3.1 Establish data system for tracking mobile van patients screening rates. Enter data and conduct test of system. Data Source: Data summary report Process Milestone 2 Estimated Incentive Payment: $48,837 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $48,837	**Process Milestone 4**: P-4. Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services Metric 1: implement PDSA cycle on issue identified by stakeholders and staff, jointly study and implement solution Data Source: PDSA summary report Process milestone 4 Estimated Incentive Payment: $N/A **Outcome Improvement Target 1** IT-12.5: increase USPSTF-endorsed screening outcome measures for diabetes Improvement Target: 300 screenings for diabetes in DY 4, Data Source: Electronic medical record, chart review Outcome Improvement target 1 Estimated Incentive Payment: $52, 244 **Outcome Improvement Target 2** IT-12.5: increase USPSTF-endorsed screening outcome measures for hypertension Improvement Target: 300 screenings for hypertension in DY 4 Data Source: Electronic medical	**Process Milestone 5**: P-4. Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services Metric 1: implement PDSA cycle on issue identified by stakeholders and staff, jointly study and implement solution Data Source: PDSA summary report Process milestone 5 Estimated Incentive Payment: $N/A **Outcome Improvement Target 4** IT-12.5: increase USPSTF-endorsed screening outcome measures for diabetes Improvement Target: 500 screenings for diabetes in DY 5 Data Source: Electronic medical record, chart review Outcome Improvement target 4 Estimated Incentive Payment: $ 75,716 **Outcome Improvement Target 5** IT-12.5: increase USPSTF-endorsed screening outcome measures for hypertension

		record, chart review Outcome Improvement target 2Estimated Incentive Payment: $52, 244 **Outcome Improvement Target 3** IT-12.5: increase USPSTF-endorsed screening outcome measures for hypercholesterolemia Improvement Target: 300 screenings for hypercholesterolemia in DY 4 Data Source: Electronic medical record, chart review Outcome Improvement target 3 Estimated Incentive Payment: $52, 244	Improvement Target: 500 screenings for hypertension in DY 5 Data Source: Electronic medical record, chart review Outcome Improvement target 5 Estimated Incentive Payment: $ 75,716 **Outcome Improvement Target 6** IT-12.5: increase USPSTF-endorsed screening outcome measures for hypercholesterolemia Improvement Target: 500 screenings for hypercholesterolemia in DY 5 Data Source: Electronic medical record, chart review Outcome Improvement target 6 Estimated Incentive Payment: $ 75,716
Year 2 Estimated Outcome Amount: $42,132	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $227,148
TOTAL ESTIMATED INCENTIVE PAYMENTS FO 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $523,686			

Identifying Outcome Measure: IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)228 *(Standalone measure)*
Unique project ID: 085144601.3.8

Performing Provider/TPI: The University of Texas Health Science Center San Antonio (UTHSCSA) / 085144601
Related Category 1 or 2 Projects: 085144601.2.4

Measure Description:

We propose to measure outcomes resultant for Process and Improvement milestones by trending improvements in the percentage of patients with controlled high blood pressure. As the CWC is implemented we will screen and identify people who have been diagnosed with hypertension but it is uncontrolled as well as people who have undiagnosed hypertension that is also uncontrolled. Implementing the core components of the CWC will identify engage these individuals in lifestyle changes, provide them support as they make behavior changes, and provide referrals to medical homes. All of these programmatic elements will result in their blood pressure will be brought under control. This will yield an increased percentage of people with controlled blood pressure.

We expect to use CWC registry data to measure this standalone measure. Patients who are enrolled in the CWC will receive a range of services that lead to a percentage increase in the number of adult patients with controlled blood pressure. We will realize an increase in those with this condition who have it controlled of at least 86 patients during life of project. Previous research shows that 50% of patients in our area are untreated even if they had a diagnosis in the past (Fisher-Hoch et al, 2012).

OD-1- Primary Care and Chronic Disease Management
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)228 *(Standalone measure)*

Process Milestones:

DY2:

P-1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-3 Develop and test data systems

P-2 – Establish baseline rates for rate

DY4:

P-4. Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services

DY5:

P-4. Conduct a plan Do Study Act (PDSA) cycle to improve data collection and navigation services

Outcome Improvement Targets:

DY4:

1-7. Controlling high blood pressure

DY5:

1-7. Controlling high blood pressure

Rationale:

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee. Many CVD risk factors such as high blood pressure, excess weight, poor diet, and diabetes can be prevented or treated through health behavior change and appropriate medication. We propose to create a CWC that increases physical activity, healthy food choices and referrals to medical homes so that holistic treatment of high blood pressure is achieved and sustained.

Outcome Measure Valuation:

a Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg)during the measurement year

b Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

Controlled blood pressure was selected due to the prevalence of this condition in our local population and its related impact on health care costs. As demonstrated in our needs assessment, among diabetics, hypertension is the leading cause of hospitalization in RHP 5. Through the community wide campaign patient education, prevention, and care coordination will occur to improve the health of population and reduce the per capita cost of health care.

We expect to use registry records of the CWC to demonstrate improvements in this outcome measure. Patient records will be kept for those receiving services with the CWC. The baseline measure will be their initial blood pressure reading. Of those characterized with hypertension, a standalone measure of controlled high blood pressure will be taken at a follow-up measure within one year of their initial measure. BP less than 140 / 90 mm Hg will be considered adequately controlled. Patients enrolled during each performance year will be included in the outcome measure assessment. We will see at least 86 patients achieve controlled blood pressure. At a minimum given the 6000 people we will reach with a more intensive form of the project we estimate at least 36 averted strokes. Based on a very conservative estimate of lifetime costs saved just from strokes avoided (Taylor et al. 1996) $5.4 million in savings will be realized. Additional substantial cost savings will come from other avoided chronic conditions including heart diseases, diabetes, and obesity since the CWC focuses on enhancing healthy lifestyles. Finally, we will also realize substantial cost savings from avoided hospitalizations. Cost savings from just the cases of diabetes avoided are estimated to be another $7.9 million in lifetime savings. Approximately 60% of those reached will be Medicaid eligible or indigent. This project will have a high cost effectiveness ratio.

Category 3 outcome measure: IT-1.7	Project ID: 085144601.3.8	Project Components 2.6.1	Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)228 *(Standalone measure)*
UTHSCSA			UTHSCSA TPI#
Related Category 1 or 2 Projects: 085144601.2.4			Identifier TPI# 085144601
Starting Point/Baseline		To be established 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 Metric 1. P-1.1. Create a project plan for CWC services, establish agreements with stakeholders, and identify resources and timelines. Data Source: Implementation planning report including summary of assessment findings Estimated Incentive Payment: $90,320	**Process Milestone 2: P-3. Develop and test data system** Metric 1: P-3.1 Establish data system for tracking CWC patients. Enter data and conduct test of system. Data Source: Data summary report Estimated Incentive Payment: $104,693 **Process Milestone 3:** P- 2 Establish baseline rates Metric 1. P-2.1. Determine baseline of controlled blood pressure among patients with hypertension enrolled in CWC services Data Source: Data Summary Report highlighting % of CWC patients with uncontrolled hypertension Estimated Incentive Payment: $104,693	**Process Milestone 4: P-4.** Conduct a plan Do Study Act (PdSA) cycle to improve data collection and intervention activities Metric 1: implement PDSA cycle on issue identified by project partners, jointly study and implement solution Data Source: PDSA report Estimated Incentive Payment: $N/A **Improvement Target 1: 1-7. Controlling high blood pressure** Metric: incremental increase in 40 patients with controlled high blood pressure reached by CWC in DY 4 Data source: CWC registry data Estimated Incentive Payment: $335,992	**Improvement Target 2: 1-7. Controlling high blood pressure** Metric: incremental increase in 46 patients with controlled high blood pressure reached by CWC in DY 5 Data source: CWC registry data Estimated Incentive Payment: $486,945 **Process Milestone 7: P-4.** Conduct a plan Do Study Act (PdSA) cycle to improve data collection and intervention activities Metric 1: implement PDSA cycle on issue identified by project partners, jointly study and implement solution Data Source: PDSA report Estimated Incentive Payment: $N/A
Year 2 Estimated Outcome Amount: $90,320	Year 3 Estimated Outcome Amount: $209,386	Year 4 Estimated Outcome Amount: $335,992	Year 5 Estimated Outcome Amount: $486,945
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $1,122,643			

F. Category 4: Population-Focused Improvements (Hospitals only)

The performing provider hospital following information should be included:
Performing Provider involved with Category 4 (including TPI).

The following narrative and table describes Category 4 Reporting for the hospital in RHP 5 that is required to complete reporting: Doctors Hospital at Renaissance.

Category 4 – Reporting Domain 1: Potentially Preventable Admissions

Performing Provider: Doctors Hospital at Renaissance (160709501)

Domain Description:

Doctors Hospital at Renaissance recognizes the region's historical healthcare challenges and provider shortage. Theoverall goal of this project is to expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, preventing unnecessary hospital admissions, and increasing patient satisfaction. Due toa shortage in the healthcare workforce, patients in the Rio Grande Valley[79] have been limited in their access tonecessary and regular provider visits that include general health check-ups and preventative screenings. This fact when coupled with socioeconomic challenges, genetics, and a low health literacy rate has led to a disproportionate impact of Diabetes and other chronic conditions in theregion. In response to these circumstances, Doctors Hospital at Renaissance will focus on reducing potentially preventable admissions forpatients through an increase in healthcareproviders who can render the right care, at the right time, in the right place, and the right manner.
Through the development of new residency programs that increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, Doctors Hospital at Renaissance will be able to increase access of and medical management for patients with chronic conditions and socioeconomic challenges thereby improving key health metrics outlined in domain one. All resident programs at Doctors Hospital at Renaissance (DHR) will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics including full use of Electronic Medical Record (EMR) technology. Through this population-based medical management approach, Doctors Hospital at Renaissance will work to decrease preventableadmissions to the hospital in an at-risk population that is currently underserved.

Improvements through DY2-DY5:

*DY2:*In DY2, the residency programsat Doctors Hospital at Renaissance will be in the process of accreditation and a gap needs assessment will be drafted to ensure proper utilization of faculty and resident services. From the needs assessment, DHR will be able to determine key areas in

[79] Four County Area in South Texas including the following counties: Hidalgo County, Cameron County, Starr County, and Willacy County.

greatest need and design response programs that allow residents and services to beallocated accordingly.
DY3: In DY3, faculty of the new resident programs will work with Doctors Hospital at Renaissance and their medical staff to design and implement acommunity outreach and an evidence-based care program that will aim to reduce preventable admissions below the national average in a five year period. The medical programs and/or clinical services will integrate and actively monitorthe key metrics and population healthcare outcomes established in domain one.Baseline metrics will be developed in DY3 when new residents enter the community for the first time.
DY4: In DY4, continuous quality improvement programs will be in operation with DHR affiliates that are receiving increased availability with the presence of residents to promote medical home and preventative care management for a healthier population. There will be an expected reduction in preventable admission rates for diabetic patients and other chronic conditions from the baseline metrics established in DY3.
*DY5:*In DY5, the introduction of additional residents and care providers from projects developed under Category One[80]and the outcome measures from Category 3 will prompt greater access alleviating healthcare workforce shortage issues and allow for greater access to preventative care thereby reducing preventable hospital admissions by the largest margin in the five year period.

Category 4 Domain Valuation:

The domain focus that is taken by the projects for DHR focuses on increasing the availability of healthcare services to the surrounding indigent population. The aim of this domain is decreasing preventable admissions, and the focus of the supporting projects is diabetic patients. As the residency programsare fully developed, continuous cohorts of new primary healthcare providers will enter the community. This increased access to providers will have a large impact in reducing avoidable healthcare cost in a community once plagued by a healthcare workforce shortage.The increase of healthcare availability in this community will positively change the quality of life for countless residents resulting in a high value for the system and the patients together. As conditions become manageable for those that are accessing the increased service availability, admissions and readmissions will decrease resulting in further cost savings stimulation as well as a healthier population.

[80] 160709501.1.1 Establish Primary Care/Internal Medicine Residency Training Program
160709501.1.2 Establish Primary Care/Family Medicine Training Program;
160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Category 4 – Reporting Domain 2: 30 Day Readmissions

Performing Provider: Doctors Hospital at Renaissance (Insert TPI)

Domain Description:

Doctors Hospital at Renaissance recognizes the region's historical healthcare challenges and provider shortage. The overall goal of this project is to expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, preventing unnecessary hospital admissions, and increasing patient satisfaction. Due to a shortage in the healthcare workforce, patients in the Rio Grande Valley[81] have been limited in their access to necessary and regular provider visits that include general health check-ups and preventative screenings. This fact when coupled with socioeconomic challenges, genetics, and a low health literacy rate has led to a disproportionate impact of Diabetes and other chronic conditions in the region. In response to these circumstances, Doctors Hospital at Renaissance will focus on reducing potentially preventable readmissions for patients through an increase in healthcare providers increasing the availability for follow-up care in the primary healthcare setting versus relying on the emergency department in the safety-net hospital system.
Through the development of new residency programs that increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, Doctors Hospital at Renaissance will be able to increase access of and medical management for patients with chronic conditions and socioeconomic challenges thereby improving key health metrics outlined in domain two. All resident programs at Doctors Hospital at Renaissance (DHR) will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics including full use of Electronic Medical Record (EMR) technology. Through this population-based medical management approach, Doctors Hospital at Renaissance will be able to focus onpreventablereadmissions to the hospital in an at-risk population that is currently underserved.

Improvements through DY2-DY5:

*DY2:*In DY2, the residency programs at Doctors Hospital at Renaissance will be in the process of accreditation and a gap needs assessment will be drafted to ensure proper utilization of faculty and resident services. From the needs assessment, DHR will be able to determine key areas in

[81] Four County Area in South Texas including the following counties: Hidalgo County, Cameron County, Starr County, and Willacy County.

greatest need and design response programs that allow residents and services to be allocated accordingly.
DY3: In DY3, faculty of the new resident programs will work with Doctors Hospital at Renaissance and their medical staff to design and implement a community outreach and an evidence-based care program that will aim towards reducing 30 day readmissions compared to the established baseline. The medical programs and/or clinical services will integrate and actively monitor the key metrics and population healthcare outcomes that are desired in domain two. Baseline metrics will be developed in DY3 when new residents enter the community for the first time.
DY4: In DY4, continuous quality improvement programs will be in operation with DHR affiliates that are receiving increased availability with the presence of residents to promote medical home and preventative care management for those patients that are able to utilize the newly expanded availability of follow-up services throughout the community. There will be an expected improvement in preventable 30 day readmission rates for diabetic patients and other chronic conditions from the baseline metrics established in DY3.
*DY5:*In DY5, the introduction of additional residents and care providers from projects developed under Category One[82] and the outcome measures from Category 3 will prompt greater access alleviating healthcare workforce shortage issues and allow for greater access to preventative care thereby reducing preventable hospital readmissions by the largest margin in the five year period.

Category 4 Domain Valuation:

The domain strategy that is taken by the projects for DHR focuses on increasing the availability of healthcare services to the surrounding indigent population. The aim of this domain is decreasing 30-day readmissions, and the focus of the supporting projects is diabetic patients. As the residency programs are fully developed, continuous cohorts of new primary healthcare providers will enter the community. This increased access to providers will have a large impact in reducing avoidable healthcare cost in a community once plagued by a healthcare workforce shortage. The increase of healthcare availability in this community will positively change the quality of life for countless residents resulting in a high value for the system and the patients together. As conditions become manageable for those that are accessing the increased service availability, admissions and readmissions will decrease resulting in further cost savings stimulation as well as a healthier population.

[82] 160709501.1.1 Establish Primary Care/Internal Medicine Residency Training Program
160709501.1.2 Establish Primary Care/Family Medicine Training Program;
160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Category 4 – Reporting Domain 3: PPCs

Performing Provider: Doctors Hospital at Renaissance (Insert TPI)

Domain Description:

Doctors Hospital at Renaissance recognizes the region's historical healthcare challenges and provider shortage. The overall goal of this project is to expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, preventing unnecessary hospital admissions, and increasing patient satisfaction. Due to a shortage in the healthcare workforce, patients in the Rio Grande Valley[83] have been limited in their access to necessary and regular provider visits that include general health check-ups and preventative screenings. This fact when coupled with socioeconomic challenges, genetics, and a low health literacy rate has led to a disproportionate impact of Diabetes and other chronic conditions in the region. In response to these circumstances, Doctors Hospital at Renaissance (DHR) will focus on reducing potentially preventable complications for patients through an increase of healthcare providers within the inpatient setting. This will be achieved by increasing the availability of inpatient, primary care consultations with each patient that is now made possible with the presence of additional resident physicians throughout DHR.

Through the development of new residency programs that increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, Doctors Hospital at Renaissance will be able to increase access of and medical management for patients with chronic conditions and socioeconomic challenges thereby improving key health metrics outlined in domain three. All resident programs at Doctors Hospital at Renaissance will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics including full use of Electronic Medical Record (EMR) technology. Through this population-based medical management approach, Doctors Hospital at Renaissance will be able to focus on preventable conditions within the hospital and throughout the community for an at-risk population that is currently underserved.

Improvements through DY2-DY5:

*DY2:*In DY2, the residency programs at Doctors Hospital at Renaissance will be in the process of accreditation and a gap needs assessment will be drafted to ensure proper utilization of faculty

[83] Four County Area in South Texas including the following counties: Hidalgo County, Cameron County, Starr County, and Willacy County.

and resident services. From the needs assessment, DHR will be able to assess how the PPCs will be addressed and design a metric that will create a baseline, assign improvement goals, and manage the PPCs accordingly.
DY3: In DY3, procedures will have been in place with proper documentation metrics to ensure proper data management. Additionally, there will be new residents available to render services in areas of the most need (deciphered by a gap needs assessment).The baselines will be developed in DY3 since this is when the residents will be available. DHR will be seeking improvement on the PPCs that have been stipulated by CMS.
DY4: In DY4, continuous quality improvement will have been underway with DHR affiliates that are receiving increased availability with the presence of the residents to promote increased results for a healthier population. As the residents complete their training, their presence within the in-patient setting will increase availability of healthcare. As a result from increased inpatient availability DHR will be seeking improvement on the PPCs that have been stipulated by CMS.
*DY5:*In DY5, continuous quality improvement will have been underway within DHR and its affiliates that are receiving increased availability with the presence of the residents to promote increased results for a healthier population. Additionally, there will be an increased number of residents available to provide services as continuous cohorts are matriculated and made available to the inpatient setting increasing the amount of patients and/or time spent with each on a case-by-case basis. DHR will be seeking improvement on the PPCs that have been stipulated by CMS.

Category 4 Domain Valuation for RD3:

The domain strategy that is taken by the projects for DHR focuses on increasing the availability of healthcare services to the surrounding indigent population. The aim of this domain is improving preventable conditions for the patients that are able to receive healthcare services due to the projects positive impact on the community at large. As the residency programs are fully developed, continuous cohorts of new primary healthcare providers will enter the community. This increased access to providers will have a large impact in reducing avoidable healthcare cost in a community once plagued by a healthcare workforce shortage. The increase of healthcare availability in this community will positively change the quality of life for countless residents resulting in a high value for the system and the patients together. As conditions become manageable for those that are accessing the increased service availability, admissions and readmissions will decrease resulting in further cost savings stimulation as well as a healthier population.

Category 4 – Reporting Domain 4: Patient-Centered Health Care

Performing Provider: Doctors Hospital at Renaissance (Insert TPI)

Domain Description:

Doctors Hospital at Renaissance realizes the opportunity for constant quality improvement that HCAHPS give further insight to. As the residency program comes to maturity, more resident physicians and physician graduates will be available in the hospital increasing the physician-to-patient ratio, creating the opportunity for increased patient satisfaction.
Because the residency programs will still be in accreditation in DY2, the HCAHPS initiative will not be in effect until DY3. The surveys will be assessed on: Care from doctors, care from nurses, hospital environment, and the patient leaving the hospital. The metrics will be:

- Numerator: HCAHPS survey result averages for DY3
- Denominator: HCAHPS survey result averages from FY11

Through the development of new residency programs that increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, Doctors Hospital at Renaissance will be able to increase access of and medical management for patients with chronic conditions and socioeconomic challenges thereby improving key health metrics outlined in domain two. All resident programs at Doctors Hospital at Renaissance (DHR) will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics including full use of Electronic Medical Record (EMR) technology. Through this population-based medical management approach, Doctors Hospital at Renaissance will be able to focus on improving admissions, readmissions, preventable conditions, and the physician-to-patient ratio.

Improvements through DY2-DY5:

*DY2:*In DY2, the hospital will continue to implement its HCAHP surveys, but the residency programs will still be in accreditation phases, so the baselines regarding the HCAHPs concerning quality of care with the addition of increased residents will be implemented come DY3.
DY3: In DY3, procedures will have been in place with proper documentation metrics to ensure proper data management. Additionally, there will be new residents available to render services through the hospital as seen appropriate by the program. The baselines will be developed in DY3 since this is when the residents will be available. There will be an expected improvement in HCAHP rates for the patients being treated in our facilities.
DY4: In DY4, continuous quality improvement will have been underway with DHR affiliates that are receiving increased availability with the presence of the residents to promote increased

results for a healthier population. There will be an expected improvement in HCAHP rates for the patients being treated in our facilities.
*DY5:*In DY5, continuous quality improvement will have been underway with DHR affiliates that are receiving increased availability with the presence of the residents to promote increased results for a healthier population. Additionally, there will be an increased number of residents available to provide services as continuous cohorts are matriculated. There will be an expected improvement in HCAHP rates for the patients being treated in our facilities assuming that the thresholds already haven't been met.

Category 4 Domain Valuation:

The strategy of this domain is patient centered health care, which influences continuous quality improvement stemming from the HCAHP evaluations each patient is asked to do. As the residency programs are fully developed, continuous cohorts of new primary healthcare providers will become available to Doctors Hospital at Renaissance (DHR) while these physicians complete their requirements throughout the program. This increased access to providers throughout the hospital will have a large impact in quality of healthcare available to the patients that are being serviced by DHR. With the increased exposure to physicians, the hospital as a whole is positively influenced as the patients now have greater access to quality healthcare resulting in positive outcomes.

Category 4 – Reporting Domain 5: Emergency Department

Performing Provider: Doctors Hospital at Renaissance (Insert TPI)

Domain Description:

This domain focuses primarily on the median time from which a patient arrives to the ED to when they are released, or taken in for observation/inpatient. This will depend on the triage system in place, the hospital procedures regarding the ED, and the available staffing resources at the time.

The goal, first and foremost is to ensure that the patients are triaged correctly so that those that are critical are stabilized, while still maintaining safe, quality care for the remaining patients in the ED. The actual description of reporting domain 5 is the following:

> ***RD-5. Emergency Department***
>
> *Admit decision time to ED departure time for admitted patients (NQF 0497)*
>
> *a. Decision Time to transfer an emergency patient to another facility (not Transport Time), i.e. decision to make the first call from arrival in transferring ED until call initiated. Recommend threshold of < 1 hour for critical patient.*

This reporting domain's requirements, in combination with the reporting domain strategies will position Doctors Hospital at Renaissance to track process improvements and make adjustments accordingly to ensure constant quality improvement for our patients. All resident programs at Doctors Hospital at Renaissance (DHR) will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics including full use of Electronic Medical Record (EMR) technology. Through this population-based medical management approach, Doctors Hospital at Renaissance will be able to incorporate each of these components into its ED processes allowing for improvements according to optimal patient value. As the demonstrations years are completed, DHR will expect to see improvements in all of the reporting measures, including the waiting times in its ED.

Improvements through DY2-DY5:

DY2:

- Create an analysis of throughput time in the ED.
- Set baselines off of historical numbers from FY11.

- Assess which areas of the ED need immediate attention for improvement
- ***Metrics:*** Decision time to transfer an emergency patient to another facility

DY3: Implementation of continuous quality improvement will help achieve an improvement on the decision time to transfer an emergency patient to another facility
DY4: Implementation of continuous quality improvement will help achieve an improvement on the decision time to transfer an emergency patient to another facility
*DY5:*Implementation of continuous quality improvement will help achieve an improvement on the decision time to transfer an emergency patient to another facility

Category 4 Domain Valuation:

The domain strategy that is taken by the projects for DHR focuses on increasing the availability of healthcare services to the surrounding indigent population. The aim of this domain is improving preventable conditions for the patients that are able to receive healthcare services due to the projects positive impact on the community at large. The services availability will be incorporated not only in areas of limited healthcare access, but also throughout the hospital so that more patients can be brought through the facility's ED with an increased number of physicians. The aim of this domain is increasing the throughput of the ED to help improve on the decision times on how patients are transferred between departments and facilities accordingly. As more patients are able to be seen, it becomes vital the this service line of the hospital be at optimal conditions to further enhance its goals of providing safe, quality healthcare.

Category 4: Population-Focused Measures *[InsertHospital Name/TPI]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$640,403.00	$396,472.00		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$396,472.00	$439,678.00	$406,130.00
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$396,472.00	$439,678.00	$406,130.00
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$439,678.00	$406,130.00
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2		1 & 2	1 & 2	1 & 2
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2		1 & 2	1 & 2	1 & 2
Domain 4 - Estimated Maximum Incentive Amount		$396,472.00	$439,678.00	$406,130.00
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2		1 & 2	1 & 2	1 & 2
Domain 5 - Estimated Maximum Incentive Amount		$396,472.00	$439,678.00	$406,130.00
OPTIONALDomain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures				

for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$n/a	$n/a	$n/a
Grand Total Payments Across Category 4	$640,403.00	$1,982,360.00	$2,198,390.00	$2,030,650.00

Category 4 Population-Focused Improvements

Starr County Memorial Hospital – 136332705

Performing Provider Name: Starr County Memorial Hospital (SCMH)

Performing Provider TPI #: 136332705

Related Category 1 or 2 Project:

- 136332705.1.1 – Expand Family Practice and OB physician availability;
- 136332705.1.2 – Increase Surgical Care Availability;
- 136332705.2.1 – Improve ED Throughput

IGT Entity for DYs 2-5: Starr County Memorial Hospital

Domain 1: Potentially Preventable Admissions (PPA) - 8 Measures

Starr County Memorial Hospital (SCMH) will be expanding their Family Practice and OB availability within its rural health clinic (Rio Grande Rural Health Clinic) to the community (#136332705.1.1) as well as increase surgical availability (#136332705.1.2) through DY2-5. Project 136332705.1.1 will also implement a diabetic educator helping people live with this disease and improve their overall quality of life. With the availability of diabetes management classes available within the community in combination with an increased availability of physician family practice healthcare, these patients will have a better chance of not being admitted into the hospital for diabetes or related conditions (such heart failure and hypertension which are commonly associated). With an increase of availability, more patients will be able to be seen for initial consults and follow-up care. As more patients are able to be seen, proper diagnosis can be provided and preventative healthcare will be received by patients resulting in the improvement of PPAs for other measures such as pediatric asthma, COPD, Influenza Immunization, bacterial pneumonia immunization.

In addition to the core measures that are associated with domain 1, the surgical availability increase (#136332702.1.2) will also help reduce admissions in areas that are most commonly associated with surgery such as wound care and infection prevention. Starr County has one of the highest diabetic population densities in Texas resulting in a higher probability for wounds that are associated with diabetics such as foot ulcers. With the increase of availability, patients will have the opportunity to be serviced in the right place at the right time preventing minor wounds from advancing to such a stage that would require admission for over 24 hours.

Project 136332705.2.1, the improvement ED throughput will enhance the affiliation of SCMH and the Rio Grande Rural Health Clinic. This partnership will facilitate the reduction of hospital admissions, readmission, and complications as patients are referred out of an improved ED to the clinic with increased physician availability. Now that patients will have more access to preventative and follow-up healthcare any conditions that can cause further complications will have the opportunity to be managed.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Value	$27,881	$31,189	$32,500	$91,570

The associated cost for completing these projects include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains that are required from reporting according to our projects. The costs include personnel, technology, and training material that will be required to adequately implement each of these projects so that they will have the greatest impact on the community.

Domain 2: Potentially Preventable Readmissions (PPRs) – 30 days (7 measures)

Starr County Memorial Hospital (SCMH) will be expanding their Family Practice and OB availability within its rural health clinic (Rio Grande Rural Health Clinic) to the community (#136332705.1.1) as well as increase surgical availability (#136332705.1.2) through DY2-5. Project 136332705.1.1 will also implement a diabetic educator helping people live with this disease and improve their overall quality of life. Once diabetic patients are discharged from the hospital there will be an opportunity for them to take advantage of the availability of diabetes management classes within the community. In combination with an increased availability of physician family practice follow-up healthcare, these patients will have a better chance of not being readmitted into the hospital for diabetes or related conditions (such heart failure and hypertension which are commonly associated). With an increase of physician availability more patients will be able to access follow-up care resulting in: continual diagnosis, preventative healthcare, and general medical care resulting in the improvement of 30-day PPRs for other measures such as behavioral health & substance abuse, COPD, stroke, pediatric asthma, and all general readmissions that would require follow-up care and health management.

In addition to the core measures that are associated with domain 1, the surgical availability increase (#136332702.1.2) will also help reduce readmissions in areas that are most commonly associated with surgical necessity such as wound care and infection prevention. Starr County has one of the highest diabetic population densities in Texas resulting in a higher level of awareness for wounds that are associated with diabetics such as foot ulcers. With the increase of availability, patients will have the opportunity to obtain follow-up healthcare in the right place at the right time to help ensure that the healing process is well under way to help prevent readmission.

Project 136332705.2.1, the improvement ED throughput will enhance the affiliation of SCMH and the Rio Grande Rural Health Clinic. This partnership will facilitate the reduction of hospital admissions, readmission, and complications as patients are referred out of an improved ED to the clinic with increased physician availability. Now that patients will have more access to preventative and follow-up healthcare any conditions that can cause further complications will have the opportunity to be managed.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Value	$27,881	$31,189	$32,500	$91,570

The associated cost for completing these projects include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains that are required from reporting according to our projects. The costs include personnel, technology, and training material that will be required to adequately implement each of these projects so that they will have the greatest impact on the community.

Domain 3: Potentially Preventable Complications (64 measures)

Starr County Memorial Hospital (SCMH) will be expanding their Family Practice and OB availability within its rural health clinic (Rio Grande Rural Health Clinic) to the community (#136332705.1.1) as well as increase surgical availability (#136332705.1.2) through DY2-5. Project 136332705.1.1 will also implement a diabetic educator helping people live with this disease and improve their overall quality of life. Once diabetic patients are discharged from the hospital or have already received physician consultation at the rural health clinic there will be

an opportunity to take advantage of the diabetes management classes within the community. In combination with an increased availability of physician family practice consultation and follow-up healthcare, PPCs will be improved on. With an improvement in both admissions and readmissions as a result of increased availability for initial and follow-up health care, potentially preventable complications will also be improved.

In addition to the core measures that are associated with domain 1, domain 3 will be enhanced by the surgical availability increase (#136332702.1.2). The most common condition that is associated with surgical services are surgical site infections (SSI), this project employs a stand-alone improvement measure that focuses on continuous quality improvement targeted at decreasing SSIs improving on PPCs and readmissions. With the increase of availability, patients will have the opportunity to obtain follow-up healthcare in the right place at the right time to help ensure that the healing process is well under way to help prevent any occurring complications.

Project 136332705.2.1, the improvement ED throughput will enhance the affiliation of SCMH and the Rio Grande Rural Health Clinic. This partnership will facilitate the reduction of hospital admissions, readmission, and complications as patients are referred out of an improved ED to the clinic with increased physician availability. Now that patients will have more access to preventative and follow-up healthcare any conditions that can cause further complications will have the opportunity to be managed.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Value	--	$31,189	$32,500	$63,689

The associated cost for completing these projects include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains that are required from reporting according to our projects. The costs include personnel, technology, and training material that will be required to adequately implement each of these projects so that they will have the greatest impact on the community.

Domain 4: Patient-Center Healthcare (2 measures)

Starr County Memorial Hospital (SCMH) will be expanding their Family Practice and OB availability within its rural health clinic (Rio Grande Rural Health Clinic) to the community (#136332705.1.1) as well as increase surgical availability (#136332705.1.2) through DY2-5. Project 136332705.1.1 will also implement a diabetic educator helping people live with this disease and improve their overall quality of life. For those patients that are utilizing the clinical and hospital services, whether it be services within the ED, surgical services, or the rural health clinic, the patient's care and satisfaction will be very important. IT-6.1, percentage improvement over baseline of patient satisfaction scores, which are being implemented in 136332705.2.1 (Improvement of ED Throughput), is specifically geared towards continuous quality improvement through process modifications that become evident through the HCAHPS surveys.

Project 136332705.2.1, the improvement ED throughput will enhance the affiliation of SCMH and the Rio Grande Rural Health Clinic. This partnership will facilitate the reduction of hospital admissions, readmission, and complications as patients are referred out of an improved ED to the clinic with increased physician availability. Now that patients will have more access to preventative and follow-up healthcare any conditions that can cause further complications will have the opportunity to be managed.

With an overall increase of availability of healthcare to the community and the implementation of HCAHPS, Starr County Memorial Hospital can maintain its goal of continuous quality improvement that revolves around the patients.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Value	$27,881	$31,189	$32,500	$91,570

The associated cost for completing these projects include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains that are required from reporting according to our projects. The costs include personnel, technology, and training material that will be required to adequately implement each of these projects so that they will have the greatest impact on the community.

Domain 5: RD-5. Emergency Department
Admit decision time to ED departure time for admitted patients (NQF 0497)

a. Decision Time to transfer an emergency patient to another facility (not transport time), i.e. decision to make the first call from arrival in transferring ED until call initiated. Recommend threshold of < 1 hour for critical patient.

Project 136332705.2.1, the improvement the ED throughput, focuses on increasing the availability of healthcare services to the surrounding indigent and Medicaid population. The aim of this domain is improving preventable conditions for the patients that are able to receive healthcare services due to the projects positive impact on the community at large. The services availability will be incorporated not only in areas of limited healthcare access, but also throughout the hospital so that more patients can be brought through the facility's ED with an increased number of physicians. The aim of this domain is increasing the throughput of the ED to help improve on the decision times on how patients are transferred between departments and facilities accordingly. As more patients are able to be seen, it becomes vital the this service line of the hospital be at optimal conditions to further enhance its goals of providing safe, quality healthcare.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Value	$27,881	$31,189	$32,500	$91,570

The associated cost for completing these projects include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains that are required from reporting according to our projects. The costs include personnel, technology, and training material that will be required to adequately implement each of these projects so that they will have the greatest impact on the community.

Category 4: Population-Focused Measures *[Insert Hospital Name/TPI]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$76,213	$35,381		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$35,381	$38,689	$39,511
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$35,381	$38,689	$39,511
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				
Domain 3 - Estimated Maximum Incentive Amount			$38,689	$39,511
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$35,381	$38,689	$39,511
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive		$35,381	$38,689	$39,511

Amount				
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$76,213	$176,905	$193,445	$197,555

Category 4: Population-Focused Improvements –

Driscoll Children's Hospital [TPI: 132812205]

Domain 1: Potentially Preventable Admissions (8 measures)

Domain Description:

Because Driscoll Children's Hospital is a pediatric facility, reporting RD 1.3 Behavioral Health and Substance Abuse Admission Rate and RD 1.6 Pediatric Asthma are the only Domain 1 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 1 because all other measures (RD 1.1, 1.2, 1.4, 1.5, 1.7 and 1.8) apply to populations age 18 and above. However, we will provide the reporting data as required.

Although we do not expect any direct project impact in domain 1, Driscoll is dedicated to serving the population through our local specialty centers. By continuing to provide services throughout the region, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospitalization is required. Appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to hospitalization if left undetected.

Domain Valuation and Rationale:

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. By preventing hospital admissions through improved outpatient care, we will not only save money but will also improve the patient's outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Domain Description:

Because Driscoll Children's Hospital is a pediatric facility, reporting RD 2.6 Pediatric Asthma is the only Domain 2 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 2 because all other measures (RD 2.1, 2.2, 2.3, 2.4, 2.5, and 2..7) apply to populations age 18 and above. However, we will provide the reporting data as required.

Although we do not expect any direct project impact in domain 1, Driscoll is dedicated to serving the population through our local specialty centers. By continuing to provide services throughout the region, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospital readmission is required. Appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to a readmission if left undetected.

Domain Valuation and Rationale:

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. By preventing hospital readmissions through improved outpatient care, we will not only save money but will also improve the patient's outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

Domain 3: Potentially Preventable Complications (64 measures)

Domain Description:

Although many of the measures included in domain 3 are specific to adult care, Driscoll Children's Hospital is prepared to report on all measures found applicable by the state PPC data. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not

have a population sufficiently large to report on many of the measures included in domain 3. However, we will provide the reporting data as required.

We do not anticipate any project impact at this time. However, Driscoll is prepared to report on all non-exempted measurements in an effort to understand the causes of PPCs and make changes to reduce complications within our organization.

Domain Valuation and Rationale:

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. By tracking and reporting PPCs, Driscoll will be required to evaluate its own performance, and will drive organizational change to reduce the potential for complications associated with hospitalization. This will not only reduce cost but will also improve the patient's outcome and quality of life. Avoiding PPCs also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

Domain 4: Patient-Centered Healthcare (2 measures)

Domain Description

Because Driscoll Children's Hospital is a pediatric facility, reporting RD 4.2 Medication Management is the only Domain 4 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, RD 4.1 patient satisfaction is not applicable to the pediatric population due to HCAHPS requirements. However, we will provide the reporting data as required.

Although Driscoll is exempted from the patient satisfaction measure we are dedicated to improving patient satisfaction whenever possible and recognize the value of tracking and reporting such measures. Research has shown that patient satisfaction has a high correlation to patient compliance of care, specifically in regards to patients following through on taking medication and following care instructions given by providers. Increasing patient satisfaction and medication management would help to increase patient compliance which in time would result in better continuum of care for the patient.

Domain Valuation and Rationale:

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. The valuation is based on a determination that Providing pediatric specialty services to patients is a high cost to organizations since these services includes but is not limited to transportation of providers and patients, access to facilities, access to a range of specialists and more.

Domain 5: Emergency Department (1 measure)

Domain Description:

Driscoll Children's Hospital will measure the admit decision time to ED departure time for admitted patients. Driscoll supports a commitment to streamlining the patient transfer process and positively impacting the overall health and well-being of the children we serve. Although none of our projects directly impact the domain 5 measure, Driscoll is committed to improving the patient transfer process.

Domain Valuation and Rationale:

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by streamlining the patient transfer process, and estimated availability of funding. Emergency room use is a high cost service line. The ED is the first contact that many patients have with our hospital. Driscoll Children Hospital ED cares for varying levels of acuity. It is imperative that the throughput is as efficient and effective as possible in order to treat these patients and improve patient flow throughout the system. Reducing the decision time to make the first call from arrival in transferring ED until call initiated the ED creates significant savings and value.

Optional Domain 6: Children and Adult Core Measures (8 measures)

Driscoll Children's Hospital will not be reporting on optional domain 6.

Category 4: Population-Focused Measures Driscoll Children's Hospital – TPI: 132812205				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$400,000	$160,000		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		$160,000	$160,000	$160,000
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$160,000	$160,000	$160,000
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				
Domain 3 - Estimated Maximum Incentive Amount			$160,000	$160,000
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		12 months prior to due date	12 months prior to due date	12 months prior to due date
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		12 months prior to due date	12 months prior to due date	12 months prior to due date
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$160,000	$160,000	$160,000

Domain 5: Emergency Department				
Measurement period for report		12 months prior to due date	12 months prior to due date	12 months prior to due date
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$160,000	$160,000	$160,000
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				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$400,000	$800,000	$800,000	$800,000

Repeat table for every hospital reporting Category 4 measures

Section VI. RHP Participation Certifications

Each RHP participant providing State match or receiving pool payments has signed the required certification for Section VI:

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

These are included in the Plan as follows:

- Hidalgo County
- Border Region Behavioral Health
- Cameron County
- DHR (Doctors Hospital at Renaissance)
- Driscoll Children's Hospital
- Nueces County
- Starr County Memorial Hospital
- Tropical Texas Behavioral Health
- University of Texas – Pan American
- University of Texas Health Science Center – San Antonio
- Rio Grande State Center

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
Ramon Garcia	Ramon Garcia	Hidalgo County

APPROVED BY
COMMISSIONERS' COURT
ON: 11/06/12

Section VI. RHP Participation Certifications

Each RHP participant that will be providing State match or receiving pool payments must sign the following certification.

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- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization
Daniel G. Castillon	Daniel G. Castillon	Border Region Behavioral Health Center

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Signature	Name	Organization
Carlos H. Cascos	*Carlos H. Cascos, CPA*	*Cameron County*

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Signature	Name	Organization
	Susan S Turley	DHR

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Signature	Name	Organization
	STEVE WOERNER	Driscoll Children's Hospital

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Signature	Name	Organization
Jonny F. Hipp	*Jonny F. Hipp*	*Nueces County Hospital District*

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- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization
Thalia H. Munoz	*Thalia H Munoz*	*Starr County Memorial Hospital*

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Signature	Name	Organization
	W Terry Crooker	Tropical Texas Behavioral Health

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Signature	Name	Organization
Robert S Nelsen	Dr. Robert S. Nelsen President	The University of Texas-Pan American

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Signature	Name	Organization
Andrea Marks	*Andrea Marks* *VP & CFO*	*UT Health Science Center at San Antonio*

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Signature	Name	Organization
W. R. Wheel	Bill Wheeler, CFO, Texas DSHS	Rio Grande State Center

Section VII. Addendums

This RHP 5 Plan includes the following documents described below. All of the Addendum documents referenced here are submitted to HHSC as PDF files. They are also included in the hard-copies of the RHP 5 Plan, below.

Private Hospital Certifications and Affiliation Agreements

Included in the Plan is a Certification of Governmental Entity Participation for Hospital Affiliates on behalf of Cameron County, Hidalgo County and Starr County.

DSRIP Collaboration Agreements are also found between Driscoll and South Texas Health System, Valley Baptist Medical Center and Doctors Hospital at Renaissance, and University of Texas Health Science Center San Antonio and Doctors Hospital at Renaissance.

Additionally, Indigent Care Affiliation Agreements are included for the following private, affiliated hospitals:

- Doctors Hospital Renaissance
- Knapp Medical Center
- McAllen Hospitals
- Mission Hospital
- Rio Grande Regional Hospital
- Valley Baptist Medical Center

DSRIP Projects Considered but Not Included in the RHP 5 Plan

A number of DSRIP projects for RHP 5 were considered but ultimately not selected to be included in the RHP 5 Plan for Pass 1 DSRIP projects. A table listing these projects is included as an addendum. These projects were originally considered by Starr County Memorial Hospital, Tropical Texas Behavioral Health and University of Texas Health Science Center San Antonio (UTHSCSA).

Supporting Evidence of Stakeholder Participation

As supporting evidence of stakeholder participation in RHP 5, we are including a letter of support from the Cameron-Willacy Counties Medical Society.

We are also including a sign-in sheet of stakeholders who participated in an anchor-sponsored meeting in January 2012.