

# Texas Healthcare Transformation and Quality Improvement Program

## REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

*March 2013*

*RHP 13*

RHP Lead Contact:

*Tim Jones, CEO*  
McCullough County Hospital District  
2008 Nine Road  
Brady, TX, 76825  
[timjones@bradyhospital.com](mailto:timjones@bradyhospital.com)  
325-792-3940

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## Instructions

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

### Timeline:

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

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

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

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

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

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

Please mail RHP Plan packets to:

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

11209 Metric Blvd.  
Austin, Texas 78758

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

**Section I. RHP Organization**

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

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

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
<b>Anchoring Entity</b>						
District	138715115	1 741791441 7 004	Non-State-owned public entity	McCulloch County Hospital District	Tim Jones	2008 Nine Road PO Box 1150 Brady, TX 76825 (325) 792 3940 timjones@bradyhospital.com
<b>IGT Entities</b>						
District	130089906	1752312009 9 001	Non State Owned Public Entity	Ballinger Memorial Hospital District	Grady Hooper	P.O. Box 617 Ballinger, TX 76821 (325) 365-2531 gradyh@bmhd.org

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
District	136144610	17524282435000	Non-State-owned public entity	Coleman County Medical Center	Mike Pruitt	310 S. Pecos Coleman, TX 76834 (325) 625-2135 mike.pruitt@trhta.net
District	091770005	17512977350002	Non State Owned Public Entity	Concho County Hospital District	Dudley White	614 Eaker Street, Eden, TX, 76837, dudleywhite@conchoch.com 325-869-5911 x211
County	N/A	17560008959016	Non State Owned Public Entity	Crockett County	Judge Fred Deaton	102 Avenue H, Ozona, TX, 76943, , 325-392-2965 Fred.deaton@co.crockett.tx.us
District	206083201	1741622343001	Non State Owned Public Entity	Kimble County Hospital District	Susan Sieker	349 Reid Rd Junction, TX. 76849 (325)446-8149 ssieker@kimblehospital.org
District	020989201	17513066260000	Non State Owned Public Entity	North Runnels Hospital District	Sidney Tucker	P.O. Box 185 Winters, TX 79567 (325) 75404141 stucker@nrhd.org
District	138715115	17417914417004	Non State Owned Public Entity	McCulloch County Hospital District (Heart	Tim Jones	2008 Nine Road PO Box 1150 Brady, TX 76825 (325) 792 3940

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)
				of Texas Mem Hosp)		timjones@bradyhospital.com
County	130616905	17460029634 000	Non State Owned Public Entity	Pecos County Memorial Hospital	Jim Horton	387 West I-10, Fort Stockton, TX, 79735, jhorton@pcmhfs.com, 432-336-4201
District	121806703	1-75-6003050-8 Outlet # 00001	Non State Owned Public Entity	Reagan Memorial Hospital District	John Perushek	805 N. Main Avenue Big Lake, TX 76932 (325) 884-2561 jperushek@trhta.net
District	179272301	12036625965000	Non State Owned Public Entity	Schleicher County Hospital District	Paul Burke	P.O. Box V Eldorado, TX 76936 (325) 853-2507 pburke@scmc.us
District	121781205	17521529333 003	Non State Owned Public Entity	Sutton County Hospital District	Keith L. Butler	P.O. Box 455 Sonora, Texas 76950 (325) 387 1200 kbutler@sonora-hospital.com
County	N/A	17560011847	County	Tom Green County	Judge Mike Brown	2018 Pulliam St, San Angelo, TX, 76905, , 325-653-3318 Mike.brown@co.tom-green@tx.us

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)
CMHC	133339505	1-75-1294432-7000	Non-State Owned Public	Central Texas MHMR dba Center for Life Resources	Dion White	408 Mulberry, Brownwood, TX 76801, dion@cflr.us, 325-643-9574
CMHC	133340307	1-74-2822017-6-001	Non-State Owned Public	Hill Country Mental Health & Developmental Disabilities Centers	David Weden	819 Water Street, Suite 300 Kerrville, TX 78028 (830) 792-3300 DWeden@mail.hillcountry.org
CMHC	109483102	1-751251523-4003	Non-State Owned Public	MHMR Services for the Concho Valley	Lynn Rutland	1501 W Beauregard, San Angelo, TX 76901, lrutland@MHMRCV.ORG, 325-658-7750
CMHC	138364812	17514017767014	Non-State Owned Public	Permian Basin Community Centers for MHMR	Larry Carroll	401 E Illinois Ave, Midland, TX 79701, lcarroll@pbmhmrc.com, 432-570-3300
CMHC	130725806	17526061696003	Non-State Owned Public	West Texas Centers	Shelley Smith	319 Runnels St, Big Spring, TX 79720, shelley.smith@wtcmhmrc.org, 432-263-0007
County Health Department	0227936-01	17560006599013	Non-State-owned public entity	San Angelo-Tom Green County Health	Sandra J. Villareal	72 W. College, San Angelo, TX 76903 sandra.villarreal@sanangel

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)
				Department		otexas.us 325-657-4493
<b>Performing Providers</b>						
Hospital	138715115	1741791441 7 003	Private	Heart of Texas Healthcare System	Ed Watson	2008 Nine Road, Brady, TX, 76825, edwatson@bradyhospital.com, 325-792-3940
Hospital	136144610	1752428243 5 000	Private	Coleman County Medical Center	Mike Pruitt	310 S. Pecos Coleman, TX 76834 (325) 625-2135 mike.pruitt@trhta.net
Hospital	179272301	1203662596 5 002	Private	Preferred Hospital Leasing Eldorado, In. dba Schleicher County Medical Center	Paul Burke	P.O. Box V Eldorado, TX 76936 (325) 853-2507 pburke@scmc.us
Hospital	131042703	1262294680 9 008	Private	Kimble County Hospital District	Susan Sieker	349 Reid Rd Junction, Tx. 76849 (325)446-8149

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)
						ssieker@kimblehospital.org
Hospital	137226005	1752559845 8 501	Private	Shannon Medical Center	Shane Plymell	120 E Harris Avenue, San Angelo, TX, 76903, shaneplymell@shannonhealth.org, 325-653-5014
District	130089906	1752312009 9 001	Non State Owned Public Entity	Ballinger Memorial Hospital District	Grady Hooper	608 Avenue B, Ballinger, TX, 76821, , 325-365-2531 <a href="mailto:gradyh@bmdh.org">gradyh@bmdh.org</a>
District	091770005	1751297735 0 002	Non State Owned Public Entity	Concho County Hospital District	Dudley White	614 Eaker Street, Eden, TX, 76837, dudleywhite@conchoch.com, 325-869-5911 x211
County	130616905	1746002963 4 000	Non State Owned Public Entity	Pecos County Memorial Hospital	Jim Horton	387 West I-10, Fort Stockton, TX, 79735, jhorton@pcmhfs.com, 432-336-4201
District	020989201	1751306626 0 000	Non State Owned Public Entity	North Runnels Hospital District	Sidney Tucker	P.O. Box 185 Winters, TX 79567 (325) 75404141 stucker@nrhd.org
District	121806703	1-75-6003050-8 Outlet	Non State Owned Public Entity	Reagan Memorial Hospital	John Perushek	805 North Main Avenue, Big Lake, TX, 76932, , 325-884-2561 x737

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)
		#00001		District		jperushek@trhta.net
CMHC	133339505	1-75-1294432-7000	Non-State Owned Public	Central Texas MHMR dba Center for Life Resources	Dion White	408 Mulberry, Brownwood, TX 76801, dion@cflr.us, 325-643-9574
CMHC	133340307	1-74-2822017-6-001	Non-State Owned Public	Hill Country Mental Health & Developmental Disabilities Centers	Linda Werlein	819 Water St, Suite 300, Kerrville, TX 78028, lwerlein@hillcountry.org, 830-792-3300
CMHC	109483102	1-751251523-4003	Non-State Owned Public	MHMR Services for the Concho Valley	Lynn Rutland	1501 W Beauregard, San Angelo, TX 76901, lrutland@MHMRCV.ORG, 325-658-7750
CMHC	138364812	17514017767014	Non-State Owned Public	Permian Basin Community Centers for MHMR	Larry Carroll	401 E Illinois Ave, Midland, TX 79701, lcarroll@pbmhm.com, 432-570-3300
CMHC	130725806	17526061696003	Non-State Owned Public	West Texas Centers	Shelley Smith	319 Runnels St, Big Spring, TX 79720, shelley.smith@wtcmhm.org, 432-263-0007

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
County Health Department	0227936-01	17560006599013	Non-State-owned public entity	San Angelo-Tom Green County Health Department	Sandra J. Villareal	72 W. College, San Angelo, TX 76903 sandra.villarreal@sanangelotexas.us 325-657-4493
<b>UC-only Hospitals</b>						
Hospital	112693002	16217624762003	Private	San Angelo Community Medical Center	Steve Ewing	3501 Knickerbocker, San Angelo, TX, 76904-7698, steven.ewing@sacmc.com , (325) 947-6400
<b>Other Stakeholders</b>						
County Medical Associations/Societies						
Regional Public Health Directors						
Other significant safety net						

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
providers within the region (specify type)						
Others (specify type, e.g. advocacy groups, associations)						

## Section II. Executive Overview of RHP Plan

RHP 13 encompasses the Heart of Texas region and areas north and west of it. This region includes Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green counties. The population of the area is approximately 190,079 or 0.76 percent of the total population of the state of Texas (population 25,145,561). Though less than 1 percent of the state's population lives in RHP 13, the top soil and sand in RHP 13 covers an expanse almost 10% of the state's total square miles. The racial/ethnic breakdown is 4.92% African-American and Other, 57.1% non-Hispanic Caucasian, and 37.98% Hispanic.

West Central Texas is a mostly rural region covering almost 25,000 square miles (9.82% of the state of Texas) and is geographically isolated from major cities and highways. The service area is larger than the size of the state of West Virginia, requiring residents in outlying areas to travel up to two hours to see a healthcare professional or to access services. In addition to geographic isolation, the region also has low rates of educational attainment, and high rates of poverty and preventable conditions such as obesity, diabetes, and heart disease. The region lacks many of the services offered in more populated areas such as easily accessible public transportation, resource centers, and public outreach programs. Sixteen of the 17 counties are designated as Health Professional Shortage Areas for Primary Care and Primary Care for Special Populations. The largest county in Region 13, Tom Green, serves as the healthcare hub for the area; has two hospital facilities; and employs 80% of the total primary and direct care physicians in the region. The uninsured rates are higher than national and state averages with uninsured rates among the counties ranging from 25.7% (Tom Green County) to 42.5% (Concho County). Many factors, such as socioeconomic status (education and income), access and utilization of healthcare, health behaviors (diet and exercise), and social environment also greatly contribute to the health disparities seen in the region.

According to the HHS Agency for Healthcare Research and Quality, the current healthcare system often does not deliver the care that Americans need to stay healthy, recover from illness, live with chronic disease or disability, or cope with death and dying. Even more disconcerting is when a person receives care that causes harm. While quality of care has seen an improvement, according to a 2011 report, socioeconomic disparities and access to care still account for inefficient healthcare for many Americans. Through the coordinated efforts of the Regional Health Partnership, participants in RHP 13 have identified two primary objectives:

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

RHP 13 has proposed DSRIP plans from 11 acute care hospitals and five Community Mental Health Centers (CMHC) and one health department. Additionally, one hospital has indicated they will be participating in the Uncompensated Care (UC) pool only. There has been wide provider participation, and the hospitals and centers have all actively participated in stakeholder meetings, brainstorming sessions, webinars, and conference calls and are now in the submission phase.

RHP 13 wants to pursue transformation to impact total population health as well as increase the Triple Aim to potentially include a fourth aim: Right Cost. Economic factors of healthcare are growing exponentially as the public payers have the need to find cost savings and better and more efficient models to deliver quality health care. Across our region, hospitals are faced with patients seeking non-emergent care in the Emergency Department. Many factors contribute to Medicaid and uninsured patients seeking primary, preventive, and mental health care in the ED. By making strategic expansions in the capacity for primary care in more rural areas, we expect to better enable appropriate diagnoses in a more timely fashion to prescribe the best treatment plan for patients. Too often, patients with urgent needs cannot get a same day appointment, or they may not know where to seek appropriate care outside the ED. Through educational pushes and increases in the capacity of mental health and primary care services, we expect to measure more appropriate ED utilization in our region. Since the Hill-Burton Act, rural communities with hospitals have relied heavily on the institutional level of care for all health care needs. As healthcare transforms to increase patient centered care models and more care outside of the hospital, it is increasingly important that the hospital lead this effort in rural communities with our residents and patients. Through the DSRIP projects to expand primary care capacity, we will be leading a great initiative to change behavior and expectations in RHP 13.

As a Tier 4 region, various collaborations were developed across providers in order to enable more robust projects to be developed regionally. Initially potential performing providers with artificially low allocations were disadvantaged and not able to consider robust projects such as transformation of care settings. Had collaborations not been developed, the level of innovative projects in RHP 13 would have been negligent. However, the encumbered DSRIP funds associated with provider projects will ignite a regional effort to address health disparities and improve patient centered and evidence based approaches.

Other transformational outcomes for Category 1 and 2 projects include patient satisfaction. As providers begin to measure patient satisfaction, it becomes increasingly clear that there is room for improvement. As the economic trends in healthcare seek to enable patients to own and to engage with providers regarding treatment options and healthy lifestyles, training for providers and staff in the hospital and clinics is essential. Patients want to be able to email the clinic to find out if they need to come in for a blood pressure check. When they go to the wellness center for their therapy or exercise session, they want to be able to ask questions about other preventive efforts they can be engaged in. Creating comprehensive care models and training staff on how to best enable the patient to manage their condition will further advance initiatives related to value-based purchasing. Value-based purchasing and payment

variances which award providers who reduce potentially preventable events, further improves clinical outcomes for patients who might otherwise have an avoidable complication when admitted on an avoidable hospitalization. Bending the cost curve in healthcare isn't happening fast, but strategic efforts to continue Pay-for-Outcome type initiatives set forth in S.B. 7 (Legislative Session, 82-1 by Senator Nelson) will further impact the slope of the curve for Medicaid and the uninsured, which will spill over to the private and commercial markets as well.

RHP 13 seeks to increase healthy competition in the healthcare arena and to increase patients' ability to self-manage and participate in healthy lifestyles over the course of their lives. Specific initiatives include increased access to primary and specialty care capacity; increased appropriate care in appropriate settings; improved patient centered treatment plans for patients with diabetes, heart disease, and at end of life; and expanded services and care for persons with Severe and Persistent Mental Illness (SPMI) through the Healthcare Transformation Waiver.

**Summary of Categories 1-2 Projects**

<b>Project Title</b> (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
<b>Category 1: Infrastructure Development</b>			
Pass 3B Old ID 130089906.1.1 New ID 130089906.1.2 Expand Primary Care Capacity  Ballinger Memorial Hospital/130089906	Ballinger Memorial Hospital Access to Care Initiative	OD-6 Patient Satisfaction Old ID 130089906.3.1 New ID 130089906.3.4  IT-6.1 Percent improvement over baseline of patient satisfaction scores	\$821,433
133339505.1.1 Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavior Health Central Texas MHMR dba Center for Life Resources/133339505	Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state	OD-9 Right Care, Right Setting  IT-9.2 ED appropriate utilization	\$674,793
Pass 3B NEW: 136144610.1.2 (OLD: 136144610.1.1 Expand Primary Care Capacity	Transform and improve access to primary and preventive care by enhancing access points, expanding clinic space, providing non-emergent	New: 136144610.3.3 Old: 136144610.3.1  OD-9 Right Care, Right Setting	\$775,974

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Coleman County Medical Center/136144610	transportation and increasing capacity for the growing need for appropriate care.	IT-9.2 ED appropriate utilization	
Pass 3B 138715115.1.1 (Old) 138715115.1.2 (New) 138715115.1.1 Expand Specialty Care Capacity Heart of Texas Hospital/138715115	End Stage Renal Disease Dialysis Center	<b>138715115.3.1 (OLD)</b> 138715115.3.3 <b>(NEW)</b> OD-2 Potentially Preventable Admissions IT-2.2 End-Stage Renal Disease	\$2,111,701
109483102.1.1 Development of Behavior Health Crisis Stabilization Services as Alternative to Hospitalization MHMR of the Concho Valley/109483102	IDD Behavioral Health Crisis Response System	OD-9 Right Care, Right Setting  IT-9.2 ED appropriate utilization	\$2,219,086
109483102.1.2 Enhance Service Availability of Appropriate Levels of Behavioral Health Care MHMR of the Concho Valley/109483102	Enhance and Expand Behavioral Health Services	OD-10 Quality of Life/Functional Status  IT-10.1 Quality of Life	\$1,931,202

<b>Project Title</b> (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
Pass 2 020989201.1.1, 1.1.2 Expand existing primary care capacity North Runnels Hospital/020989201	Primary Care Capacity by adding a Physician or Physician Assistant	020989201.3.2 OD-9 Right Care, right setting  IT-9.2 ED appropriate utilization	\$317,370
Pass 3B <i>New 130616905.1.3 Pass 3b (Old 130616905.1.1)</i> Expand Primary Care Capacity Pecos County Memorial Hospital/130616905	Transform access to care by establishing a primary care clinic in Sanderson	<i>New 130616905.3.7 Old 130616905.3.1</i> OD-9 Right Care, Right Setting	\$1,629,321
		IT-9.2 ED Appropriate Utilization	
Pass 2 130616905.1.2 Expand Primary Care Capacity Pecos County Memorial Hospital/130616905	Emergency Department Fast Track Program	130616905.3.5 OD-9 Right Care, Right Setting  IT-9.2 ED Appropriate Utilization	\$1,292,480
138364812.1.1 Expand Specialty Care Capacity  Permian Basin Community Centers/138364812	PBCC intends to increase Behavioral Health Care capacity, primarily psychiatric and counseling services, to patients who do not meet the Department of State Health Services (DSHS) definition of "Target Population"	138364812.3.1 OD-6 Patient Satisfaction  IT-6.1 Percent improvement over baseline of patient satisfaction scores	\$642,091

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
<b>Pass 3B</b> <b>New ID 121806703.1.2</b> <b>OLD 121806703.1.1</b> 1 Expand Primary Care Capacity  Reagan Memorial Hospital/121806703	Reagan Memorial Hospital will expand primary care capacity by opening a primary care clinic under its own name	<b>New:121806703.3.2</b> <b>Old:121806703.3.1</b> OD-6 Patient Satisfaction  IT-6.1 Percent improvement over baseline of patient satisfaction scores	\$821,633
0227936-01.1.1 Expand Primary Care Capacity  San Angelo-Tom Green County Health Department/0227936-01	Establish a Sexually Transmitted Disease Clinic	0227936-01.3.1, 0227936-01.3.2, 0227936-01.3.3 OD-12 Primary Care and Primary Prevention  IT-12.6 Other	\$887,500
137226005.1.1 Expand Primary Care Capacity  Shannon Medical Center/137226005	Establish North Urgent Care Clinic	137226005.3.1 OD-9 Right Care, Right Setting IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits	\$5,658,911
Pass 3B Project: Old Project Unique ID #: 137226005.1.2 New Project Unique ID #:	Chronic conditions disease registry	Old ID: 137226005.3.5 New ID: 137226005.3.7 OD-1 Primary Care and Chronic Disease Management;	\$6,274,048

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
137226005.1.4, 1.3 Implement a Chronic Disease Management Registry  Shannon Medical Center/137226005		IT-1.10 Diabetes Care: HbA1c poor control (>9%) – NQF 0059 (standalone measure)	
Pass 2 137226005.1.3, 1.9 Expand Specialty Care Capacity	Extending specialty care to rural communities surrounding Tom Green County.	137226005.3.6 OD-6, Patient Satisfaction:	\$2,509,620
Shannon Medical Center/137226005		IT-6.1 Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
130725806.1.1 Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavior Health  West Texas Centers/130725806	West Texas Center Telemedicine Expansion	130725806.3.1 OD-6 Patient Satisfaction  IT-6.1 Percent Improvement Over Baseline of Patient	\$469,688

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
		Satisfaction Scores	
Pass 2 130725806.1.2, 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system  West Texas Centers/130725806	Expand the capacity of West Texas Center’s behavioral health services	130725806.3.2 OD-6 Patient Satisfaction with improvement measure  IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	\$184,184
<b>Category 2: Program Innovation and Redesign</b>			
Pass 3B <b>Old ID 130089906.2.1 New ID 130089906.2.2</b> , 2.2.2– Apply evidence-based care management model to patients identified as having high-risk health care needs	Expand chronic care management models	Old ID 130089906.3.2 New ID 130089906.3.5 Old ID 130089906.3.3 New ID 130089906.3.6 OD-2- IT-3.2, IT-3.3	\$322,308

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Ballinger Memorial Hospital/130089906		IT-3.2 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 IT-3.3 Diabetes care: BP control (<140/80mm Hg) - NQF 0061	
Pass 3B NEW: 136144610.2.2 (OLD: 136144610.2.1) Enhance/Expand Medical Homes	CCMC will implement an evidence-based prenatal care model through a medical home initiative to provide prenatal care to improve prenatal health care the likeability that a mother carries the baby to 39 weeks, and the outcomes for the child.	New: 136144610.3.4 (Old: 136144610.3.2) OD-8 Perinatal Outcomes	\$827,704
Coleman County Medical Center/136144610		IT-8.2 Percentage of Low Birth-weight births	
Pass 3B: New ID: 091770005.2.2 Pass 3B Old ID 091770005.2.1 - Implement Evidence-based Health Promotion Programs	Concho County Hospital Health and Wellness Promotion	NEW 091770005.3.2 OLD: 091770005.3.1 OD-1 Primary Care and Chronic Disease Management	\$821,633

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Concho County Hospital/091770005		IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059	
Pass 3 138715115.2.1., 2.6 Implement Evidence-based Health Promotion Programs Heart of Texas Hospital/138715115	CATCH® in Motion	OD-10 Quality of Life  IT-10.1 Quality of Life (standalone measure)	\$2,878,264
133340307.2.1	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder	133340307.3.1 OD-10 Quality of Life/Functional Status	\$223,696
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) TPI: 133340307		IT-10.2 Activities of Daily Living	
133340307.2.2	Provide an intervention for a targeted behavioral health population to prevent	133340307.3.2 OD-10 Quality of Life/Functional Status	\$363,907

<b>Project Title</b> (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) TPI: 133340307	unnecessary use of services in a specific setting: Trauma Informed Care	IT-10.2 Activities of Daily Living	
Pass 2 133340307.2.3, 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services	Expand Veteran Peer Coordinators in Kimble, Mason, Menard, Schleicher and Sutton counties	133340307.3.3 OD-10 Quality of Life/Functional Status	\$102,909
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) TPI: 133340307		IT-10.2 Activities of Daily Living	
Pass 2 133340307.2.4, 2.18.1 Recruit, train and support consumers of mental health services to provide peer support services Whole Health Peer Support	Expanding peer services	133340307.3.4 OD-10 Quality of Life/Functional Status	\$103,531

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
Hill Country Community MHMR Center (dba Hill Country MHDD Centers) TPI: 133340307		IT-10.2 Activities of Daily Living	
Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2 Implement Evidence-based Disease Prevention Programs  Kimble Hospital/206083201	Disease Prevention Programs	NEW: 2060833201.3.2 OLD: 2060833201.3.1 OD-2 Potentially Preventable Admissions IT-2.1 Congestive Heart Failure Admission rates	\$732,167
<u>Pass 3B</u> <u>New ID - 109483102.2.2; Old ID - 109483102.2.1, 2.15.1</u> Integrate Physical and Behavioral Health Care MHMR of the Concho Valley/109483102	"Integrate Primary and Behavioral Health Care"	New ID:109483102.3.4 Old ID: 109483102.3.3 OD-10 Quality of Life/Functional Status  IT-10.1 Quality of Life	\$1,857,286
PASS 3B New 020989201.2.2 Old 020989201.2.1 Redesign for Cost Containment	Redesign for Cost Containment- Imaging System	020989201.3.3 Old 020989201.3.1 OD-5 Cost of Care	\$821,634

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5
North Runnels Hospital/020989201		IT-5.1 Improved cost savings: demonstrate cost savings in care delivery	
<p>Pass 3b  New ID:130616905.2.3  Old ID: (130616905.2.1)  130616905.2.1 Expand Chronic Care Management Models</p> <p>Pecos County Memorial Hospital/130616905</p>	Expand Chronic Care Management Models	<p><i>New 130616905.3.8</i>  <i>New 130616905.3.9</i>  <i>New 130616905.3.10</i>  <i>Old 130616905.3.2</i>  <i>Old 130616905.3.3</i>  <i>Old 130616905.3.4</i></p> <p>OD-3 Potentially Preventable Re-Admissions</p> <p>IT-3.2 Congestive Heart Failure Readmission rate</p> <p><i>IT-3.6 CAD 30 day readmission rate</i></p> <p>IT-3.9 Chronic Obstructive Pulmonary Disease 30 Day Readmission Rate</p>	\$1,629,321
Pass 3 130616905.2.2, 2.6 Implement Evidence-based Health Promotion Programs	CATCH® in Motion	130616905.3.2 OD-10 Quality of Life	\$2,878,263
Pecos County Memorial Hospital/130616905		IT-10.1 Quality of Life (standalone measure)	

<b>Project Title</b> (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
Pass 3B OLD: 179272301.2.1 NEW: 179272301.2.2 Enhance/Expand Medical Homes Schleicher County Medical Center/179272301	Schleicher County Medical Home Feasibility and Implementation	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1 OD-9 IT-9.2 ED appropriate utilization	\$172,790
137226005.2.1 Redesign to Improve Patient Experience  Shannon Medical Center/137226005	Improve Patient Experience	137226005.3.2 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores	\$3,961,237
137226005.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency  Shannon Medical Center/137226005	Implement LEAN processes	137226005.3.3 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores	\$3,678,292
137226005.2.3 Use of Palliative Care Programs  Shannon Medical Center/137226005	Expand Palliative Care	137226005.3.3 OD-13 Palliative Care IT-13.4 Proportion admitted to the ICU in the last 30 days of life	\$4,810,075

<b>Project Title</b> (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
Pass 3B OLD 121781205.2.1 Establish/Expand a Patient Care Navigation Program Sutton County Hospital District dba Lillian M. Hudspeth Memorial Hospital/121781205	Community Paramedic Program	121781205.3.1 OD-2 Potentially Preventable Admissions  IT-2.13 Other Admission Rate	\$1,316,993

**Section III.**

**Community Needs Assessment**

**Regional Healthcare Partnership**

**Region 13**

**October 2012**

Dick Sweeden  
TMSI, Inc.  
Austin, Texas

## Demographics

Region 13 includes Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green counties. The population of the area is approximately 190,079 citizens, which represents a growth of 2% since the 2000 census, and is 0.76% of the State's total population. The ratio of female to male residents in the Region is approximately 49%-51%, respectively. The Region encompasses a land area of 25,721 square miles, with a population density that ranges from less than one person per square mile in Terrell County to 69.4 per square mile in Tom Green County.

West Central Texas is a mostly rural region that covers nearly 10% of the state, but is geographically isolated from major cities and highways. The service area of Region 13 is larger than the state of West Virginia. Adjacent Regions 11 and 14 are also large, and when combined with Region 13, account for 48 of the 254 counties in Texas. Most of the 48 counties have limited hospital resources, and the more complicated medical cases are sent to the most appropriate larger safety net hospital, regardless of the region. There are a number of variables, including distance and need that influence the patient's decision to seek medical attention at a healthcare facility outside their residing region. (See Appendix page 19). In addition to geographic isolation, Region 13 has low rates of educational attainment, high rates of poverty, and high rates of chronic diseases such as obesity, diabetes, and heart disease.

The median age of Region 13 is 39.2 years, and the median household Income is \$39,578. The average wage per job is \$34,403. The unemployment rate for the Region is 6.7%, with the number of uninsured children and adults at 28.4%. Currently, 18% of the Region is living below the poverty rate, and 28.3% of children live below the poverty rate.

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<b>Unemployment rate</b>	<b>6.7%</b>	<b>Range: 4.1--9.0%</b>
<b>Residents below Poverty Rate</b>	<b>18.0%</b>	<b>Range: 9.6--28.4%</b>
<b>Children below Poverty Rate</b>	<b>28.3%</b>	<b>Range: 14.5--40.9%</b>
<b>Uninsured 0 – 64 years</b>	<b>28.4%</b>	<b>Range: 25.7--42.5%</b>

**Source: Health Facts Profile [www.dshs.state.tx](http://www.dshs.state.tx)**

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78% of residents in the Region have a high school diploma, with a range from 61.9% in Crockett County to 86.3% in Coke County. Those residents with a Bachelor's degree or higher are at 19% of the population, with a range from 9.1% in Crockett County to 28.9% in Mason County.<sup>1</sup>

Ethnicity and/or race are important demographic measures for the Region to consider, as certain diseases affect some ethnic groups and races at a higher rate than other groups. In particular, African-Americans and Hispanics tend to have a higher incidence of diabetes and hypertension. These two chronic diseases tend to lead to other illnesses, including cardiac and vascular disease. Access to primary care and specialty care is an issue, especially in rural communities, and therefore increases the impact that chronic diseases can have on at-risk populations, not only in Region 13 but throughout Texas. The racial/ethnic breakdown in the Region is 57.1% non-Hispanic Caucasian, 37.98% Hispanic, and 4.92% African-American.<sup>2</sup>

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<sup>1</sup> quickfacts.census.gov

<sup>2</sup> quickfacts.census.gov

## Insurance

Region 13's population includes a broad variety of ages, socio-economic groups, and insured/non-insured individuals. As the number of residents who are 65 and older continues to grow, the utilization of Medicare resources grows. This growth is not only with the raw number of individuals, but also with the increase of chronic diseases, such as diabetes, cardiac disease, circulatory diseases, and mental health issues. Likewise, the number of uninsured/underinsured is growing as unemployment remains high, and as small businesses choose to not offer health benefits.

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

Using the Medicaid data from April 2012, the number of Medicaid enrollees in the Region is 22,461, or 11.8% of the population. Medicare enrollees in 2011 were at 33,433, or 17.6% of the population. The number of CHIP enrollees in the Region for July 2012, was an average of 97 for the 16 rural counties, and a total of 2,308 for Tom Green County.

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	<b>Number</b>	<b>Percentage</b>
<b>Medicare</b>	<b>33,433</b>	<b>17.60%</b>
<b>Medicaid</b>	<b>22,641</b>	<b>11.80%</b>
<b>CHIP</b>	<b>97*</b>	
<b>Uninsured</b>	<b>53,970</b>	<b>28.39%</b>
<b>Insured</b>	<b>80,215</b>	<b>42.20%</b>

**\*Average enrollment for Rural Counties; Tom Green County enrollment is 2,308.**

Source: [www.hhsc.tx.us](http://www.hhsc.tx.us) Medicaid Enrollment files, CHIP Enrollment files, [www.county-health.findthedata.org](http://www.county-health.findthedata.org)

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

### Current Healthcare Structure

The hospitals and medical centers operating within Region 13 include two major urban medical centers and seven community hospitals operating in rural communities:

- Coleman County Medical Center
  - 25 beds
  - Hospital District
- Concho County Hospital

- 16 beds
  - Hospital District
- Kimble Hospital
  - 15 beds
  - Hospital District
- Heart of Texas Memorial Hospital
  - 25 beds
  - Hospital District
- Iraan General Hospital District
  - 14 beds
  - Hospital District
- Pecos County Memorial Hospital
  - 27 beds
  - Hospital District
- Reagan Memorial Hospital
  - 14 beds
  - Hospital District
- North Runnels Hospital
  - 25 beds
  - Hospital District
- Ballinger Memorial Hospital
  - 25 beds
  - Hospital District
- Schleicher County Medical Center
  - 14 beds
  - Hospital District
- Sutton County Hospital District
  - 12 beds
  - Hospital District
- River Crest Hospital
  - 80 beds
  - Investor-owned/ Mental Health
- San Angelo Community Medical Center
  - 171 beds
  - Investor-owned
- Shannon Medical Center
  - 409 beds
  - Not-for-profit

In addition to acute care, the operations of these facilities include Rural Health Clinics, Home Health Agencies, and other mechanisms to address the needs for primary care access as well as for specialty care.

- Skilled Nursing Facilities
- Primary Care clinics
- Specialty Care clinics
- Mental Health clinics---Seniors, other Adults, Adolescents
- Outpatient Rehabilitation clinics
- Wellness and Fitness Centers
- Cardiac Rehabilitation
- Sleep Labs
- Senior Health Centers
- Wound Care/Hyperbarics
- Teleradiology
- Other specialty care---Heart Centers, Stroke Centers, Cancer Centers

Further, Mental Health Authorities, Health Districts, Emergency Management Districts, Cities, and Counties are represented in the Regional Health Partnership, and are key participants in the effort to create innovative methods of healthcare delivery.

The U.S. Department of Health and Human Services, through its' Health Resources and Services Administration (HRSA), designates Health Professional Shortage Areas (HPSA) as having a shortage of Primary Care Providers, and/or Dental and Mental Health Providers. HRSA also designates Medically Underserved Areas/Populations (MUA/P) as having too few Primary Care Providers, high infant mortality, high poverty, and/or high elderly population. Region 13 has both HPSA designations and MUA/P designations in every county it represents, whether for the entire county, or for special populations, as is the case for Tom Green County. In particular, a shortage of Primary Care Providers and of Mental Health Providers exists throughout the Region.

**Population per Physician**

	<b>County</b>	<b>Texas</b>	<b>U.S.</b>
<b>Coke</b>	<b>0</b>	<b>1050:1</b>	<b>631:1</b>
<b>Coleman</b>	<b>4447:1</b>		
<b>Concho</b>	<b>0</b>		
<b>Crockett</b>	<b>0</b>		
<b>Irion</b>	<b>0</b>		
<b>Kimble</b>	<b>1108:1</b>		
<b>Mason</b>	<b>0</b>		
<b>McCulloch</b>	<b>1312:1</b>		
<b>Menard</b>	<b>1063:1</b>		
<b>Pecos</b>	<b>1324:1</b>		
<b>Reagan</b>	<b>1511:1</b>		
<b>Runnels</b>	<b>1281:1</b>		

<b>Schleicher</b>	<b>910:1</b>
<b>Sterling</b>	<b>0</b>
<b>Sutton</b>	<b>719:1</b>
<b>Terrell</b>	<b>919:1</b>
<b>Tom Green</b>	<b>1108:1</b>

Source: [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

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As the numbers indicate, six of the seventeen counties in Region 13 have no primary care physicians, and most of the remaining counties suffer from a shortage of primary care physicians. Additionally, while some of the rural hospitals offer some Specialty Clinics, there are shortages in that area as well. Patients and families are required to travel long distances to access the care they need, particularly if it involves specialists. Such travel can be difficult for the elderly and the poor, whose numbers are significant in rural Texas.

Healthy People 2020 has established numerous goals to address the health issues faced by Americans today. One goal is to “improve access to comprehensive, quality health care services”. It points out that the four components of access are: coverage, services, timeliness, and workforce. Healthy People 2020 also addresses the barriers to services: lack of available resources, cost, and lack of insurance coverage. Those who lack coverage are less likely to get care, and more likely to experience poor health status and pre-mature death.<sup>3</sup>

According to the Henry J. Kaiser Foundation, nearly one in five Americans lack adequate access due to a shortage of primary care physicians in their communities. Medical school training programs report a decline in the number of students entering into primary care, for a variety of reasons. The Foundation reports that only about 8% of medical school graduates go into Family Medicine, which impacts communities everywhere, but especially in rural areas.<sup>4</sup> For Region 13, already facing a shortage of primary care providers, the increasing shortage creates an even greater challenge.

There are provisions in the Patient Protection and Affordable Care Act to increase training slots, and to offer financial incentives for primary care providers. However, it is not known at this time how those incentives will balance with the addition of individuals seeking care through the new insurance exchanges and/or Medicaid expansion.

As noted above, Region 13 is a Mental Health Professional Shortage Area. Lack of access to mental health professionals in the rural communities creates significant problems in terms of Emergency Room visits, untreated mental health conditions, and complications in treating medical conditions which are worsened by the presence of mental health issues. Another goal of Healthy People 2020 is to “improve mental health through prevention and by assuring access to appropriate, quality mental health services”. Healthy People 2020 addresses the close connection between mental and physical health, and how dealing with one makes it difficult for the patient to overcome the other.

Further, Healthy People 2020 points out the emergence of new mental health issues, to include the needs of Veterans who have experienced physical and mental trauma, and the needs of the elderly, who are dealing with dementia and related disorders. Region 13, with the

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<sup>3</sup> [www.healthypeople.gov](http://www.healthypeople.gov)

<sup>4</sup> [kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx](http://kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx)

presence of Goodfellow Air Force Base in San Angelo, and with many rural areas where the elderly and military retirees reside, is a prime area for addressing these two growing issues.

According to an article in the San Antonio Business Journal, October 17, 2010, by W. Scott Bailey, a study by the National Alliance on Mental Illness (NAMI) found that 833,000 Texans suffer from serious mental illness, but only 21% of that population is being served by a state mental health agency.<sup>5</sup> NAMI indicates that an unknown percentage of these Texans may be receiving help from other sources, or may be ineligible for assistance. The same article reports that the Mental Health Association in Texas indicates that mental illness costs the State as much as \$17 million annually due to lost productivity and family income.

According to NAMI, one in four adults and one in ten children are impacted by mental illness, and in a report published in November 2011, stated that Texas now ranks last in per capita funding for people with mental illness.<sup>6</sup> This is despite an increase of 4.3% in funding over the last three years.

In comments to the HHSC 2012 Summit on August 8, 2012, Octavio Martinez, MD, MPH, MHA, Executive Director of the Hogg Foundation for Mental Health, reported that only one third of adults and one fourth of children in Texas with serious mental illness receive services through the Community Mental Health System.

Dr. Martinez also reported that most mild to moderate mental health conditions are seen in the primary care setting, and patients with chronic medical conditions tend to have a high rate of behavioral health problems.

According to Dr. Martinez, less than fifty percent of referrals for specialty mental health care are pursued by patients due to lack of insurance, poverty level, transportation issues, and/or cultural beliefs. Additionally, Dr. Martinez pointed out that in behavioral health settings, more than 50% of medical conditions go unrecognized. The opportunities for dramatic improvement in the delivery of mental health care in Texas lie in the ability of the Hospitals, primary care providers, and mental health providers to develop a network of continuous care across all three domains.

Region 13 residents are served by a variety of mental health agencies, providing adult, child, and adolescent mental health services, as well as Intellectual and Developmental Disabilities/Early Childhood Intervention. Agencies include The Central Texas MHMR dba Center for Life Resources, covering Coleman and McCulloch counties, MHMR Concho Valley, covering Tom Green, Coke, Crockett, Irion, Sterling, Reagan, and Concho counties, West Texas Centers, covering Runnels and Terrell counties, Hill Country MHMR, covering Kimble, Mason, Menard, Schleicher, and Sutton counties, and Permian Basin Community Centers, covering Pecos County. (See Appendix page 18 for details). Barriers to care cited by these agencies include:

- Lack of transportation/no bus system
- Shortage of all physicians, including psychiatrists
- Lack of psychiatric hospitals
- Cost of medications

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<sup>5</sup> San Antonio Business Journal, October 17, 2010, W. Scott Bailey

<sup>6</sup> The Texas Tribune, November 10, 2011, Claire Cordona

- Co-pay for clinic services
- Clinic hours of operation conflict with patients' work schedules
- Lack of insurance
- Poverty

Anticipated changes in the Region

During the next four years of the Waiver, changes are anticipated both in the population of the Region as well as in the number of insured. As the Baby Boomers move into the Medicare age, greater needs will exist for access to care, especially relating to chronic health needs. Transportation will become more of an issue as well, impacting the need for improved access at the community level for both primary and specialty care. Projections by DSHS show an expected decrease in population of 1% for the Region by 2020.

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**REGION 13 Population Projection**

<b>2012</b>	<b>2020</b>
<b>189,956</b>	<b>187,629</b>

**Source: Texas Health Data Population Projections, DSHS**

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Further, as the roll out of the Medicaid Managed Care program extends through the Region, it is anticipated that more of the current 28% uninsured will move into some form of coverage, either through Medicare, Medicaid, or the Insurance Exchanges that are anticipated.

Key Health Challenges

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute have developed an excellent interactive program (County Health Rankings and Roadmaps) which ranks counties and states according to numerous factors impacting the health of communities. Utilizing data on health outcomes, the program looks at mortality and morbidity, including premature death, low birth weight, and poor physical and mental health days. In conjunction with those measures, the model also addresses health factors, including health behaviors, clinical care (access), socio-economic factors, and physical environment.

The rankings are then determined by county (See Data Sources p.17, Appendix). The purpose of using this model is to not only identify the major factors affecting the health of a community; it also provides enough data to develop a roadmap to improve the overall health of that community. Region 13 has a variety of health issues to address, but as with all of Texas, the following stand out in particular:

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<b>Adult Diabetes</b>	<b>10.3%</b>	<b>Range: 9.0--11.8%</b>
<b>Adult Obesity</b>	<b>29.2%</b>	<b>Range: 26.7--34.0%</b>
<b>Low income Pre-school Obesity*</b>	<b>13.4%</b>	<b>Range: 7.3--21.6%</b>

**Source: [www.cdc.gov](http://www.cdc.gov) Texas Surveillance Data; \* [www.city-data.com](http://www.city-data.com) (Average of ten Counties reporting)**

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Obesity is an area of concern, both in adults and in children, as it can lead to Diabetes, Coronary Artery Disease, Circulatory Disease, and many other chronic conditions as well as premature death. According to the Texas Diabetes Council, 9.7% of adults in Texas who are age 18 and above have been diagnosed with Diabetes (approximately 1.8 million adults)<sup>7</sup>. The comparative rate in the United States is 9.3% (approximately 22 million adults). The Council reports that while there is not a significant difference between males and females in the prevalence of diabetes, the rate increases with age, impacting the elderly.

The prevalence of diabetes among Blacks in Texas is significantly higher, at 16.5%, compared to other race/ethnic groups. Among Hispanics, the rate is 11%, and among Whites, it is 8.2%. In a 2009 survey by the Texas Diabetes Council, using the Behavioral Risk Factor Surveillance System (BRFSS), the information on adults with diabetes was collected, along with data for those less than 18 years of age. Among that population, it was estimated that 26,000 Texas youth had been diagnosed with either Type I or Type II Diabetes.<sup>8</sup>

Providers across Texas, including those in Region 13, are dealing with the issue of diabetes, and with obesity, through clinics, educational programs, and in the case of childhood diabetes and obesity, by working with the school districts on education regarding proper nutrition and exercise. According to the Centers for Disease Control, 17% of children between the ages of 2 to 19 are obese, and 1 of 7 low income pre-school children are obese.<sup>9</sup> One in three Texas children is obese in Texas including almost half of Hispanic children in Texas.<sup>10</sup>

Additional diseases being addressed in the Region include Cardiovascular Disease, Respiratory Disease, Hypertension, and Congestive Heart Failure, among others. The Texas Department of State Health Services provides data that indicates Potentially Preventable Hospitalizations, by county, listing these and other conditions (See Data Sources p.17, Appendix). The premise of these reports is that the referenced hospitalizations could have potentially been prevented if the patient had access to and complied with the appropriate outpatient care. It serves as a source for providers to consider as they look at the need to address access, quality, cost effectiveness, and coordination of care.

Additionally, adding to the shortage of primary care and specialty providers in rural communities, many rural areas of Texas suffer from a lack of adequate Emergency Medical Services (EMS). According to the Texas Elected Officials' Guide to Emergency Medical Services, many rural areas of Texas are dependent on the availability of community volunteers, who contribute much time and energy to serve the needs of their fellow citizens.<sup>11</sup>

Often the lack of funds impacts the availability of trained volunteers and needed equipment. EMS is a major factor in addressing access to quality healthcare for the citizens of Texas in general, and the citizens of Region 13 specifically.

In a related issue, according to the National Association of Community Health Centers (NACHC), the lack of access to primary care providers is increasingly driving patients to rely on Emergency Departments (EDs) for non-urgent care. Because there are fewer primary care

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<sup>7</sup> [www.texasdiabetescouncil.org](http://www.texasdiabetescouncil.org)

<sup>8</sup> [www.cdc.gov/obesity](http://www.cdc.gov/obesity)

<sup>9</sup> [www.texasdiabetescouncil.org](http://www.texasdiabetescouncil.org)

<sup>10</sup> (Arons, 2011)

<sup>11</sup> TX EMS Elected Official Guide, pp. 13-18

options available, many patients, especially Medicaid beneficiaries and the uninsured, turn to the ED for care that could be handled through primary care resources. The NACHC reports that one third of all ED visits are non-urgent, and that more than \$18 billion are spent annually for these visits.<sup>12</sup>

The Galen Institute, a not-for-profit health and tax policy research organization, likewise reports data that shows that Medicaid patients are twice as likely to use the ED for routine care, referencing a study in the *Annals of Emergency Medicine* (“National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries”). Primary author Adit Gingle, M.D., University of Colorado School of Medicine, Aurora, Colorado, states that even Medicaid patients who have a primary care provider report significant barriers to seeing their physician. Dr. Gingle further reports that “Medicaid patients tend to visit the ER more, partly because they tend to be in poorer health overall. But they also visit the ER more because they can’t see their primary care provider in timely fashion or at all”.<sup>13</sup>

For Region 13, the opportunity to address the shortage of primary care providers is an opportunity to help community members access the appropriate levels of care, whether for wellness, non-urgent, or urgent care. Further, it presents an opportunity to reduce healthcare costs by moving the care into the most appropriate and cost-effective setting, and can improve the overall quality of the care being delivered, due to the timeliness factor.

### Opportunities

Opportunities that exist for Region 13 are numerous:

- Expansion of Primary Care in Communities
- Expansion of Specialty Services across the Region
- Coordination with mental health providers to enhance access for all counties
- Joint efforts within and across communities to address major health issues such as Diabetes, Congestive Heart Failure, Respiratory Diseases, and Obesity
  - Development of registries
  - Education for all age levels
  - Coordination with physicians and other providers, including use of protocols across the Region
- Development of models for use of Telehealth
- Local and Regional approaches to Emergency Medical Services, focusing on access and time to transfer
- Addressing cost/operational efficiencies
- Establishment of Dialysis services
- Addressing patient satisfaction
- Addressing teen pregnancy

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<sup>12</sup> [www.nachc.com](http://www.nachc.com)

<sup>13</sup> [www.galen.org](http://www.galen.org)



Identification Number	Brief Description of Community Needs Addressed through REGION Plan	Data Source for Identified Need
CNA-001	Adult Diabetes rate is 10.3%; range is 9.0% to 11.8%	<a href="http://www.citydata.com">www.citydata.com</a>
CNA-002	Obesity rate is 29.2% for adults; range is 26.7% to 34.0%	<a href="http://www.citydata.com">www.citydata.com</a>
CNA-003	One in three Texas children is overweight or obese	<a href="http://www.citydata.com">www.citydata.com</a> ; <a href="http://www.texasdiabetescouncil.org">www.texasdiabetescouncil.org</a> Childhood Obesity in Texas, 2010 Hospital Discharge Data; DSHS
CNA-004	Potentially Preventable Hospitalizations , including Diabetes with short-term and long-term complications	<a href="http://www.dshs.state.tx.us/ph">www.dshs.state.tx.us/ph</a>
CNA-005	Shortage of Primary Care Providers in Region	<a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a> ; Health Resources and Services Administration
CNA-006	Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers	Health Resources and Services Administration; National Alliance on Mental Illness; Octavio Martinez, MD, HHSC 2012 Summit; Center for Health Care Strategies, Inc. <a href="http://www.chcs.org">www.chcs.org</a>
CNA-007	Inappropriate utilization of Emergency Room	<a href="http://www.nachc.com">www.nachc.com</a> ; <a href="http://www.galen.org">www.galen.org</a>
CNA-008	Measuring patient satisfaction	The American Journal of Managed Care, Vol. 17:41-48, January, 2011
CNA-009	Access to Specialty Care	Window on State Government <a href="http://www.window.state.tx.us/specialrpt/tif/healthcare.html">www.window.state.tx.us/specialrpt/tif/healthcare.html</a>

Identification Number	Brief Description of Community Needs Addressed through REGION Plan	Data Source for Identified Need
CNA-010	Dialysis	<a href="http://www.esrdnetwork.org">www.esrdnetwork.org</a>
CNA-011	Addressing cost/waste through LEAN process: Improve efficiencies, streamline admin costs, reduce readmissions and preventable admissions	Institute of Medicine <a href="http://resources.iom.edu/widgets/vsrt/healthcare-waste.html">http://resources.iom.edu/widgets/vsrt/healthcare-waste.html</a>
CNA-012	Pregnancy rate ages 13-17 in Coleman County is 47.3% compared to 26.1% at the State level	<a href="http://www.dshs.state.tx.us/hcqueryreport">www.dshs.state.tx.us/hcqueryreport</a>

## Appendix

Data Sources

1. [quickfacts.census.gov](http://quickfacts.census.gov) U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
2. [www.dshs.state.tx.us/ph](http://www.dshs.state.tx.us/ph) Texas Department of State Health Services. Details potentially preventable hospitalizations.
3. [www.Countyhealthrankings.org](http://www.Countyhealthrankings.org) Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Ranks Counties and States according to major health factors.
4. [www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc](http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc). Texas Department of State Health Services. Details demographics, socioeconomic issues, natality, communicable diseases reported, and mortality, by County.
5. Arons, Abigail. (2011). Childhood Obesity in Texas: The Costs, The Policies, and a Framework for the Future. Prepared for the Children’s Hospital Association for Texas (CHAT).

Mental Health Services Region 13\*

	Mental Health	Intellectual and Developmental	Waiting List
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		Disabilities	
Central Texas MHMR dba Center for Life Resources	Age 4-17: 35 Age 18-99: 104	Age 0-3: 52 Age 4-17: 6 Age 18-99: 58	Age 0-3: 0 Age 4-17: 0 Age 18-99: 0
Concho Valley MHMR	Age 3-17: 185 Age 18-99: 475	Age 4-17: 47 Age 18-99: 369	Age 3-17: 3 Age 18-99: 12
Hill Country MHMR	Youth: 65 Adults: 109	N/A	Youth: 1 Adults: 0
Permian Basin MHMR	Youth: 16 Adults: 92	Age 18-99: 12	Youth: 0 Adults: 0
West Texas Centers	Youth: 33 Adults: 109	N/A	Youth: 1 Adults: 0

### Patient Flow Analysis

RHP Region Destination	From 13	From 14	TOTAL
Region 11	9,677	576	10,253

RHP Region Destination	From 11	From 14	TOTAL
Region 13	2,450	1,801	4,251

RHP Region Destination	From 11	From 13	TOTAL
Region 14	847	4,933	5,780

Total 20,284

### Section IV. Stakeholder Engagement

### ***RHP Participants Engagement***

In May 2012, the Health and Human Service Commission finalized Heart of Texas region with 17 counties included in Regional Healthcare Partnership 13. McCullough County Hospital District was designated as the RHP 13 anchor and began engaging stakeholders. Stakeholder forums were hosted in the central, suburban center of San Angelo, Texas throughout the spring, summer, and into the fall. Hospitals, Community Mental Health Centers and health departments all participated in meetings. Once Pass 1 allocations were released by HHSC, performing providers were more clearly delineated and took leadership roles in researching and publishing projects to meet the needs for access to care and delivery reform in RHP 13. Participating providers have engaged one-on-one within RHP 13 in order to finalize plans, workbooks and projects.

In addition to face-to-face meetings, RHP 13 utilized webinars, conference calls and email distribution to quickly and effectively communicate with providers across the region. We expect to continue all forms of communication in order to ensure all providers have the appropriate information regarding their participation in the RHP 13 plan. Additionally, there are regional projects, such as the CATCH project, which will also facilitate a learning collaborative and share evidence based protocols to engage providers across the region.

### ***Public Engagement***

In May 2012, the Health and Human Service Commission finalized the region with 17 counties included in Regional Healthcare Partnership 13. McCullough County Hospital District was designated as the RHP 13 anchor and began engaging stakeholders. Stakeholder forums were hosted in the western, urban center of San Angelo, Texas throughout the summer.

#### **RHP 13 Meetings:**

On March 5, 2012 there was a formation meeting.

RHP 13 held planning meetings at Shannon Medical Center on the following dates: March 5, 2012, May 21, 2012, April 2, 2012, July 19, 2012, and October 19, 2012.

RHP 13 hosted conference calls to discuss project plans on the following dates: May 14, 2012, June 22, 2012, July 5, 2012, July 9, 2012, July 12, 2012, August 22, 2012, August 29, 2012, and August 31, 2012.

#### **Additional Meetings:**

Concho County Hospital: Board of Trustees Meetings held on September 27, 2012 and October 23, 2012.

Kimble Hospital: Board Meeting on October 22, 2012.

Schleicher County Medical Center: Board Meeting on October 8, 2012.

Ballinger Memorial Hospital District had board meetings May 21, July 12, July 23 and September 17 where the 1115 Waiver was discussed in open session.

MHMR of the Concho Valley – Board of Trustees Meetings held: December 15, 2011, January 26, 2012, March 22, 2012, April 26, 2012, May 24, 2012, June 28, 2012, August 23, 2012, and September 27, 2012.

Tom Green County – Tom Green County Budget Workshop on June 15, 2012, Tom Green County Commissioners Meeting on August 27, 2012, Tom Green County Focused 1115 Workshop on September 5, 2012.

On August 7 – 8, 2012 a group of providers met in Austin for the Waiver Summit hosted by HHSC.

#### Medical Providers:

Shannon Clinic will be considered a new provider in Pass 2. Their leadership has met to discuss Pass 2 projects and the results of the needs assessment.

#### Medical Societies:

RHP 13 reached out to the only medical society located in Region 13, Concho Valley Counties Medical Society, and we will continue to reach out to them for input and support. Currently they are inactive, and the Texas Medical Association is running things. We have reached out to TMA and will work with them if they have any concerns or questions about the plan.

RHP 13 distributed a newsletter to providers and stakeholders shortly after the HHSC Waiver Summit in August 2012. We also held a webinar for providers and stakeholders to provide step by step instructions on how to fill out the workbook and complete the plan template. Throughout the process the anchor has updated providers via email and the website to keep providers up to speed. At each new juncture, RHP 13 provided communication using tools that would best communicate important information to participants.

Throughout the stakeholder process and plan development phase, the 12 public hospitals and five Community Mental Health Providers have had public board meetings where discussions of the waiver, IGT and financing were discussed.

On November 5, 2012, the RHP 13 Pass 1 projects were posted to the RHP 13 website, [www.texasrhp13.com](http://www.texasrhp13.com), for public comment. A public comment form was imbedded in the website for stakeholders to easily provide feedback on the projects identified under Pass 1 allocations. This draft was officially posted for 5 business days. However, the plan was not pulled down immediately and remained up for almost a month. Hospital District boards

have received ongoing updates on the waiver and projects selected by hospitals which receive public funds from the districts.

On December 3, 2012, the RHP 13 plan with Pass 1, Pass 2 and Pass 3 projects was posted again to the Texas RHP 13 website and notices were distributed. A public comment form was used on the website for persons to submit public comments and or concerns. Again, the plan was officially posted for 5 business days, but a copy remained on the website longer in order to allow for more public comment. There were no comments submitted through the online form.

Ongoing RHP activities will include regular email updates and conference calls to keep providers abreast of the updates from CMS and HHSC. Additional meetings may be required in order to coordinate other specifics. There will be multiple providers who work together to implement their projects.

## Section V. DSRIP Projects

### ***RHP Plan Development***

RHP 13 is a Tier 4 region, meeting the required 4 projects from Categories 1 and 2, with at least 2 of the 4 projects selected from Category 2.

Through the stakeholder engagement forum, participating providers in Pass 1 provided strategic projects to address the critical access to care hindrances and needed transformation in the delivery system. Once Pass 1 funds were allocated to support transformation across the region and to fight the foundation barriers to access, Pass 2 projects were discussed amongst providers. Many providers felt like their number one area of concern or barrier to transformation was address in Pass 1 and therefore did not participate in Pass 2. Providers in Pass 2 worked together to make sure providers who put forward projects were able to have funding allocated to them. In Pass 3, three providers are working together to implement the CATCH program in two areas. This was a joint effort after all projects under Pass 2 submissions were funded.

Face-to-face meetings provided time for providers to discuss project selection and to provide any concerns and/or disapproval for projects submitted by other providers. For the most part, there was no negative feedback on provider project selection. The goal for RHP 13 was to include as many providers as want to participate in DSRIP in the program. RHP 13 was allocated the least amount of DSRIP funds over the course of the waiver which proved challenging in the allocation of funds. However, providers worked together to help one another and the region.

Projects not included in the RHP Plan:

1. Concho Valley MHMR-Psychiatric urgent care
2. Concho Valley MHMR -Develop the local fortified inpatient CSU capacity
3. Concho Valley MHMR -Implement tele-health capacity
4. Concho Valley MHMR -Structured peer support program
5. Hill Country MHDD Centers- 1.12.3 Mobile behavioral health clinic to serve outlying areas of Kimble, Mason, Menard, Schleicher and Sutton counties
6. Hill Country MHDD Centers- 2.16.1 24 hour a day, 7 day a week Psychiatric Consultation for hospitals and primary care providers within Kimble, Mason, Menard, Schleicher, and Sutton counties
7. Pecos County Memorial Hospital- Infusion/Cancer Treatment Center, to administer chemotherapy, antibiotics, blood projects, etc. in this setting, which is currently being performed in our ED.
8. Shannon Medical Center - Enhance/Expand Medical Home: Access Clinic
9. Shannon Medical Center - Clinical Redesign: Rothman Project
10. Shannon Medical Center - Implement Evidence-based Health Promotion Programs: Regional Diabetes Project

## 11. Shannon Medical Center - Enhance Interpretation Services & Culturally Competent Care

Based on the Community Needs Assessment, RHP 13 established goals to further the Triple Aim: right care, right setting and right time as well as progress transformational delivery system reform such as right cost and patient centered healthcare. In order to address these goals, RHP 13 providers concentrated on the number one issue facing local communities, access to primary care. In order to impact the cost curve, providers see the need for taking care outside the hospital and back into the clinic and or the home. RHP 13 projects show this commitment and lead our communities back to this delivery model. This extends to the CATCH project which is a collaboration reaching children in three communities throughout the region. Transformational projects, such as patient experience, have also been deployed to build on the primary care infrastructure of access. These projects engage patients to take ownership of their own health and hold providers accountable.

Providers Exempt from Category 4:

Reporting Status	Provider Name	Hospital County	RHP
Exempt	Ballinger Memorial Hospital District	Runnels	13
Exempt	Reagan Memorial Hospital	Reagan	13
Exempt	Heart of Texas Healthcare System	McCulloch	13
Exempt	Coleman County Medical Center	Coleman	13
Exempt	Concho County Hospital	Concho	13
Exempt	Pecos County Memorial Hospital	Pecos	13
Exempt	Iraan General Hospital	Pecos	13
Exempt	Lillian M Hudspeth Memorial Hospital	Sutton	13
Exempt	North Runnels Hospital	Runnels	13

### ***Project Valuation***

After HHSC released the Pass 1 allocations, RHP 13 reflected on the artificially low allocations to providers who had been working toward robust projects that would not be supported by their low allocations. Therefore, providers across the region collaborated to support more robust projects to meet the needs of our rural region. These collaborations support the larger investments which providers will have to make in order to improve access and engage in regional transformation. Additionally, the goals of the region were established and supported these projects which will build up the needed primary and specialty care infrastructures. While slight variances remain with regard to like projects, providers reported that variances exist around recruitment of physicians which is one of the largest costs. Loan repayment programs and coverage requirements for the Emergency

Department, OB and other emergency services can also create added challenges for providers seeking to recruit additional providers to their community.

General provider valuation methodology considered the patient impact, project size and scope, the community need and potential for regional transformation. Additionally, the goals of the region were established and supported these projects. While slight variances remain with regard to like projects, providers used industry standards to estimate patient impact for new services and reported that variances exist with regard to their individual and hospital investments and the community need priority. Loan repayment programs and coverage requirements for the Emergency Department, OB and other emergency services can also create added challenges for providers seeking to recruit additional providers to their community, which is an increased barrier to successful implementation of DSRIP projects. Thereby increasing the difficulty for transformation in regions where access to primary care is vital to change patient behaviors and engage them in their health choices and outcomes.

### **Pass 3B**

In January 2013, HHSC issued guidance from CMS that certain collaboration projects should be removed from the RHP Plan. Based on this guidance from HHSC, RHP 13 pulled certain collaboration projects from Pass 1 and Pass 2 and rebid the funds under Pass 3B. \$25.1 million was freed up for distribution under Pass 3B. RHP 13 announced the funds which were available and requested providers bid on valuations with project submissions. All projects requested and valuations were awarded. Please see the email bid in the appendix.

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

## Category 1 Projects

*Performing Provider: Ballinger Memorial Hospital*

**Pass 3b**  
**Expand Primary Care Capacity –RHP Project**  
**Old ID 130089906.1.1 New ID 130089906.1.2**  
**Ballinger Memorial Hospital Access to Care Initiative**  
**Ballinger Memorial Hospital District/130089906**

*Summary Information*

- Provider: The Ballinger Memorial Hospital District owns and operates Ballinger Memorial Hospital, a 25 bed critical access hospital and the Ballinger Hospital Clinic, a provider based rural health clinic located in Ballinger, Texas. The District services approximately 515 square miles and provides services to 4,000 people annually.
- Intervention(s): This project will implement telemedicine to provide patient consultations by specialists and expand access to care for our patients.
- Need for the project: We currently only provide general acute care in a family practice setting. Patients must travel at least forty miles to see a specialist. In some cases, patients must travel to large urban areas such as Houston, San Antonio, or Dallas to receive care. There is a need to provide our patients with an alternative and the opportunity to receive as much care as possible locally.
- Medicaid and Uninsured Target population: The target population is our entire population of patients that need services from specialists. Approximately 11% of our patients in the rural health clinic are either Medicaid eligible or indigent, so we expect they will benefit from about the same percentage of the consults. In addition, we have a very large Medicare population of 36% which would also benefit from this service.
- Category 1 or 2 expected patient benefits: The project seeks to provide 80 additional clinic encounters in DY3, 100 in DY4, and 121 in DY5.
- Category 3 outcomes: This is listed as to be determined with the approval of CMS and HHSC based on DY1 implementation metrics to benchmark future years.

**Project Description:** As a provider within a Health Professionals Shortage Area (HPSA) and a Medically Underserved Area (MUA), Ballinger Memorial Hospital District (BMHD) in Runnels County, Texas plans to expand access to primary care by expanding our rural health clinic, Ballinger Hospital Clinic (BHC) and outpatient retail pharmacy to ensure people in our community receive quality care in the most cost effective and appropriate setting. BMHD will expand primary care capacity by expanding the rural health clinic to accommodate more patients, reduce costs for both the healthcare system and the patients by expanding care through telemedicine and place the outpatient pharmacy at the same location as the rural health clinic to ensure that our patients have access to primary and preventive healthcare services. Goals of the project include: 1. Expand primary care access by expanding clinical and outpatient retail pharmacy space; 2. Increase clinic visits annually; 3. Provide the new telehealth option to patients who require specialty care for the treatment of diabetes, obesity, mental illness, and other specialties that are needed by patients; 4. Provide meeting space for community education and support groups. The current challenge of reaching these goals include: 1. Lack of space; 2. Lack of capital funding; 3. Distance between rural health clinic and outpatient pharmacy, and 4. Lack of specialty services in the community. Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population. The goals of the project directly reflect the needs of the region by addressing the adult diabetes rate, adult obesity rate, potentially preventable readmissions, access to mental health issues, and patient satisfaction. The expected 5-year outcomes of the project would be improved access to care, improved patient centered care, and improved overall health and wellbeing of patients.

- **Starting Point/Baseline:** The rural health clinic had an average of 8,077 visits for the fiscal years 2012 and 2011. This would be a baseline number to start the project in DY3. The number of rural health clinic visits would be increased by the addition of the telehealth visits. DY2 would be a planning year for the project. Currently there is no means of telehealth in the community.
- **Rationale:** In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the

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

**Project 1.1.2 – Expand existing primary care capacity**

**a) Expand primary care clinic space**

BMHD will be expanding the rural health clinic allowing for two dedicated telehealth exam rooms and the expansion will accommodate the retail pharmacy.

**b) Expand primary care clinic hours**

BMHD will expand clinic hours by creating new hours specifically for telehealth.

**c) Expand primary care clinic staffing**

BMHD will not be fulfilling this core project component. BMHD will be able to use the current staff and cross train them to meet the telehealth requirements of the project. This will save costs to the healthcare delivery system and this will increase efficiencies of current staff.

CNA-008 Measuring Patient Satisfaction is addressed with the accomplishment of this project. A larger rural health clinic will enable patients to receive more services, more timely care, and a comprehensive continuum of care. The telehealth portion will increase patient satisfaction by allowing patients to stay close to home to receive their healthcare saving time and money for the patient. Currently, patients have to travel at least forty miles to receive consultations from specialists when they could receive the same service via telehealth.

CNA-001 Adult Diabetes Rate and CNA-002 Obesity Rate are addressed through the success of this project. Telehealth will be used in the treatment of diabetic patients. The increased space will allow for a meeting room so that community education and support groups can meet.

**Performance Milestones selected:**

- 1.1.2 P-1 Establish additional/expand existing/relocate primary care clinics
  - Metric: Number of additional clinics or expanded hours or space  
BMHD will increase the number of square feet in the rural health clinic. The detailed expansion plans will be provide the documentation of the milestone.

**Improvement Milestones selected:**

- 1.1.2 I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services

- Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.  
 BMHD will increase the number of rural health clinic visits by 1% in DY3, 1.25% in DY4 and 1.5% in DY5 over the baseline. The EHR system will be used to document the milestone.

**Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction 130089906.3.1**

As per the RHP 13 Community Needs Assessment, Measuring Patient Satisfaction is a need of the region. This measure fully addresses the issue by survey patients on satisfaction levels with the following measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)

(1) are getting timely care, appointments, and information.

An expansion to the rural health clinic will provide a greater access to care, save the patients time and money by having the ability to be treated locally, and improve overall patient health and satisfaction.

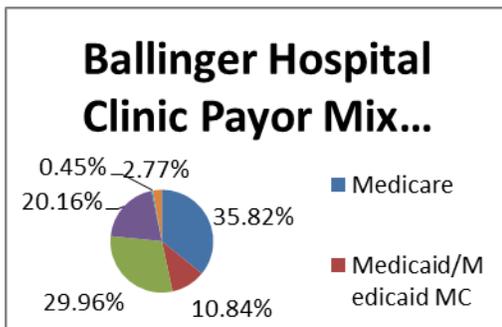
As a provider within a Health Professionals Shortage Area (HPSA) and a Medically Underserved Area (MUA), Ballinger Memorial Hospital District (BMHD) plans to expand access to primary care by expanding our rural health clinic and outpatient pharmacy to ensure people in our community receive quality care in the most cost effective and appropriate setting.

- **Relationship to other Projects: N/A**
- **Relationship to Other Performing Providers' Projects in the RHP:** RHP is a large region in total miles covered and with such a large region there are several performing providers all choosing to focus on 1.1.2. Coleman County Medical Center is expanding clinic space and increasing capacity for the growing need of appropriate care. Pecos County plans on establishing a clinic in Sanderson to provide access to care for that specific area. Reagan County wants to establish a clinic in its area. BMHD's Access to Care Initiative follows the same idea and addresses the RHP 13's overall goals. BMHD will not be overlapping care to any other performing provider with the same project of 1.1.2.
- **Plan for Learning Collaborative: N/A**
- **Project Valuation:** The needs for expansion warrant the valuation of the project. For FY 2012, the Ballinger Hospital Clinic had 2,798 unique patients totaling 8,269 visits. According to the US Census Bureau, the 2010 population of the Ballinger Memorial Hospital District (Ballinger and Rowena) was 5,537. This leaves almost half (2,739) of

residents receiving healthcare outside of the district or receiving no healthcare at all. Based on the findings of the 2011 Community Needs Assessment for Runnels County prepared by Texas Tech University Health Sciences Center, “There is a need for transportation. The elderly do not want to travel to San Angelo because of time and cost involved.” The assessment also states that “There is a general need for personal responsibility for preventive and primary care.”

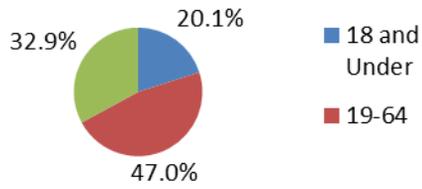
As shown in Addendum A, 66.82% of the total BHC patients belong to three distinctive financial classes (Medicare, Medicaid/Medicaid Managed Care and Private Pay). Addendum B displays that only 47% of the patient population is the range of 19-64 years of age during the prime age target to be gainfully employed and afford healthcare. The remaining population is either too young or too old to be amply employed. The BHC population vastly differs from the population of Texas as based on the 2010 US Census (Addendum C). The BHC population is 30.81% more than the state in the categories of 18 and under and 65 and over resulting in the needs of the local population based on age compared to the needs of the state as a whole vary. An expansion of the primary care capacity would greatly help reduce out-of-pocket costs for patients, provide efficiencies, and improve the quality and continuum of care for these patients by allowing access to care locally.

**Addendum A:  
Ballinger Hospital Clinic Payor Mix FY2012**



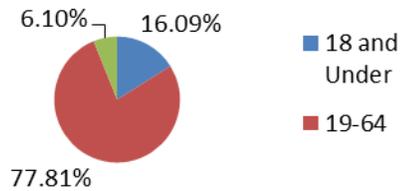
**Addendum B:  
Ballinger Hospital Clinic Patient Mix by Age FY2012**

### Ballinger Hospital Clinic Patient Mix...



### Addendum C: Texas Population based on 2010 US Census

### Texas Population based on 2010 US...



Old ID 130089906.1.1 New ID 130089906.1.2	1.1	<b>1.1.2</b>	<b>BALLINGER MEMORIAL HOSPITAL ACCESS TO CARE INITIATIVE</b>	
<i>Ballinger Memorial Hospital District</i>				130089906
<b>Related Category 3 Outcome Measure(s):</b>	OD-6- IT-6.1	Old ID 130089906.3.1 New ID 130089906.3.4	Patient Satisfaction	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p><b>Milestone 1</b> P-1: Establish additional/expand existing/relocate primary care clinics</p> <p><u>Metric 1</u> P-1.1: Number of additional clinics or expanded hours or space</p> <p>Baseline/Goal: Baseline - None/Goal – Documentation of detailed expansion plans</p> <p>Data Source: Detailed expansion plans</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$189,595</p>	<p><b>Milestone 2</b> I-12: Increase primary care clinic volume of visits and evidence of improves access for patients seeking services</p> <p><u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period</p> <p>Baseline/Goal: Baseline – 8,077 visits/Goal – 1% increase over baseline</p> <p>Data Source: EMR</p> <p>Milestone 3 Estimated Incentive Payment: \$219,765</p>	<p><b>Milestone 3</b> I-12: Increase primary care clinic volume of visits and evidence of improves access for patients seeking services</p> <p><u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period</p> <p>Goal: 1.25% increase over baseline</p> <p>Data Source: EMR</p> <p>Milestone 5 Estimated Incentive Payment: \$222,037</p>	<p><b>Milestone 4</b> I-12: Increase primary care clinic volume of visits and evidence of improves access for patients seeking services</p> <p><u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period</p> <p>Goal: 1.5% increase over baseline</p> <p>Data Source: EMR</p> <p>Milestone 6 Estimated Incentive Payment: \$190,036</p>	

Old ID 130089906.1.1 New ID 130089906.1.2	1.1	<b>1.1.2</b>	<b>BALLINGER MEMORIAL HOSPITAL ACCESS TO CARE INITIATIVE</b>	
<i>Ballinger Memorial Hospital District</i>			130089906	
<b>Related Category 3 Outcome Measure(s):</b>	OD-6- IT-6.1	Old ID 130089906.3.1 New ID 130089906.3.4	Patient Satisfaction	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$189,595	Year 3 Estimated Milestone Bundle Amount: \$219,765	Year 4 Estimated Milestone Bundle Amount: \$222,037	Year 5 Estimated Milestone Bundle Amount: \$190,036	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$821,433				

## CENTRAL TEXAS MHMR DBA CENTER FOR LIFE RESOURCES

### Project 133339505.1.1 - Telemedicine

#### Project Summary

#### Category 1 Project Narrative Center for Life Resources – 133339505.1.1

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

**RHP Project Identification Number:** 133339505.1.1

**Performing Provider Name:** Center for Life Resources

**Performing Provider TPI #:** 133339505

#### Project Summary

- **Provider Description:** Center for Life Resources (CFLR) is a local mental health authority (LMHA) serving: Brown, Coleman, McCulloch, San Saba, Mills, Comanche, and Eastland Counties. CFLR serves a variable number of clients based on Department of State Health Services (DSHS)/Department of Aging and Disabled Services (DADS) contractual agreements. Currently, (FY 13) we are serving approximately 1,250 clients in a 7,074 square mile area with a population of approximately 102,497.
- **Intervention:** Through the implementation of a telemedicine model we will provide clinically appropriate treatment as indicated by a psychiatrist or other qualified provider throughout this expansive area. Thus reducing unnecessary emergency department (ED) and service use and improve consumer satisfaction/access were previously limited or unavailable.
- **Project Status:** This is a new project for this region (RHP 13 Counties of McCulloch and Coleman Counties). We will determine a baseline in DY2 that will serve as a foundation for future progress and monitoring. We expect to see a progressive increase in those served through DY5.
- **Project Need:** There currently is very limited to no access to psychiatric or other mental health care providers in this region (CN2.6). This fact has led to the federal distinction of mental health professional shortage area. <http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm>. This limited availability often lends itself to utilization of unnecessary or

inappropriate ED use. Further, as highlighted through the mental health professional shortage area map; there are inadequate numbers of providers willing to relocate to rural and frontier regions. We believe innovative solutions, such as telemedicine, must be considered and attempted to address the stated community need (CN 2.6).

- **Target Population:** The to be determined target populations we intend to serve are individuals residing in McCulloch and Coleman Counties suffering from serious mental illness. These primarily include but are not limited to individuals who either are Medicaid eligible or are indigent. Our estimation based on current calculations and past billing is that no less than 50% of our clients currently meet this distinction. This would imply that at least half of those we serve in this new capacity through telemedicine would be Medicaid eligible or indigent.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 84 -telemedicine encounters in DY4 and 96 in DY5. Through the implementation and subsequent provision of telemedicine services this project seeks to provide a satisfying, individually tailored service that also works to reduce unnecessary emergency department usage. Customer satisfaction will be measured using evidenced based satisfaction tools in DY4 and DY5. These two years will be compared and steps to ensure continued satisfaction will be based on the subsequent data. Frequency of unnecessary emergency department usage will be accounted for through internal tracking in our electronic health records.
- **Category 3 outcomes:** IT-9.2 ED appropriate Utilization (Standalone measure). Our goal is to reduce ED visits for the target conditions of behavioral health/substance abuse with baseline to be determined in DY2.

**Category 1 Project Narrative**  
**Center for Life Resources – Project 133339505.1.1**

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

**RHP Project Identification Number:** 133339505.1.1

**Performing Provider Name:** Center for Life Resources

**Performing Provider TPI #:** 133339505

**Project Description:**

**Telemedicine in McCulloch and Coleman Counties**

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

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

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

Core Components:

- A. *Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state;*

Center for Life Resources or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (McCulloch and Coleman) Counties as defined as a mental health professional shortage area.

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

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

- C. *Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.*

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

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

**Goals and Relationship to Regional Goals:**

Project Goals:

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

This project meets the following Regional Goals:

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

**Challenges:**

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

**5- Year Expected Outcome for Provider and Patients:**

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

**Starting Point/Baseline:**

Baseline will be determined over the course of DY2 and implemented in DY3. This will be found through data collection sources such as local hospitals, law enforcement, and other sources as indicated.

**Rationale:**

Community Need Addressed:

Community Need Area: CN.2 - Limited access to mental health/behavioral health services

Specific Community Need: CN.2.6 – Limited access to behavioral health services for rural populations in McCulloch and Coleman Counties.

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

According to [txpricepoint.org](http://txpricepoint.org), the average cost accounted for just one possibly preventable condition such as psychosis at Shannon Medical Center (SMC) is \$2,193.00 a day with a median charge of \$13,638.00 located in Tom Green County. Further research shows the average cost to transport an individual to a local hospital by local EMS services has a base price of \$655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from \$12.50 to \$25+ per hour, so in an average situation this would be an additional \$30-\$75 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around \$17,000 per year. This number may vary from \$15,000-\$20,000 depending on hours of law enforcement time and travel time for EMS services. The given \$17,000 is solely an average and our best estimation based on prior experience prior to extensive data being collected.

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

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

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

We do not currently receive any U.S. Department of Health and Human Services funding that will be directly used for the implementation of telemedicine services.

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

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

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

**Relationship to other Projects:**

We are proposing to implement/enhance telemedicine services in seven counties covering RHP 8 (Project #133339505.1.1), RHP 11(Project #13339505.1.1 & #13339505.1.2), and RHP13 (Project #133339505.1.1). Each of these projects will work to in tandem with the intended purpose of greatly increasing the likelihood of right care, at the right time, in the right setting.

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

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

**Project Valuation:**

This project seeks to provide 84 telemedicine encounters in DY4 and 96 in DY5. We plan to do this where no known or limited services are being provided currently. Due to the nature of these locations and their distinction as mental health professional shortage areas, it is often difficult or even prohibitive for individuals to receive appropriate services in the right setting. Our valuation places priority on patient and community benefit through our pursuit of providing the right care at the right time in the

right place. We have attempted to demonstrate the current cost of providing these services and the advantages of providing them locally through our proposed telemedicine project. The data will clearly demonstrate the need to attempt telemedicine services in this area.

Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly \$17,000 per event. The stated per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 84 encounters we intend to provide in DY4 in the current system would cost over 1.4 million dollars ( $84 * 17,000 = 1,428,000$ ). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 3 million dollars ( $96 * 17,000 = 1,632,000 + 1,396,080 = 3,060,000$ ). Given the total four-year incentive payment of \$674,793 the cost savings and value of providing right care in the right setting is a fraction of the cost (22%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.

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

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



133339505.1.1	1.11	1.11.1.A – 1.11.1.C	<b>PROCURE AND BUILD THE INFRASTRUCTURE NEEDED TO PILOT OR BRING TO SCALE A SUCCESSFUL PILOT OF THE SELECTED FORMS OF SERVICE IN UNDERSERVED AREAS OF THE STATE (THIS MUST BE COMBINED WITH ONE OF THE TWO INTERVENTIONS BELOW).</b>		
Center for Life Resources			133339505		
<b>Related Category 3 Outcome Measure(s):</b>	133339505.3.1	IT-9.2	ED Appropriate Utilization		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>		<b>Year 4 (10/1/2014 – 9/30/2015)</b>	
<p><b>Milestone 1 [P-1]:</b> Identify Texas Counties having availability of high speed broadband communication lines.</p> <p><b>Metric 1 [P-1.1]:</b> Documentation of assessment of counties that identifies areas of state that have or lack capacity for high speed broadband connections capable of supporting telemedicine, telehealth, telemonitoring</p> <p><b>Baseline/Goal:</b> Baseline - Results of the assessment rationale/evidence; Goal - Implement telemedicine in underserved area to improve</p>		<p><b>Milestone 2 [P-7]:</b> Hiring of tele-presenters, as needed, for remote site equipment operation.</p> <p><b>Metric 1 [P-7.1]:</b> Number of staff hired and trained.</p> <p><b>Baseline/Goal:</b> Hire appropriate staff.</p> <p><b>Data Source:</b> Interviews with staff, review of hiring or payroll records, appropriate licensure records.</p> <p><b>Milestone 2 Estimated Incentive Payment: \$166,438</b></p>		<p><b>Milestone 3 [P-10]:</b> Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service.</p> <p><b>Metric 1 [P-10.1]:</b> Project planning and implementation documentation that describes plan, do, study act quality improvement cycles.</p> <p>a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement). Project</p>	<p><b>Milestone 4 [I-15]:</b> Satisfaction with telemental services.</p> <p><b>Metric 1 [1.15.1]:</b> XX #% of consumer, peer and provider surveys indicates satisfaction with telemental services.</p> <p>a. Numerator: - 72 of patients, peers and providers reporting satisfaction</p> <p>b. Denominator: - 96 of patients, peers and providers surveyed</p> <p><b>Baseline/Goals -</b>We set as our goal for 72 of the 96 (75%) encounters we plan to provide to be classified as satisfying to the individual by the end of DY5. Depending on the actual</p>

133339505.1.1	1.11	1.11.1.A – 1.11.1.C	<i>PROCURE AND BUILD THE INFRASTRUCTURE NEEDED TO PILOT OR BRING TO SCALE A SUCCESSFUL PILOT OF THE SELECTED FORMS OF SERVICE IN UNDERSERVED AREAS OF THE STATE (THIS MUST BE COMBINED WITH ONE OF THE TWO INTERVENTIONS BELOW).</i>	
Center for Life Resources			133339505	
<b>Related Category 3 Outcome Measure(s):</b>	133339505.3.1	IT-9.2	ED Appropriate Utilization	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>		<b>Year 4 (10/1/2014 – 9/30/2015)</b>
<p>access and provide right care, right setting service.</p> <p><b>Data Source:</b> Filed record of research.</p> <p><b>Milestone 1 Estimated Incentive Payment: \$159,980</b></p>				<p>reports also include output measures which describe the number and type of telemental transactions which occur.</p> <p><b>Baseline/Goal:</b> After implementation we will use real-time data analysis of our Anasazi database system. Specifically, telemedicine will have its own tracking code through which we can run real-time monitoring.</p> <p><b>Data Source:</b> Standards will be set and routinely monitored through Anasazi</p> <p><b>Milestone 3 Estimated Incentive Payment:</b></p>
				<p>encounter numbers, should they vary, we maintain a goal that 75% of encounters will be classified as satisfying to the individual.</p> <p><b>Data Source:</b> Use of evidenced based satisfaction tools used in appropriate format.</p> <p><b>Milestone 4 Estimated Incentive Payment: –\$86,000</b></p> <p><b>Milestone 6 [I-X]:</b> Provide telemedicine services.</p> <p><b>Metric 1 [I-X.1]:</b> Provide documentation of telemedicine encounters.</p> <p><b>Baseline/Goal:</b> Provide 96</p>

133339505.1.1	1.11	<b>1.11.1.A – 1.11.1.C</b>	<b>PROCURE AND BUILD THE INFRASTRUCTURE NEEDED TO PILOT OR BRING TO SCALE A SUCCESSFUL PILOT OF THE SELECTED FORMS OF SERVICE IN UNDERSERVED AREAS OF THE STATE (THIS MUST BE COMBINED WITH ONE OF THE TWO INTERVENTIONS BELOW).</b>	
<i>Center for Life Resources</i>			133339505	
<b>Related Category 3 Outcome Measure(s):</b>	133339505.3.1	IT-9.2	ED Appropriate Utilization	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
		<p><b>\$88,187.50</b></p> <p><b>Milestone 4 [I-X]:</b> Provide telemedicine services.</p> <p><b>Metric 1 [I-X.1]:</b> Provide documentation of telemedicine encounters.</p> <p><b>Baseline/Goal:</b> Provide 84 telemedicine encounters over baseline.</p> <p><b>Data Source:</b> Standards will be set and routinely monitored through Anasazi our electronic health record system</p> <p><b>A. Milestone 4 Estimated Incentive</b></p>	<p>telemedicine encounters.</p> <p><b>Data Source:</b> Standards will be set and routinely monitored through Anasazi our electronic health record system.</p> <p><b>Milestone 6 Estimated Incentive Payment: \$86,000</b></p>	

133339505.1.1	1.11	<b>1.11.1.A – 1.11.1.C</b>	<b>PROCURE AND BUILD THE INFRASTRUCTURE NEEDED TO PILOT OR BRING TO SCALE A SUCCESSFUL PILOT OF THE SELECTED FORMS OF SERVICE IN UNDERSERVED AREAS OF THE STATE (THIS MUST BE COMBINED WITH ONE OF THE TWO INTERVENTIONS BELOW).</b>	
Center for Life Resources			133339505	
<b>Related Category 3 Outcome Measure(s):</b>	133339505.3.1	IT-9.2	ED Appropriate Utilization	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
		\$88,187.50		
<b>Year 2 Milestone Bundle Amount: \$159,980</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$166,438</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$176,375</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$172,000</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$674,793</b>				

## Summary Information

Performing Provider: Coleman County Medical Center

Pass 1 Project

Project Unique ID #: NEW: 136144610.1.2 (OLD: 136144610.1.1), 1.1 Expand Primary Care

- Provider: Coleman County Hospital is a 25-bed Critical Access Hospital. It is the only hospital, clinic and ambulance service in Coleman County covering 1,281 square miles. Coleman County is located within a HPSA. The closest tertiary medical center is approximately 60 miles distance over farm roads. It serves a market population of approximately 10,000. 27.10% of the population lives below the poverty line, including 36.3% of those under age 18 and 24.4% of those over the age of 65.
- Intervention(s): New project. Project seeks to improve access to primary and preventive care by enhancing access points, expanding clinic space, providing non-emergent transportation, nurse advice line and increasing capacity for the growing need for appropriate level of care. We will add a physician and support staff and implement a nurse triage line to better assist patients in need of urgent care to access care in the clinic. A new physician will also be covering our emergency room, providing OB care & delivery services and treating nursing home patients at our two county nursing homes. Therefore, even with the addition of another provider we are projecting the addition of 1,100 Clinic visits annually by DY5; which is below traditional standard visits for a Clinic practice physician only. Additionally we will expand hours to provide afterhours care and increase choice for patients.
- Need for the project: 35% of patients are utilizing the sole County hospital's ER due to inability to access primary care. Project enhances preventive care as well as reducing non-emergent utilization of the ED.
- Medicaid and Uninsured Target population: The County unduplicated Medicaid recipients' represents 29.09% of the entire population. Uninsured population is approximately 14%. Average TANF & SNAP (food stamp) participants represent over 19% of the county population. This project increases the Medicaid/Uninsured access to primary care and preventive care, thus reducing use of the ER for non-emergent care and improves their overall health.
- Category 1 or 2 expected patient benefits: Over the next four years of the waiver, we expect to increase clinic capacity from approximately 11,000 visits per year to 12,100 visits per year. The project seeks to increase primary care visits by 10% by DY5 and reduce non-emergency care by minimum 10% by DY5. Our new physician provider will also be covering our emergency room, providing OB care & delivery services and

treating nursing home patients at our two county nursing homes. Therefore, even with the addition of another provider we are projecting the addition of 1,100 Clinic visits annually by DY5; which is below traditional standard visits for a Clinic practice physician only. Project will also provide nurse advice line in DY4 & DY5. By increasing primary care access, the expected patient benefit will be a significantly reduced cost of ER utilization for primary and non-emergent care. Total potential Medicaid and Uninsured population served is approximately 3,800 individuals within Coleman County. The nurse triage line is expected to help 250 patients in DY 4 and 350 in DY 5.

- Category 3 outcomes: IT-9.2 Our goal is to reduce cost of care to patients by increasing access to care and providing treatment or right care, in the right clinical setting and at the right time. Outcome measure is 10% reduction in non-emergency care in ER by DY5.

### **Category 1: Infrastructure Development**

- **Identifying Project and Provider Information:**

- 1.1 Expand Primary Care Capacity
- 136144610.1.2 (New) 136144610.1.1 (Old)
- Coleman County Medical Center/136144610.

- **Project Description:**

Coleman County Medical Center (CCMC), as a Critical Access Hospital, serves a rural area of uninsured, Medicaid, and Medicare households. 27.10% of the population lives below the federal poverty level. 21.7% of the County population is 65 year of age or older, and within 10 years, an additional 15% of the county population will be of retirement age. CCMC is also located within a HPSA. Based on these factors, we will transform and improve access to primary and preventive care by enhancing access points, expanding clinic space, providing non-emergent transportation and increasing capacity for the growing need for appropriate care. We will add a physician and support staff and implement a nurse triage line to better assist patients in need of urgent care to access care in the clinic. Additionally we will expand hours to provide afterhours care and increase choice for patients. This will also improve access for the uninsured. This expansion will also increase our physician visits to nursing homes to provide an enhanced access point for patients who reside there. Over the next four years of the waiver, we expect to increase clinic capacity from approximately 11,000 visits per year to 12,100 visits per year. This project achieves the goals of RHP 11 to transform healthcare and impact total population health outcomes by establishing a backbone of primary and preventive care in the system.

- **Starting Point/Baseline:**

As of December 2011, the primary care clinic was seeing 11,000 clinic visits per year with a need remaining as not all patients can be seen. This has resulted in patients using the ER for minor illnesses and non-emergent care.

- **Rationale:**

CCMC has identified project option

1.1.2 Expand existing primary care capacity

Required core project components:

- a) Expand primary care clinic space
- b) Expand primary care clinic hours
- c) Expand primary care clinic staffing

CCMC as of December 2011 had two full time physicians and one nurse practitioner, practicing primary and preventive care in the clinic setting. Because these providers have been experiencing fatigue and burnout, it is critical that we recruit another physician to alleviate the local burden and the need identified by the RHP 13 Community Needs Assessment in as supported by CN.5. and CN.7. Our physicians, as family practitioners, also provide prenatal care and deliver babies as well as cover the

Emergency Department in the hospital. This adds to their stress and burnout fatigue as well. If we don't recruit another physician to provide relief, we are at high risk of losing our current physicians due to the extreme burnout related to ED and OB coverage requirements. In order to add another physician, we must expand our clinic space. Our clinic is at full capacity with our current staffing model. Additionally we have a visiting cardiologist who fills up the entire clinic, waiting area and exam rooms, when he is in town. When he is in the clinic, access to primary care is very limited or not available. Thereby adding clinic space will also provide access to primary care, while the specialist is visiting and seeing patients. We have identified the need for a nurse advice line to help educate patients who may not know where to seek appropriate care. This will mitigate unnecessary visits and further educate patients on when and where to seek care.

By providing additional primary care capacity, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with non-emergent care treatment in the ED. Additionally, we will expand clinic hours on designated days in the evening to increase patient experience and increase availability of care.

- **Related Category 3 Outcome Measure(s):** [Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:
  - Data supporting why these outcomes are a priority for the RHP;
  - Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
  - Explanation of how focusing on the outcomes will help improve the health of low-income populations.]
  
- **Related Category 3 Outcome Measure(s):**

CCMC has selected OD-9, IT-9.2 ED appropriate utilization to reduce all ED visits (including ACSC), <http://archive.ahrq.gov/data/safetynet/billappb.htm>.

  - Non-emergent utilization of the CCMC ED, a 2010 rate of approximately 30% percent, supports the need to address improper utilization of the ED.
  - Various studies support access to primary and preventive care reduces non-emergent utilization of the ED. Additionally studies also support that nurse advice lines which will be included in this project divert non-emergent ED cases.
  - Almost 30 percent of Coleman County residents live below the federal poverty level. As the largest provider in the county, we expect to impact all low income, uninsured and Medicaid populations by increase capacity for primary and preventive care.
  
- **Relationship to other Projects:**

CCMC projects interrelate as the addition of Primary Care (1.1) Family Practitioners will provide relief and support the Patient Centered Medical Home initiative (2.1) for

pregnant women. Additionally increased capacity in Primary Care will also increase disease prevention (2.7) activities in the clinic and community settings. Additionally, all of these projects will impact the reporting on rates in Category 4 for PPAs, PPRs, ED utilization and Patient Satisfaction.

- **Relationship to Other Performing Providers' Projects in the RHP:** The regional focus for RHP 13 is on Primary Care
- **Project Valuation:**
- Access to primary care is the foundation to building and improving patient health outcomes, improving preventive health and screenings and achieving patient access in low cost settings. We seek to provide the approximately 8,500 residents in Coleman County access to primary and preventive care. As evidenced in the Department of State Health Services 2010 County Report , 36% of children 0 - 17 live below poverty with limited access to healthcare and almost 30% of the total population in Coleman County live below the poverty level. In Texas as a whole, 24% of children and 17% of the total population live below poverty. This further identifies the need for access to appropriate levels of care as populations below poverty typically are uninsured and have chronic conditions. Additionally, by adding a Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program, we will be able to provide access to insurance for patients who would otherwise remain uninsured and have fragmented care. By increasing access to primary care, we expect to grow volume capacity from 11,000 visits per year to 12,100 visits per year. With the backing of Coleman County or Coleman Hospital District we have approximately \$400,000 in local funds to be invested each year for all of the CCMC DSRIP projects. . The nurse triage line is expected to help 250 patients in DY 4 and 350 in DY 5.

NEW: 136144610.1.2 OLD: 136144610.1.1	<b>1.1.2.</b>	<b>1.1.2.A</b> <b>1.1.2.B</b> <b>1.1.2.c</b>	1.1 Expand Primary Care Capacity	
Coleman County Medical Center			136144610	
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.3 Old: 136144610.3.1	<i>IT-9.2</i>	<b>ED appropriate utilization (<i>Standalone measure</i>)</b> Reduce all ED visits	
<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
<b>Milestone 1</b> P-1. Milestone: Establish additional/expand existing/relocate primary care clinics  P-1.1. Metric: Number of additional clinics or expanded hours or space Documentation of detailed expansion plans  Baseline/Goal: Remodel or expand clinic space to accommodate additional provider with an office, nursing station and at least two exam rooms. Increased operating hours of Clinic.	<b>Milestone 3</b> P-7. Milestone: Establish a nurse advice line and/or primary care patient appointment unit.  P-7.1. Metric: Documentation of nurse advice line and/or primary care patient appointment unit.  Baseline/Goal: Serving at least 250 patients annually Data Source: Documentation of advice line and appointment unit implementation, operating hours and triage policies. Advice line system logs, triage procedures or algorithms and appointment unit operations/	<b>Milestone 6</b> I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period  Goal: Increase of 750 visits per year to provide capacity of treating 11,750 patients annually. Our new physician will also be covering our emergency room, providing OB care & delivery services and	<b>Milestone 9</b> I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period  Goal: 12,100 visits per year by DY 5 or 1,100 visits over baseline.  Data Source: Registry, EHR, claims or other Performing Provider source	

NEW: 136144610.1.2 OLD: 136144610.1.1	<b>1.1.2.</b>	<b>1.1.2.A</b> <b>1.1.2.B</b> <b>1.1.2.c</b>	1.1 Expand Primary Care Capacity	
Coleman County Medical Center			136144610	
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<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
Data Source: Performing Provider document or other plans as designated by Performing Provider.  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$94,888  <b>Milestone 2</b> P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  P-5.1. Metric: Documentation of increased number of providers and staff and/or	policies.  Milestone 3 Estimated Incentive Payment: \$69,011  <b>Milestone 4</b> I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.  Goal: Goal of additional 500 clinic patients annually, or 11,500 total clinic visits.	treating nursing home patients at our two county nursing homes. Therefore, even with the addition of another provider we are projecting the addition of 1,100 Clinic visits annually by DY5; which is below traditional standard visits for a Clinic practice physician only.  Data Source: Registry, EHR, claims or other Performing Provider source  Milestone 6 Estimated Incentive Payment: \$69,212  <b>Milestone 7</b> I-13. Milestone: Enhanced	Milestone 9 Estimated Incentive Payment: \$57,175  <b>Milestone 10</b> I-13. Milestone: Enhanced capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within average of 1 calendar day of request. Demonstrate improvement over baseline rates a. Numerator: number of patients receiving urgent care	

NEW: 136144610.1.2 OLD: 136144610.1.1	<b>1.1.2.</b>	<b>1.1.2.A</b> <b>1.1.2.B</b> <b>1.1.2.c</b>	1.1 Expand Primary Care Capacity	
Coleman County Medical Center			136144610	
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<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
<p>clinic sites.</p> <p>Baseline/Goal: Increase provider and staff base by 1 and train/orient . Goal of 250 additional clinic visits annually, or 11,250 patient visits. A new physician will also be covering our emergency room, providing OB care &amp; delivery services and treating nursing home patients at our two county nursing homes. Therefore, even with the addition of another provider we are projecting the addition of 1,100 Clinic visits annually by DY5; which is below traditional standard visits for a Clinic practice physician only.</p>	<p>Data Source: Clinic Appointment Registry, EHR, claims or other Performing Provider source</p> <p>Milestone 4 Estimated Incentive Payment: \$69,012</p> <p><b>Milestone 5</b> I-13. Milestone: Enhanced capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate</p>	<p>capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 1.5 calendar days of request. Demonstrate improvement over baseline rates a. Numerator: number of patients receiving urgent care appointment within 1.5 days of request b. Denominator: number of patients requesting urgent care appointment.</p>	<p>appointment within average of 1 day of request b. Denominator: number of patients requesting urgent care appointment.</p> <p>Goal: Improve: ER triage protocols and referral/appointment process to Clinic for primary care treatment. Demonstrated Clinic appointment availability for urgent care patients within average of 1 day of presentation to ER or request for appointment. Reduction in non-emergency ER care by 300 patient visits annually.</p>	

NEW: 136144610.1.2 OLD: 136144610.1.1	<b>1.1.2.</b>	<b>1.1.2.A</b> <b>1.1.2.B</b> <b>1.1.2.c</b>	1.1 Expand Primary Care Capacity	
Coleman County Medical Center				136144610
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.3 Old: 136144610.3.1	<i>IT-9.2</i>	<b>ED appropriate utilization (<i>Standalone measure</i>)</b> Reduce all ED visits	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation.  Milestone 2 Estimated Incentive Payment: \$94,888	improvement over baseline rates a. Numerator: number of patients receiving urgent care appointment within average of 2 days of request b. Denominator: number of patients requesting urgent care appointment.  Goal: Provide Clinic appointments within average of 2 days of request or referral by ER. Provide referral process of patients needing Medical Advocacy Services for Healthcare or Medicaid eligibility assistance program  Data Source: Registry, EHR,	Goal: ER triage and referral/appointment process to Clinic for primary care treatment. Demonstrated Clinic appointment availability for urgent care patients within 1.5 days of presentation to ER or request for appointment. Reduction in non-emergency ER care by estimated 100 patients annually.  Data Source: Registry, EHR, claims or other Performing Provider scheduling source  Milestone 7 Estimated Incentive Payment: \$69,212  <b>Milestone 8</b>	Data Source: Registry, EHR, claims or other Performing Provider scheduling source  Milestone 10 Estimated Incentive Payment: \$57,175  <b>Milestone 11</b> I-14. Milestone: Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period.  I-14.1. Metric: Number of patients served by the nurse advice line. Demonstrate	

NEW: 136144610.1.2 OLD: 136144610.1.1	<b>1.1.2.</b>	<b>1.1.2.A</b> <b>1.1.2.B</b> <b>1.1.2.c</b>	1.1 Expand Primary Care Capacity	
Coleman County Medical Center			136144610	
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.3 Old: 136144610.3.1	IT-9.2	<b>ED appropriate utilization (<i>Standalone measure</i>)</b> Reduce all ED visits	
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	claims or other Performing Provider scheduling source  Milestone 5 Estimated Incentive Payment: \$69,012	I-14. Milestone: Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period.  I-14.1. Metric: Number of patients served by the nurse advice line. Demonstrate improvement over baseline rates. a. Numerator: number of unique records created from calls received to the nurse advice line. b. Denominator: total number of calls placed to the nurse advice line (distinct from	improvement over baseline rates. a. Numerator: number of unique records created from calls received to the nurse advice line. b. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered).  Goal: Increase of number of patients served by the nurse advice line to 350 patients annually.  Data Source: Automated data from call center	



NEW: 136144610.1.2 OLD: 136144610.1.1	<b>1.1.2.</b>	<b>1.1.2.A</b> <b>1.1.2.B</b> <b>1.1.2.c</b>	1.1 Expand Primary Care Capacity	
Coleman County Medical Center			136144610	
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.3 Old: 136144610.3.1	IT-9.2	<b>ED appropriate utilization (Standalone measure)</b> Reduce all ED visits	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$189,776	Year 3 Estimated Milestone Bundle Amount: \$207,035	Year 4 Estimated Milestone Bundle Amount: \$207,637	Year 5 Estimated Milestone Bundle Amount: \$171,526	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$775,974				

## Summary Information

*Performing Provider: Heart of Texas Healthcare System*

*Pass 1 Project*

*Project Unique ID #: 138715115.1.1 (Old)*

*Project Unique ID #: 138715115.1.2 (New)*

- Provider: Hospital is a 25-bed hospital in Brady, Texas serving an 80 square mile area and a population of approximately 15,000.
- Intervention(s): This project will implement Dialysis Center to provide ESRD patients the ability to receive treatment in order to reduce Potentially Preventable Admissions from complications because distance traveled causes non-compliance and skipped sessions.
- Need for the project: We currently have 50 ESRD patients within our normal service territory. Adding these services and reducing travel issues would reduce emergency department visits and admissions and/or transfers to tertiary care facilities for related complications.
- Medicaid and Uninsured Target population: The target population is our patients that need dialysis. Approximately 78% of the patients presented are either Medicaid eligible or indigent, so we expect they will benefit directly from local treatment.
- Category 1 or 2 expected patient benefits: The project seeks to provide local treatment for 50 ESRD diagnosed patients in order to reduce the 156 ED and Acute care admissions and/or EMS transfers because of complications of long distance travel for care. 628 Patients were diagnosed with Renal Failure, related Kidney Disease, or ESRD within the last twelve months at our facility thru the Emergency department or acute stay. 78% are Indigent or Medicaid patients. Average cost ranges from \$5,800 to \$32,000 per inpatient stay. Single ER visit averages \$2,600. The reduction in PPA's would enable the hospital to reallocate resources otherwise tied to ESRD. Research shows a cost/benefit of \$1:1.7 thru local care, increasing compliance, and relieving pressures on EMS and Hospital resources. Our goal is to reduce hospital PPA's by 5% each year or 8 PPA's per year due to travel related complications. In DY1 and DY2 we will be the construction and opening phases of the specialty clinic. In DY3, it is our intent to begin reducing PPA's. In DY4 and DY5 we have the same annual goal for a total project reduction of 15% or 24 admissions. Initially, the total cost savings could be immense as the number of patients and admissions continues

to increase.

- Category 3 outcomes: Our goal is to reduce potentially preventable admissions by 5% each year thru DY5. With multiple ESRD, chronic kidney disease and/or renal failure diagnosis admissions, there have been numerous transfers for additional and higher level of care.

#### ***B. Category 1: Infrastructure Development***

- **Identifying Project and Provider Information:**  
ESRD Dialysis Center – 138715115.1.1 (Old)  
ESRD Dialysis Center – 138715115.1.2 (New)  
Heart of Texas Memorial Hospital – 138715115

- **Project Description:**

To increase the capacity of providing specialty care services and the availability of targeted specialty providers to better accommodate high demand so that patients have increased access to specialty care services.

**Increase Service** - Since 2000, Texas ESRD Patient growth has been 66.7% and research shows an increasing amount of patients with End Stage Renal Disease (ESRD) in our area. McCulloch County currently does not have a Nephrologist or treatment capabilities for ESRD patients. The closest towns to see a doctor are 50-70 miles away. Currently for treatment, there are no options for ESRD patients without having to travel greater than 60 minutes one way. In a 30 mile radius of Brady, Texas, research shows 20 active ESRD patients. At 70 miles, the number increases to 50.

**Increase Specialty Clinic Locations** – In order to meet the needs of this medical care segment, we would like to start by opening the clinic in Brady, TX. ESRD patients have many complications which lead to additional ER visits and inpatient stays due to traveling long distances. Studies show patients that travel 60 minutes or more have higher ER and hospitalization rates, complications, withdrawal issues, and mortality. The dialysis center would reduce the length of travel and help decrease the related care cost. In addition, most patients rely on others for transportation to facilities for their care, which includes multiple treatment sessions a week.

Research shows, preventing or delaying the onset of ESRD also becomes especially crucial in the context of the economic impact on the healthcare system. For example, ESRD patients constitute one-half of 1% of Medicare beneficiaries but account for 5% of Medicare program expenditures or an estimated \$29 Billion per year. A study by the Center for Health Care Research & Policy demonstrated the Cost / Benefit ratio for having dialysis and the savings because of reduced additional healthcare without. The C/B results were \$1:1.7. Analysis results show the median monthly healthcare costs for persons before the onset of ESRD is \$1,765. The month before the onset of ESRD, the median monthly average rises

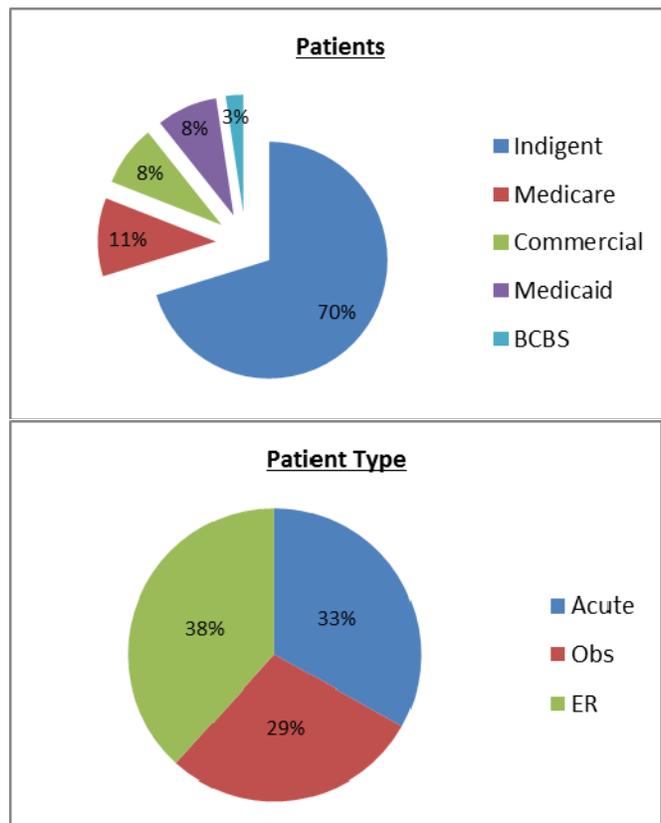
to \$8,211. If the patient has diabetes, the costs were \$2,946 and \$9,152 respectfully. After the onset of ESRD, monthly costs skyrocket to 26,507 and 26,789. Adding services to treat ESRD patients will help decrease Emergency Department(s) (ED) pressures, acute hospital stays and other related patient care due to complications. By DY 5, we believe the amount of the transfers to tertiary facilities for ESRD related issues will be reduced, have increased treatment program compliance, and have less disease related complications. In short, this would alleviate additional care expenses and resources required for the treatment of ESRD across the region because of the amount of travel. It is the right care, in the right setting, and at the right time.

**Implement transparent, standardized referrals across town** – Once the project is moving forward, training of the staff would commence. Included would be to upgrade our visiting doctor program to a permanent resident. Local physicians and visiting staff would be introduced and trained in the care and referral of patients to the clinic. Our scheduling system would capture the data to form the statistical baseline and measure changes moving forward. After the initial patients are receiving treatment, it is our goal to reach out further in our service territory to capture more patients by reducing their travel times. Included would be the introduction of services and training for additional doctors to refer area patients.

**Conduct Quality Improvement Project** – Reducing PPA's from complications and non-compliance issues because of >60 minutes of travel for ESRD and ESRD related treatment begins our project. Resources that are dedicated to these admissions can be better utilized in other areas of the hospital. Secondly, increasing the quality of care and the quality of life aspects provide for better community living. Each year, it is our goal to increase referrals and widen the circle of coverage. From 2000 to 2010, Texas ESRD patient incidence and prevalence increased 416,000 and 51,000. In the last five years, 649 patients have presented themselves to the hospital. In the last twelve months, 84 have required treatment, with a visit rate of 1.83. After the initial phases, our goal is to develop the statistical package to gauge the full impact accurately and increase referrals in order to facilitate a permanent doctor. The number of referrals, amount of travel, other related costs and the continuum of care would be just the initial measurements. Receiving the care locally would increase the quality of life of our citizens and help our community take care of its population.

- **Starting Point/Baseline:**

Currently we have two nephrologists visiting our campus, one day a month. Between them they see between 10-25 ESRD patients on the days they are in Brady. Our goal is to increase the number of patients seen and increase the number of days the doctors are present. Thus, patient travel requirements would be reduced and treatment programs would be more successful. Our research shows that in the last twelve (12) months, 84 ESRD patients presented themselves in 154 visits. The following graphs show what type of patients and their percentages from the last twelve months:



- **Rationale:**

With the prevalence of ESRD patients in our territory and the projected growth rate, the vitality of a dialysis treatment center would reduce unnecessary ER visits (CNA-007), acute stays, and EMS transfers, all related to ESRD treatment and travel distances. With the current obesity and diabetic levels in our region (CNA-001, 002, 003), disease related issues will continue to rise also.

The study will identify the baseline data for the region. Preparation and structure augmentation for equipment and patient accessibility points will begin. Purchase and implementation of the necessary equipment for treatment will be completed. Hiring of staff, care givers; educate current staff and doctors, for the impending services to be performed. Collection of associated data for the measurement of treatment costs, patient travel, changes in other hospital department utilization and patient satisfaction levels will follow.

Currently, in the last twelve (12) months, the hospital has had an average PPA treatment cost per ESRD or ESRD related patient of \$5,848, with the top five averaging \$32,086. The average ER visit cost by a patient with discharge diagnosis code for renal failure has been roughly \$2,600. This does not take in account the

transportation cost of transferring to tertiary facilities if not admitted. 78% of the patients seen are either Indigent or Medicaid eligible.

Without local care and with the increasing numbers of ESRD patients, more admissions will be realized unless we change this behavior due to travel times. Reducing PPA's, is inherent to lowering the cost of healthcare when resources can be utilized towards other concerns. Cost of travel is not just monetary, even though it is one of the most expensive cash costs outside of the medical arena. An ESRD patient must have someone to take them and remain with them most of the day. While out of town, there will be other expenses. At three times a week, food and vehicle costs could be greater than \$500 a month.

We will use this data and internal reviews to learn and implement quality initiatives. This includes implementation of the following Project Option and Core Components.

1.9.2 Improve access to specialty care

b) Increase number of specialty clinic locations

- **Related Category 3 Patient Outcome Measure(s):** OD-2, IT-2.2

Study shows that most ESRD PPA's are elevated due to the length of travel time and skipped or shortened sessions. The admissions driven by external care factors increase cost and dedicate resources necessary for other means. This is directly related to the Category 1 project due to the treatment programs for ESRD and their frequency. Adherence to treatment plans would diminish the related admissions and/or tertiary care center transfer. With the poverty levels of our region, care located closer to the patients would greatly reduce complications, decrease Potentially Preventable Admissions, and transfers for any secondary care. Our goal is to reduce hospital PPA's by 5% each year or 8 PPA's per year due to travel related complications. In DY1 and DY2 we will be the construction and opening phases of the specialty clinic. In DY3, it is our intent to begin reducing PPA's. In DY4 and DY5 we have the same annual goal for a total project reduction of 15% or 24 admissions. Initially, the total cost savings could be immense as the number of patients and admissions continues to increase.

- **Relationship to other Projects:**

This project is a continuation of care that stems from different regional issues, ie: obesity, diabetes; which lead to ESRD much faster without preventative steps. Once ESRD is present, there are no local care options, which intensify other secondary health issues.

- **Plan for Learning Collaborative:** As we move forward, educating the region about ESRD and the life choices that can be made earlier will enhance the long term efforts reducing the number of unnecessary hospital visits or stays. Plans

are to incorporate long term populace education thru various agencies and programs.

- **Project Valuation:**

The value to the community can be measured thru the reduction in resources and cost dedicated to ED and acute admissions and transfers of ESRD patients. 628 Patients were admitted with diagnosis of renal failure, related kidney disease, or ESRD within the last twelve months thru the Emergency department or acute stay. The project seeks to provide local treatment for 50 ESRD diagnosed patients in order to reduce the 156 ED and Acute care admissions and/or EMS transfers because of complications of long distance travel for care. 78% are Indigent or Medicaid patients. Average cost ranges from \$5,800 to \$32,000 per inpatient stay. Single ER visit averages \$2,600. The reduction in PPA's would enable the hospital to reallocate resources otherwise tied to ESRD complications. Research shows a cost/benefit of \$1:1.7 thru local care, increasing compliance, and relieving pressures on EMS and Hospital resources. Our goal is to reduce hospital PPA's by 5% each year or 8 PPA's per year due to travel related complications. In DY1 and DY2 we will be in the construction and opening phases of the specialty clinic. In DY3, it is our intent to begin reducing PPA's. In DY4 and DY5 we have the same annual goal for a total project reduction of 15% or 24 admissions. Initially, the total cost savings could be immense as the number of patients and admissions continues to increase. Our local hospital district will support this project to provide access for these patients.

<b>PROJECT</b> 138715115.1.1 (Old) 138715115.1.2 (New)	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>	
<i>Heart of Texas Memorial Hospital</i>			<i>138715115</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<b>138715115.3.1 (OLD)</b> 138715115.3.3 (NEW)	IT-2.2	<i>Potentially Preventable Admissions</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<b>Milestone 1:</b> [P-1]: Conduct specialty care gap assessment based on community need <u>Metric</u> [P-1.1]: Documentation of gap assessment <u>Data Source:</u> Needs Assessment <u>Goal:</u> 1 <u>Documentation:</u> Admin. Documentation  Milestone 1 Estimated Incentive Payment: \$ 487,283	<b>Milestone 2:</b> [P-11]: Milestone: Launch / expand a specialty care clinic <u>Metric</u> [P-11.1]: Establish / expand specialty care clinics A. Number of patients served by specialty care clinic <u>Data Source:</u> Documentation of new/expanded specialty care clinic <u>Rationale/Evidence:</u> Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. Additionally, specialty care clinics allow for	<b>Milestone 3:</b> [P-3a]: Collect baseline data for wait times, backlog, and/or return appointments in specialties. <u>Metric</u> [P-3.1a] Metric: Establish baseline for performance indicators A. <u>Numerator:</u> TBD by the Performing Provider B. <u>Denominator:</u> TBD by the Performing Provider C. <u>Data Source:</u> TBD by the Performing Provider D. <u>Rationale/Evidence:</u> TBD by the Performing Provider. Document data and resources used. Use Clinic scheduler, EMR, Discharge	<b>Milestone 4:</b> [P-3b]: Collect data for wait times, backlog, and/or return appointments in specialties. For data comparison. <u>Metric</u> [P-3.1b] Metric: Establish baseline+1 for performance indicators A. <u>Numerator:</u> TBD by the Performing Provider B. <u>Denominator:</u> TBD by the Performing Provider C. <u>Data Source:</u> TBD by the Performing Provider D. <u>Rationale/Evidence:</u> TBD by the Performing Provider. Document data and resources used. Use Clinic	

<b>PROJECT</b> 138715115.1.1 (Old) 138715115.1.2 (New)	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>	
<i>Heart of Texas Memorial Hospital</i>			<i>138715115</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<b>138715115.3.1 (OLD)</b> <b>138715115.3.3 (NEW)</b>	IT-2.2	<i>Potentially Preventable Admissions</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
	enhanced care coordination for those patients requiring intensive specialty services. <u>Goal:</u> 1 <u>Documentation:</u> Admin. Documentation  Milestone 2 Estimated Incentive Payment: \$ 564,825	Data. <u>Goal:</u> 1 <u>Documentation:</u> Admin. Documentation  [I-23a]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric [I-23.1a]</u> Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY3). A. Total number of visits for reporting period <u>Data Source:</u> Registry, EHR,	scheduler, EMR, Discharge Data. <u>Goal:</u> DY4+1 <u>Documentation:</u> Admin. Documentation  [I-23b]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services compared to DY4. <u>Metric [I-23.1a]</u> Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY4). Total number of visits for reporting period	

<p><b>PROJECT</b> 138715115.1.1 (Old) 138715115.1.2 (New)</p>	<p><b>1.9.2</b></p>	<p><b>1.9.2</b></p>	<p><b>ESRD DIALYSIS CENTER</b></p>		
<p><i>Heart of Texas Memorial Hospital</i></p>			<p>138715115</p>		
<p><b>Related Category 3 Outcome Measure(s):</b></p>	<p><b>138715115.3.1 (OLD)</b> 138715115.3.3 <b>(NEW)</b></p>	<p>IT-2.2</p>	<p><i>Potentially Preventable Admissions</i></p>		
<p><b>Year 2 (10/1/2012 – 9/30/2013)</b></p>		<p><b>Year 3 (10/1/2013 – 9/30/2014)</b></p>		<p><b>Year 4 (10/1/2014 – 9/30/2015)</b></p>	
				<p>claims or other Performing Provider source <u>Rationale/Evidence:</u> This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Documentation of baseline. Collection of data for changes in volume and visits. <u>Goal:</u> Increase Clinic Visits to reduce current related PPA's by 5%. <u>Documentation:</u> Admin. Documentation, EMR [OD-2(a), IT 2.2] ESRD</p>	
<p><b>Year 5 (10/1/2015 – 9/30/2016)</b></p> <p><u>Data Source:</u> Registry, EHR, claims or other Performing Provider source <u>Rationale/Evidence:</u> This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Documentation of baseline. Collection of data for changes in volume and visits. <u>Goal:</u> Increase Clinic Visits to reduce current related PPA's by 5%. <u>Documentation:</u> Admin. Documentation, EMR</p>					

<b>PROJECT</b> 138715115.1.1 (Old) 138715115.1.2 (New)	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>		
<i>Heart of Texas Memorial Hospital</i>			138715115		
<b>Related Category 3 Outcome Measure(s):</b>	<b>138715115.3.1 (OLD)</b> 138715115.3.3 (NEW)	IT-2.2	<i>Potentially Preventable Admissions</i>		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>		<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>		<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	
				<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>  Admission Rates Survey/measure/report. (Baseline) A. <u>Numerator</u> : All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease.  B. <u>Denominator</u> : Discharges in the numerator are assigned to the denominator based on the Metro Area1 or county of the patient residence, not the Metro Area or county of the hospital where the discharge occurred. C. <u>Data Source</u> : EHR, Claims D. <u>Rationale/Evidence</u> :	
				[OD-2(a), IT 2.2] ESRD Admission Rates Survey/measure/report. (Baseline) A. <u>Numerator</u> : All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease.  B. <u>Denominator</u> : Discharges in the numerator are assigned to the denominator based on the Metro Area1 or county of the patient residence, not the Metro Area or county of the hospital where the discharge occurred. C. <u>Data Source</u> : EHR, Claims	

<b>PROJECT</b> 138715115.1.1 (Old) 138715115.1.2 (New)	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>	
<i>Heart of Texas Memorial Hospital</i>			138715115	
<b>Related Category 3 Outcome Measure(s):</b>	<b>138715115.3.1 (OLD)</b> 138715115.3.3 (NEW)	IT-2.2	<i>Potentially Preventable Admissions</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
		Hospitalization rates are an important indicator of patient morbidity and quality of life. On average, dialysis patients are admitted to the hospital twice a year and hospitalizations account for approximately 36 percent of total Medicare expenditures for dialysis patients (U.S. Renal Data System, 2007). Measures of the frequency of hospitalization help efforts to control escalating medical costs, and play an important role in providing cost effective health care.	D. <u>Rationale/Evidence:</u> Hospitalization rates are an important indicator of patient morbidity and quality of life. On average, dialysis patients are admitted to the hospital twice a year and hospitalizations account for approximately 36 percent of total Medicare expenditures for dialysis patients (U.S. Renal Data System, 2007). Measures of the frequency of hospitalization help efforts to control escalating medical costs, and play an important role in providing cost	

<b>PROJECT</b> 138715115.1.1 (Old) 138715115.1.2 (New)	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>	
<i>Heart of Texas Memorial Hospital</i>			138715115	
<b>Related Category 3 Outcome Measure(s):</b>	<b>138715115.3.1 (OLD)</b> 138715115.3.3 (NEW)	IT-2.2	<i>Potentially Preventable Admissions</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
		<u>Goal:</u> Reduce current related PPA's by 5%. <u>Documentation:</u> Admin. Documentation, EMR  Milestone 3 Estimated Incentive Payment: \$ 570,663	effective health care. <u>Goal:</u> Reduce current related PPA's by another 5%. <u>Documentation:</u> Admin. Documentation, EMR  Milestone 4 Estimated Incentive Payment: \$ 488,931	
Year 2 Estimated Milestone Bundle Amount: \$487,283	Year 3 Estimated Milestone Bundle Amount: \$564,825	Year 4 Estimated Milestone Bundle Amount: \$570,663	Year 5 Estimated Milestone Bundle Amount: \$488,931	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$2,111,701</b>				

### Summary Information^^

Performing Provider: MHMR Services for the Concho Valley

Pass 1 Project

Project Unique ID #: 109483102.1.1

Provider: MHMR Services for the Concho Valley (MHMRCV) is a small sized rural community mental health/IDD center located in San Angelo, TX. MHMRCV serves people with IDD and specific mental illnesses who have Medicaid entitlement or are indigent via a contract with DADS and DSHS. The people served by the Center must have proof of residence in Coke, Concho, Crockett, Irion, Reagan, Sterling or Tom Green Counties. The approximate total population of this seven county catchment area is 128,000. MHMRCV is contracted by DSHS to serve 413 unduplicated Medicaid/indigent adults and 65 Medicaid/indigent children with mental illness each six months during the fiscal year. The Center served 505 Medicaid/indigent adults and 236 children with mental illness from August 2012 – January 2013. MHMRCV is contracted by DADS to serve an average of 48 unduplicated Medicaid/indigent adults with IDD during a month in the fiscal year. The Center served 142 Medicaid or indigent people with IDD from August 2012 – January 2013.

Intervention(s): This project will implement an IDD Behavioral Health Crisis Response System to provide community based crisis intervention services to patients with IDD and mental illness in order to prevent hospitalization and inappropriate utilization of local emergency departments.

Need for the project: There are currently not any community based crisis resolution alternatives available for people with IDD living in the MHMRCV catchment area. People with IDD who are experiencing a behavioral health crisis rely solely on the local emergency department for immediate intervention and crisis resolution.

Medicaid and Uninsured Target population: The potential target population is any individual living in the previously described seven county catchment area with a diagnosis of IDD who is also experiencing a mental health crisis. There are approximately 4,065 people with IDD in the seven county catchment area. Studies show that on average, 60% of the IDD population also has a mental health diagnosis. If any of these 4,065 people were to experience a mental health crisis, they would be eligible to receive crisis intervention services made available via this DSRIP project. According to the Community Needs Assessment data, 11.8% of the RHP 13 population was enrolled in Medicaid as of April 2012 and 28.4% of the population was uninsured.

Category 1 expected patient benefits: The project seeks to achieve increased utilization of appropriate crisis alternatives and emergency department cost avoidance. By DY 4 it is projected that this project will result in 122 unduplicated people dually diagnosed with IDD and mental illness utilizing appropriate crisis alternatives. By DY 5, it is expected that an additional 121 unduplicated people dually diagnosed with IDD and mental illness will utilize appropriate crisis alternatives. The patient impact grand total is 243 people (combination of DY 4 patient impact plus DY 5 patient impact). This DSRIP project intervention will result in a 60% cost avoidance as compared to the cost of intervention via the emergency department by DY 5.

Category 3 outcomes: IT-9.2 Our goal is to reduce emergency department utilization for IDD mental health crises that can be resolved in the community or a less restrictive environment. Baseline rates will be determined in DY 3 and subsequent emergency department utilization reduction goals set for achievement in DY 4 and DY 5. Per CMS and HHSC, Category 3 methodology for targets will be redefined.

## “IDD Behavioral Health Crisis Response System”

- **Identifying Project and Provider Information:** “IDD Behavioral Health Crisis Response System”, 109483102.1.1, MHMR Services for the Concho Valley/109483102
- **Project Description:** MHMR Services for the Concho Valley (MHMRCV) proposes to develop a community based Behavioral Health (BH) Crisis Response System tailored to individuals with Intellectual and Developmental Disabilities (IDD). This crisis response system would include an IDD BH: Mobile Crisis Outreach Team (MCOT), crisis respite program and outpatient clinic (OPC) wraparound services. This project will follow the evidence based long-term crisis intervention and stabilization START services model ([www.centerforstartservices.com](http://www.centerforstartservices.com)). This DSRIP project is designed to serve individuals who specifically live in Coke, Concho, Crockett, Irion, Reagan, Sterling or Tom Green counties. The precise aim of only serving residents of the seven counties previously listed ensures there is not a duplication of services via DSRIP projects of other local mental health authorities in RHP 13.

The IDD BH MCOT will provide a combination of crisis services in the community including emergency care, urgent care, and crisis follow-up and relapse prevention to individuals with IDD who are experiencing a mental health crisis or significant behavioral issues. The MCOT will be a clinically staffed mobile treatment team that provides prompt face-to-face crisis services 24 hours per day, 365 days per year. The goals of the MCOT include: prompt assessment and evaluation in the community, stabilization in the least restrictive environment, crisis resolution, linkage to appropriate services and reduction of inpatient and law enforcement interventions.

To further support the IDD BH MCOT, MHMRCV will develop an IDD Crisis Respite program. The crisis respite would provide short-term, community-based residential, crisis treatment to persons who have low risk of harm to self or others and may have some functional impairment who require direct supervision and care, but do not require hospitalization. The IDD Crisis Respite location would be a safe haven away from the site where the crisis originated. The goals of crisis respite include: avoidance of an impending crisis due to housing challenges or other identified stressors, avoid the need for more restrictive service setting, provide appropriate supervision and assistance in a non-stressful environment, medication monitoring in a structured environment and avoidance of unnecessary hospitalization.

Finally, MHMR will develop an IDD BH Outpatient Clinic designed to provide psychiatric diagnostic evaluations and subsequent pharmacological management services delivered by a board certified psychiatrist. This portion of the proposed project would serve as wrap-around support to manage behavioral health symptoms. The goals of the OPC include: medication management of psychiatric symptoms and prevention of inpatient hospitalization.

Overarching goals for all three initiatives associated with this project include: working to resolve the IDD/Behavioral Health crisis in the least restrictive environment and to build competency in associated staff positions to better serve those individuals with IDD who are experiencing a BH crisis or behavioral issue.

There are four primary anticipated challenges associated with this project. The first challenge is community education regarding available resources. We will address this item via community stakeholder meetings to be held in DY 2. Stakeholder meetings will serve as a forum to educate interested parties about the planned project and brainstorm to ensure mutual outcomes are being prioritized and implemented. The second and third challenges are, locating and hiring the best staff to support the mission of this project and training staff to ensure required competencies and the proven ability to blend the approaches of the project for optimal outcomes for individuals served. As we assess the behavioral health needs of patients and determine the types and volume of services needed to resolve crises as part of the project in DY2 we will be able to tailor job postings and descriptions to ensure the right staff are attracted. The final challenge is locating an appropriate respite location. During DY2 MHMRCV will develop implementation plans for the crisis services proposed. Time will be dedicated for locating an appropriate service site.

As a performing provider, MHMRCV expects the following outcomes at the end of the five year waiver: (1) an operational and effective IDD BH MCOT that is that is utilized to immediately respond to IDD/BH crises or behavioral issues in the community (instead of in the local emergency rooms) and is recognized by stakeholders in the community as a vital resource; (2) a useful and fully functional IDD crisis respite facility that can shelter individuals in crisis as they work to alleviate the crisis; (3) a successful and thriving IDD BH Outpatient Clinic staffed by a psychiatrist who is working with patients to successfully manage symptoms of mental illness in the community versus in a more restrictive environment.

For the individuals we serve, MHMRCV expects that at the end of the five year waiver that people have easily accessible and prompt and effective community based crisis resolution services in order to avoid hospitalization. By DY 4 it is projected that this project will result in 122 unduplicated people dually diagnosed with IDD and mental illness utilizing appropriate crisis alternatives. By DY 5, it is expected that an additional 121 unduplicated people dually diagnosed with IDD and mental illness will utilize appropriate crisis alternatives. The patient impact grand total is 243 people (combination of DY 4 patient impact plus DY 5 patient impact). This DSRIP project intervention will result in a 60% cost avoidance as compared to the cost of intervention via the emergency department by DY 5.

The RHP 13 goals are transformation of the healthcare system and further advances toward the Triple Aim: right care, right setting, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone

for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

- **Starting Point/Baseline:** In regard to the three initiatives associated with this project (IDD BH MCOT, Crisis Respite and OPC), the only baseline data available is related to the OPC. MHMRCV has hired Dr. Jimmy Mercer to provide psychiatric services to individuals in the community who have IDD and behavioral health issues. Dr. Mercer is a board certified psychiatrist that has an extensive work history including experiences gained from working at Big Spring State Hospital for 9 years and for 2 years at the San Angelo State Supported Living Center where he worked with individuals with IDD and mental illness. The only trained provider at this point is the physician. Dr. Mercer began providing care to IDD patients with BH crises or behaviors on July 9, 2012. Between December 11, 2011 and July 8, 2012, there were a total of 28 unduplicated IDD patients receiving psychiatric outpatient care at the existing MH Outpatient Clinic. The IDD BH MCOT and Crisis Respite portions of this project will be new to the community and therefore there is not any baseline data to report.
- **Rationale:** Project option 1.13.1 was selected to address CNA-006 and CNA-007 as defined in the RHP 13 Community Needs Assessment (CNA) document. As part of RHP 13, MHMRCV is located just 16 miles south of the San Angelo State Supported Living Center (SSLC) located in Carlsbad, TX. This SSLC is home to approximately 245 individuals with IDD. Due in part to the 2009 State of Texas and United States Department of Justice settlement agreement that included discharge plans for individuals, there has been an increase in the number of people diagnosed with IDD who are living in the community and have a higher level of need for care/crisis intervention. In addition, MHMRCV has a geographically proportionally high number of individuals with IDD funded via the state Home and Community Based Services (HCS) Medicaid waiver who are living in our community. These two factors have combined to create a large demand for outpatient crisis resolution services. Over time, there have been an increasing number of individuals in this community with IDD who experience a mental health crisis for which there is not a reasonable community based resolution. In most cases when a person with IDD in the community experiences a mental health crisis, the result is hospitalization. Hospitalization is not only costly, but also a very restrictive environment. A less restrictive option is possible, but access to this solution is not available in the community currently. The RHP 13 CNA indicates that the lack of access to Mental Health Professionals in the rural communities creates significant problems in terms of Emergency Room visits. The development of an IDD MCOT, IDD Crisis Respite and IDD Behavioral Health OPC would provide less restrictive alternatives for resolving

the crisis. MHMRCV intends to engage in all of the required core components associated with project option 1.13.1 a – e.

- **Required QI:** MHMRCV will conduct quality improvement for this DSRIP project by using the rapid cycle improvement method. Specifically, process milestone P-6 “evaluate and continuously improve crisis services” was selected for inclusion in DY 4 – DY 5. MHMRCV will utilize its standing Quality Assurance Committee as a forum for documented discussion of monthly project reports and recommendations for improvement. Reports will include real time data from the Center’s electronic health record data system to guide improvements and/or changes in implementation as needed to ensure the project’s success and achievement of milestones and metrics.
- **Related Category 3 Outcome Measure(s):** Process Milestone P-3 (develop and test data systems); Process Milestone P-2 (establish baseline rates); Improvement Target – OD-9 (right care in right setting) IT-9.2 (ED appropriate utilization). As a result of a lawsuit filed by Disability Rights Texas against DSHS, referred to as the “forensic patient capacity lawsuit”, there are fewer beds available for civil capacity at the state hospital. Capacity for local crisis stabilization inpatient beds is also at a critical point. As a proactive response, all efforts to reduce the non-critical utilization of inpatient psychiatric care must be explored so that beds are available for appropriate critical psychiatric care. Implementing the initiatives defined in this project will result in crisis resolution for individuals with IDD in the community setting when appropriate and therefore preserving the scarce inpatient beds for other patients.
- **Relationship to other Projects:** MHMRCV is the local authority that provides services within the following counties of RHP 13: Coke, Concho, Crockett, Irion, Reagan, Sterling and Tom Green. The other four local authorities (Center for Life Resources, Hill Country MHDD Centers, Permian Basin Community Centers and West Texas Centers) provide services to the remaining counties within Regional Healthcare Partnership 13 and service areas do not overlap. This MHMRCV DSRIP project entitled “IDD BH Crisis Response System” is related to Project #133340307.2.2 entitled “Intervention for a Targeted Behavioral Health Population: Trauma Informed Care” in that each project is directed at a specific behavioral health population in an attempt to provide an intervention that will prevent the utilization of the emergency department.
- **Project Valuation:** MHMRCV considered several factors in valuing this project including reductions in costs associated with hospitalizations for developmental disorders, emergency room visits, and law enforcement interventions. The project will also avoid unnecessary commitments/admissions to state supported living centers which will save an average of \$125,507 per year per person according to Legislative Budget Board data on institutional costs.  
By DY 4 it is projected that this project will result in 122 unduplicated people dually diagnosed with IDD and mental illness utilizing appropriate crisis alternatives. By DY 5, it is expected that an additional 121 unduplicated people dually diagnosed with IDD and

mental illness will utilize appropriate crisis alternatives. The patient impact grand total is 243 people (combination of DY 4 patient impact plus DY 5 patient impact). This DSRIP project intervention will result in a 60% cost avoidance as compared to the cost of intervention via the emergency department by demonstration year 5.

<b>109483102.1.1</b>	<b>1.13.1</b>	<b>1.13.1.A,B,C,D,E</b>	<b>IDD BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-9</b>	109483102.3.1	IT-9.2	Right Care, Right Setting - ED appropriate utilization	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b><u>Milestone 1</u></b> P-1: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health service providers <b><u>Metric 1</u></b> P-1.1: Number of meetings and participants <b><u>Baseline/Goal:</u></b> 5 meetings during DY2. <b><u>Data Source:</u></b> Attendance Lists</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$174,873</p> <p><b><u>Milestone 2</u></b> P-2: Conduct mapping and gap</p>	<p><b><u>Milestone 4</u></b> P-5: Develop administration of operational protocols and clinical guidelines for crisis services. <b><u>Metric 1</u></b> P-5.1: Completion of policies and procedures. <b><u>Baseline/Goal:</u></b> Develop policies and procedures in DY3. <b><u>Data Source:</u></b> Internal policy and procedures documents</p> <p>Milestone 4 Estimated Incentive Payment: \$230,774</p> <p><b><u>Milestone 5</u></b> P-4: Hire and train staff to implement identified crisis</p>	<p><b><u>Milestone 6</u></b> P-6: Evaluate and continuously improve crisis services. <b><u>Metric 1</u></b> P-6.1: Project planning and implementation demonstrates plan, do, study, act quality improvement cycles. <b><u>Goal:</u></b> Bimonthly quality improvement meetings. <b><u>Data Source:</u></b> Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.</p> <p>Milestone 6 Estimated Incentive Payment: \$313,534</p>	<p><b><u>Milestone 8</u></b> P-6: Evaluate and continuously improve crisis services. <b><u>Metric 1</u></b> P-6.1: Project planning and implementation demonstrates plan, do, study, act quality improvement cycles. <b><u>Goal:</u></b> Bimonthly quality improvement meetings. <b><u>Data Source:</u></b> Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.</p> <p>Milestone 7 Estimated Incentive Payment: \$201,951</p> <p><b><u>Milestone 9</u></b> I-12: Utilization of appropriate crisis alternatives.</p>	

<b>109483102.1.1</b>	<b>1.13.1</b>	<b>1.13.1.A,B,C,D,E</b>	<b>IDD BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM</b>	
MHMR Services for the Concho Valley			109483102	
<b>Related Category 3 Outcome Measure(s): OD-9</b>	109483102.3.1	IT-9.2	Right Care, Right Setting - ED appropriate utilization	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>analysis of current crisis system.</p> <p><u>Metric 1</u> P-2.1: Produce a written analysis of community needs for crisis services.</p> <p><u>Baseline/Goal:</u> One written analysis completed prior to the end of DY 2.</p> <p><u>Data Source:</u> Written plan</p> <p>Milestone 2 Estimated Incentive Payment: \$174,892</p> <p><u>Milestone 3</u> P-3: Develop implementation plans for needed crisis services.</p> <p><u>Metric 1</u> P-3.1: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community</p>	<p>stabilization services.</p> <p><u>Metric 1</u> P-4.1: Number of staff hired and trained.</p> <p><u>Baseline/Goal:</u>8 staff</p> <p><u>Data Source:</u> Staff rosters and training curricula.</p> <p>Milestone 5 Estimated Incentive Payment: \$230,773</p>	<p><u>Milestone 7</u> I-12: Utilization of appropriate crisis alternatives.</p> <p><u>Metric 1</u> I-12.1: increase in utilization of appropriate crisis alternatives.</p> <p><u>Goal:</u> 122 people utilizing appropriate crisis alternatives.</p> <p><u>Data Source:</u> Claims, encounter and/or clinical record data.</p> <p>Milestone 7 Estimated Incentive Payment: \$313,534</p>	<p><u>Metric 1</u> I-12.1: increase in utilization of appropriate crisis alternatives.</p> <p><u>Goal:</u> 121 people utilizing appropriate crisis alternatives.</p> <p><u>Data Source:</u> Claims, encounter and/or clinical record data.</p> <p>Milestone 7 Estimated Incentive Payment: \$201,951</p> <p><u>Milestone 10</u> I-11: Costs avoided by using lower cost crisis alternative settings.</p> <p><u>Metric 1</u> I-11.1: Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization.</p> <p><u>Goal:</u> 60% decrease in cost as</p>	

<b>109483102.1.1</b>	<b>1.13.1</b>	<b>1.13.1.A,B,C,D,E</b>	<b>IDD BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-9</b>	109483102.3.1	IT-9.2	<i>Right Care, Right Setting - ED appropriate utilization</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
based on gap analysis and assessment of needs. <u>Baseline/Goal</u> : One written action plan completed in DY2. <u>Data Source</u> : Written plan  Milestone 3 Estimated Incentive Payment: \$174,872			compared to emergency department cost. <u>Data Source</u> : Claims, encounters and service event data from ER, forensic records, community mental health assessment data.  Milestone 8 Estimated Incentive Payment: \$201,951	
Year 2 Estimated Milestone Bundle Amount: \$524,618	Year 3 Estimated Milestone Bundle Amount: \$461,547	Year 4 Estimated Milestone Bundle Amount: \$627,068	Year 5 Estimated Milestone Bundle Amount: \$605,853	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$2,219,086</b>				

## **Summary Information^^**

*Performing Provider: MHMR Services for the Concho Valley*

*Pass 1 Project*

*Project Unique ID #: 109483102.1.2*

Provider: MHMR Services for the Concho Valley (MHMRCV) is a small sized rural community mental health and IDD center located in San Angelo, TX. MHMRCV serves people with IDD and specific mental illnesses who have Medicaid entitlement or are indigent via a contract with the Texas Department of Aging and Disability Services (DADS) and the Department of State Health Services (DSHS). The people served by the Center must have proof of residence in Coke, Concho, Crockett, Irion, Reagan, Sterling or Tom Green Counties. The approximate total population of this seven county catchment area is 128,000. MHMRCV is contracted by DSHS to serve 413 unduplicated Medicaid/indigent adults and 65 Medicaid/indigent children with specific mental illnesses each six months during the fiscal year. The Center served 505 Medicaid/indigent adults and 236 children with mental illness (as defined by DSHS contract) from August 2012 – January 2013.

Intervention(s): This project will allow MHMRCV to increase the current mental health service delivery capacity and improve existing adult and children's mental health services delivered to residents in the seven county catchment area. Specifically, the project will afford MHMRCV the ability to serve adults with a broader variety of Axis I diagnoses than ever before. Currently MHMRCV can only serve adults with a specific diagnosis of Schizophrenia, Bipolar Disorder and Major Depression via the contract with DSHS. This project will also improve efficiencies in already existing adult and children's services through implementation of evidence based interventions.

Need for the project: MHMRCV currently has greater demand for services than capacity to deliver services. We know based on MHMRCV intake versus admission Utilization Management data that over time 22% of adult individuals who present at intake for admission to services are denied admission due to not meeting the strict DSHS target population Axis I diagnostic admission requirements. Over a four year period from 2008 - 2012 this represents a total of 728 adult people from our community who reached out for help and were unable to receive treatment due to the limited Axis I diagnosis admission criteria.

Medicaid and Uninsured Target population: The target population for this project is any individual living in the previously described seven county catchment area with an Axis I diagnosis and an ability to benefit from the existing service array provided by MHMRCV. According to the Community Needs Assessment data, 11.8% of the RHP 13 population was enrolled in Medicaid as of April 2012 and 28.4% of the population was uninsured.

Category 1 expected patient benefits: The project seeks to increase utilization of community based mental health services by providing mental health care to 125 new adult patients by the end of DY 4 and 125 additional new/unduplicated adult patients by the end of DY 5. The combined DY 4 and DY 5 patient impact is 250 new adult patients receiving mental health intervention for an Axis I diagnosis other than Schizophrenia, Bipolar Disorder or Major Depression.

Category 3 outcomes: IT-10.1 Our goal is to demonstrate improvement in quality of life scores, as measured by an evidence based and validated assessment tool, for the target population. Baseline rates will be determined by DY 3 and subsequent quality of life score improvement goals set for achievement in DY 4 and DY 5. Per CMS and HHSC, Category 3 methodology for targets will be redefined.

### **“Expand and Enhance Behavioral Health Services”**

- **Identifying Project and Provider Information:** “Expand and Enhance Behavioral Health Services”; 109483102.1.2; MHMR Services for the Concho Valley/109483102.
- **Project Description:** MHMR Services for the Concho Valley (MHMRCV) aims to expand and enhance its rural behavioral health services via the following initiatives: (1) increasing the variety of adult mental health Axis I eligibility diagnoses, (2) eliminating current waiting lists for adult and children’s services, (3) adding access to a larger number of adult mental health Cognitive Behavioral Therapy (CBT) trained counselors and (4) Alcohol and Drug Abuse Council (ADAC) Licensed Chemical Dependency Counselors (LCDC), and (5) implementing a form of open access to behavioral healthcare. This DSRIP project is designed to serve individuals who specifically live in Coke, Concho, Crockett, Irion, Reagan, Sterling or Tom Green counties. The precise aim of only serving residents of the seven counties previously listed ensures there is not a duplication of services via DSRIP projects of other local mental health authorities in RHP 13.

MHMRCV is funded in part by the Texas Department of State Health Services (DSHS) to provide routine mental health services only to those adult individuals age 18 and older who have an Axis I diagnosis of schizophrenia, bipolar disorder or major depression. Today, adult individuals who present for intake and have a diagnosis of schizophrenia, bipolar disorder or major depression but do not have Medicaid are given an opportunity to join our waiting list for services. People who present for services and do not have a diagnosis of schizophrenia, bipolar disorder or major depression are deemed ineligible for MHMRCV services. Even with this diagnostic admission constraint, in a given six month period MHMRCV serves approximately 505 unduplicated adult patients. Axis I diagnostic admission criteria for children and adolescents is much more liberal. However, some non-Medicaid individuals are placed on a waiting list due to resource limitations. In a given six month period, MHMR Services for the Concho Valley serves approximately 236 unduplicated child and adolescent patients.

Historical MHMRCV adult intake appointment data versus admission data indicates that there is a need in the community for treatment of a broader range of Axis I diagnoses in an outpatient setting via both traditional CBT counseling and substance abuse counseling services and medication services. In addition, our local utilization management data indicates steady use of the waiting list. The purpose of this project is to augment our current adult and children’s staffing to replicate service delivery efficiencies already in place and expand to serve individuals with a demonstrated need in our community.

To complement the planned expansion of services, MHMRCV intends to implement a variety of open access strategies to improve the patient admission process into mental health services. The goal of each strategy is to work in concert to reduce the amount of time a patient has to wait between an initial intake appointment and their first opportunity to see a prescribing provider. Specifically, strategies such as collaborative documentation,

strategic scheduling actions (confirmation calls, appointment back filling, alternative scheduling) and walk-in intakes will be implemented. Results of these open access strategies include more appointments available sooner for people to receive mental health care.

The goals of this expansion and enhancement project include the elimination of the use of waiting lists for services, meeting the demand for specific mental health services demonstrated in our community and doing so in an efficient and patient focused manner.

There are three primary anticipated challenges associated with this project. The first challenge is community education regarding the expansion of services. For a long time MHMRCV has been known by reputation in the community for only serving individuals with severe and persistent mental illness who are also indigent. With our plan to broaden the Axis I diagnoses eligible for services we will also need a plan for public awareness of this change. We will address the public relations needs of this project during the project planning phase. The second challenge is locating and hiring the proper staff to support the increased demand created as a result of this project. As we fine tune the expected volume of services as part of the project in DY3 we will be able to tailor job postings and descriptions to ensure the right staff are attracted. The final challenge is locating an appropriate service location. During DY2 MHMRCV will develop project plans for the expanded and enhanced services proposed. Time will be dedicated for locating an appropriate service site.

At the end of the five year waiver, as a performing provider, MHMRCV hopes that the mental health needs of our community are better met and provided in a comfortable, appropriate, lower cost environment.

From a patient perspective, it is our hope that we have achieved the goal of serving those individuals who sought services when they needed them. The project seeks to increase utilization of community based mental health services by providing mental health care to 125 new adult patients by the end of DY 4 and 125 additional new/unduplicated adult patients by the end of DY 5. The combined DY 4 and DY 5 patient impact is 250 new adult patients receiving mental health intervention for an Axis I diagnosis other than Schizophrenia, Bipolar Disorder or Major Depression.

The RHP 13 goals are transformation of the healthcare system and further advances toward the Triple Aim: right care, right setting, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined

target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

- **Starting Point/Baseline:** As of September 30, 2012 the current waiting list at MHMRCV for all services had 11 individuals listed. MHMRCV has worked hard to keep the waiting list numbers low. This is achieved by the Center exercising its ability to override state diagnostic requirements via the DSHS “Resiliency and Disease Management Utilization Management special circumstances admission criteria” on a case by case basis. This proactive decision has ensured that mental health services were provided to individuals in the community instead of eventually via hospitalization. These special circumstance admissions have played a part in boosting the number of adult people served over the DSHS required 413 target. The Center is currently only admitting adult Medicaid patients who have a diagnosis of schizophrenia, bipolar disorder or major depression and child and adolescent patients who have Medicaid and an Axis I diagnosis. The capacity to provide counseling to patients is currently at a maximum of 20 unduplicated people per month served via four part-time Licensed Professional Counselors. The current wait time for an admitted patient to see a prescribing provider is one to three weeks. Local UM data confirms that adult mental health intake staff must deny admission access to approximately 182 adult individuals per year who present for services but do not have a diagnosis of schizophrenia, bipolar disorder or major depression.
- **Rationale:** According to the RHP 13 Community Needs Assessment (CNA) document, one of the six opportunities that exist for Region 13 is expansion of specialty services. Considering that psychiatry is a specialty service, project option 1.12.4 was selected to address community need identification number CNA-006 as defined in the RHP 13 CNA document. Our decision to enhance and expand behavioral health services can also be deemed a proactive strategy to prepare for future increases in demand. To clarify, the CNA document indicates that currently 28.4% of the region’s population is uninsured and 11.80% have Medicaid coverage. It is anticipated that with the continued roll out of Medicaid Managed Care programs that more of the 28% uninsured will move into some form of coverage, potentially Medicaid. As a community mental health center, MHMRCV is the designated safety net for mental health services. People who present for services, are diagnostically eligible and have Medicaid coverage are entitled to admission. It is clear that preparation to meet demand must be started now. This project aims to augment our service providers and enhance our delivery system capitalizing on current efficiencies in order to prepare for this increased demand. We know based on MHMRCV intake versus admission Utilization Management data that over time 22% of individuals who present at intake for admission to services are denied admission due to not meeting the strict Department of State Health Services target population Axis I diagnostic admission requirements. Over a four year period from 2008 - 2012 this represents a total of 728 people from our community who reached out for help and were unable to receive treatment due to the limited Axis I diagnosis admission criteria. In addition, the center wide waiting list further supports the fact that the demand is present in the community, but the resources to support the demand is not. Finally, the CNA explains that according to the Healthy People 2020 government website

there is an emergence of a new mental health issue including the needs of veterans who have experienced mental trauma. Region 13 is home to Goodfellow Air Force Base located in San Angelo, TX. The presence of this base and with many rural areas where military retirees reside indicate to us that this project may meet the needs presented by these growing issues.

- **Required QI:** MHMRCV will conduct quality improvement for this DSRIP project by using the rapid cycle improvement method. Specifically, process milestone P-7 “evaluate and continuously improve” was selected for inclusion in DY 4 – DY 5. MHMRCV will utilize its standing Utilization Management Committee as a forum for documented discussion of monthly project reports and recommendations for improvement. The Center’s Utilization Management Committee reports to the Center’s Quality Assurance Committee. Reports will include real time data from the Center’s electronic health record data system to guide improvements and/or changes in implementation as needed to ensure the project’s success and achievement of milestones and metrics.
- **Related Category 3 Outcome Measure(s):** The process milestone selected to support project option 1.12.4 is P-2, establish baseline rates. The improvement target is Quality of Life/Functional Status, OD-10. The specific standalone measure is IT-10.1, Quality of Life. This outcome is a priority for the RHP because it supports the CNA description that mental and physical health is closely connected. More specifically, untreated mental health issues lead to increased emergency room utilization and complications in treating medical conditions which are worsened by the presence of mental health issues. By providing greater community access to expanded and enhanced mental health services the community is avoiding emergency department cost for mental health treatment. In addition, when mental health treatment is available and successful the person’s quality of life is improved.
- **Relationship to other Projects:** MHMRCV is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 13: Coke, Concho, Crockett, Irion, Reagan, Sterling and Tom Green. The other four local mental health authorities (Center for Life Resources, Hill Country MHDD Centers, Permian Basin Community Centers and West Texas Centers) provide mental health services to the remaining counties within Regional Healthcare Partnership 13 and service areas do not overlap. This MHMRCV DSRIP project entitled “Expand and Enhance BH Services” is related to the following other projects within RHP 13:
  - Project #130725806.1.11.1 entitled “West Texas Center Telemedicine Expansion” and Project #133339505.1.1 entitled “Technology Assisted Services”– each project is directed at expanding mental health services to those people living in rural areas of RHP13. All projects share the goal of improving overall healthcare access in the region by expanding access to behavioral health care services

- Project #133340307.2.1 entitled “Co-occurring Psychiatric and Substance Use Disorder Intervention” – each project shares the aim of expanding service to individuals with psychiatric and substance abuse disorders.
- **Project Valuation:** MHMRCV considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral health disorders, emergency room visits, and law enforcement interventions. The project will also result in enhanced quality of life for individuals with behavioral health disorders living in the Concho Valley by providing improved access to behavioral health care. The project seeks to increase utilization of community based mental health services by providing mental health care to 125 new adult patients by the end of DY 4 and 125 additional new/unduplicated adult patients by the end of DY 5. The combined DY 4 and DY 5 patient impact is 250 new adult patients receiving mental health intervention for an Axis I diagnosis other than Schizophrenia, Bipolar Disorder or Major Depression.

<b>109483102.1.2</b>	<b>1.12.4</b>	<b>N/A</b>	<b>EXPAND AND ENHANCE BEHAVIORAL HEALTH SERVICES</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-10</b>	109483102.3.2	IT-10.1	Quality of Life/Functional Status – Quality of Life	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b><u>Milestone 1</u></b> P-2: Identify licenses, equipment requirements and other components needed to implement and operate options selected.</p> <p><b><u>Metric 1</u></b> P-2.1: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components.</p> <p><u>Goal</u>: Development of one project plan before the end of DY2.</p> <p><u>Data Source</u>: Project plan.</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$454,813</p>	<p><b><u>Milestone 2</u></b> P-3: Develop administrative protocols and clinical guidelines for projects selected.</p> <p><b><u>Metric 1</u></b> P-3.1: Manual of operations for the project detailing administrative protocols and clinical guidelines.</p> <p><u>Goal</u>: Development of protocols and guidelines before the end of DY3.</p> <p><u>Data Source</u>: Administrative protocols; clinical guidelines</p> <p>Milestone 2 Estimated Incentive Payment: \$280,103</p> <p><b><u>Milestone 3</u></b></p>	<p><b><u>Milestone 4</u></b> P-5: Establish extended hours</p> <p><b><u>Metric 1</u></b> Number of areas prioritized for intervention with options in operation. <u>Goal</u>: 1 area prioritized for intervention with options in operation. <u>Data Source</u>: Number of patients served during extended hours.</p> <p>Milestone 4 Estimated Incentive Payment: \$155,323</p> <p><b><u>Milestone 5</u></b> P-7: Evaluate and continuously improve services.</p> <p><b><u>Metric 1</u></b> P-7.1: Project planning and</p>	<p><b><u>Milestone 7</u></b> P-7: Evaluate and continuously improve services.</p> <p><b><u>Metric 1</u></b> P-7.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles.</p> <p><u>Goal</u>: Bimonthly quality improvement meetings.</p> <p><u>Data Source</u>: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.</p> <p>Milestone 6 Estimated Incentive Payment: \$150,071</p>	

<b>109483102.1.2</b>	<b>1.12.4</b>	<b>N/A</b>	<b>EXPAND AND ENHANCE BEHAVIORAL HEALTH SERVICES</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-10</b>	109483102.3.2	IT-10.1	Quality of Life/Functional Status – Quality of Life	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
	<p>P-4: Hire and train staff to operate and manage projects selected.</p> <p><b><u>Metric 1</u></b> P-4.1: Number of staff secured and trained.</p> <p><u>Goal:</u> 50% of required staff will be hired and trained.</p> <p><u>Data Source:</u> Project records; training curricula as developed in P-2.</p> <p>Milestone 3 Estimated Incentive Payment: \$280,103</p>	<p>implementation documentation demonstrates plan, do, study act quality improvement cycles.</p> <p><u>Goal:</u> Bimonthly quality improvement meetings. <u>Data Source:</u> Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.</p> <p>Milestone 5 Estimated Incentive Payment: \$155,323</p> <p><b><u>Milestone 6</u></b> I-11: Increased utilization of community behavioral healthcare.</p> <p><b><u>Metric 1</u></b> I-11.1: Utilization of community behavioral healthcare services.</p>	<p><b><u>Milestone 8</u></b> I-11: Increased utilization of community behavioral healthcare.</p> <p><b><u>Metric 1</u></b> I-11.1: Utilization of community behavioral healthcare services. <u>Goal:</u> Serve 125 new, unduplicated patients. <u>Data Source:</u> Claims data and encounter data from community behavioral health sites.</p> <p>Milestone 7 Estimated Incentive Payment: \$150,071</p> <p><b><u>Milestone 9</u></b> I-13: Adherence to scheduled appointments.</p> <p><b><u>Metric 1</u></b> I-13.1: % decrease in the number of canceled or no-</p>	

<b>109483102.1.2</b>	<b>1.12.4</b>	<b>N/A</b>	<b>EXPAND AND ENHANCE BEHAVIORAL HEALTH SERVICES</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-10</b>	109483102.3.2	IT-10.1	<i>Quality of Life/Functional Status – Quality of Life</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
		<u>Goal:</u> Serve 125 new patients  <u>Data Source:</u> Claims data and encounter data from community behavioral health sites.  Milestone 7 Estimated Incentive Payment: \$155,324	show appointments.  <u>Goal:</u> 5% decrease  <u>Data Source:</u> Clinical records from expanded access sites.  Milestone 8 Estimated Incentive Payment: \$150,071	
Year 2 Estimated Milestone Bundle Amount: \$454,813	Year 3 Estimated Milestone Bundle Amount: \$560,206	Year 4 Estimated Milestone Bundle Amount: \$465,970	Year 5 Estimated Milestone Bundle Amount: \$450,213	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$1,931,202</b>				

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*Summary Information*

*Performing Provider: North Runnels County Hospital TPI#020989201*

*Pass 2 Category 1 Project: Expand Primary Care Capacity*

*Project Unique ID#: 020989201.1.1*

Provider: 020989201 North Runnels County Hospital is a 25–bed Critical Access Hospital in Winters, TX serving the surrounding North Runnels County with a population of approximately 2562.

Intervention(s): This project will help the healthcare providers to better accommodate the demands of the patient and hospital. This will help the patient by allowing them to find a healthcare provider in their community and in turn this will decrease the cost to the patient. This will also enhance service availability for faster and prompt access to the residents of North Runnels County and the surrounding area.

Need for the project: North Runnels County Hospital has selected the Expand Primary Care Capacity project because we are in need of another healthcare provider to help relieve the physicians in the clinic and ED. This will help the healthcare providers to better accommodate the demands of the patients and hospital. This will also relieve the current provider's in the clinic and ED to provide prompt and better services to increase access to primary care. It will enhance service availability for faster and prompt access to the residents of Runnels County and the surrounding areas. At this time all patients have to wait to be seen in the clinic because physicians are booked and an appointment can't be made until days after. If the patient has to be seen immediately, the patient then will have to seek another healthcare provider out of town or be seen in the ED for a non-emergency care visit. If another healthcare provider were available, there would be a significant reduction in ED and travel cost to the patient. With prompt access, the health outcome for our patients will improve in the short and long-term, as well as the delivery system cost of providing care.

Medicaid and Uninsured Target Population: Targeted area covers the northern district of Winters TX population of 2562 and the population of the surrounding Runnels County area to patients that need medical services. By adding another healthcare provider it will lower the cost to patients that are on Medicaid, Uninsured or Indigent. NRCH serves around 50% of the above patients.

Category 1 expected patient benefits: To provide faster and better service to the patients and hospital. This will help the patient by allowing them to find a healthcare provider in their community and in turn this will decrease the cost to the patient. By adding another primary care physician, this will alleviate the problem of not having enough staff on hand. This will accommodate the patients that can't be seen in the clinic because lack of staff. The patient will be seen in the clinic with a faster response time and the patient will not have to go to another facility to be seen by another physician. This has been a problem due to the impact of cost to the patient and decreased response time for immediate care. This will benefit the patient and will improve the overall health to the patient, including the Medicaid and/or indigent patients. By DY4, we hope to recruit another provider within that year but month of hire unknown. We are expecting the provider to work more in the ER and half-time doing hospital rounds and expecting 800 clinic visits. By DY5, we would like to see the provider working in a half-time status but we do understand that the provider will still be building their

practice. We expect to see in DY5 clinic visits of 1000. In DY2, DY3 and/or DY4 we will start the recruiting process and before or within DY4 and DY5 we would like to have staffed a healthcare provider and staff. Number of increase targeted population: DY2 0 and DY3 TBD and DY4 800 clinic visits 15 admissions and DY5 1000 clinic visits 25 admissions.

Category 3 outcomes: IT-9.2 ED appropriate Utilization – Reduce patient ED visits for non-emergency care.

### **C. Category 1: Infrastructure Development**

#### **Project Option 1.1. - Expand Primary Care Capacity**

- **Identifying Project and Provider Information:**
  - 1.1 Expand Primary Care Capacity
  - 1.1.2 Expand Existing Primary Care Capacity
  - Expand Primary Healthcare Provider
  - 020989201.1.1
  - 020989201

#### **Project Description:**

As a provider within a Health Provider Shortage Area, North Runnels Hospital plans to Expand Primary Care Capacity to the residents of Runnels County and the surrounding areas by adding a Physician or Physician Assistant. North Runnel County Hospital has selected this project because we are in need of another Health provider to help relieve the other physicians in the clinic and emergency room, especially for the Emergency room Department. This will help the health care providers to better accommodate the demands of the patient and hospital. This will also help the patient by allowing them to find an additional healthcare provider in their community and in turn this will decrease the cost to the patient. It will enhance service availability for faster and prompt access to the residents of Runnels County and surrounding areas. With faster and prompter access, the health outcomes for our patients will improve in the short- and long-term, as well as the delivery system costs of providing care.

#### **Goals and Relationship to Regional Goals:**

Expand the existing capacity of primary care for the North Runnels residents, to better accommodate their needs, and to increase the availability of care for the patient population. This will allow them to receive the right care at the right time in the right setting. Based on the community needs assessments our goals include the following:

#### **Project Goals:**

- Develop a regional approach to health care delivery that will improve on existing programs and infrastructure.
- To respond to patient needs, and improve health care outcomes and patient satisfaction.
- Increase access to primary care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- To coordinate a delivery model that improves patient satisfaction and health outcomes that will reduce unnecessary or duplicative services. This will help build on the accomplishments of our existing health care.
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation process.

**Challenges:**

North Runnels County Hospital's biggest challenge of this project is recruiting the appropriate candidate willing to relocate and provide care to an underserved rural community. This will take some time and effort to find the provider. Currently, we are faced with not having enough health care provider coverage for the clinic or relief for those providers in the emergency room. By adding one more provider this will alleviate the stress and shortage of care.

**5-Year Expected Outcome for Provider and Patients:**

North Runnels County Hospital's expected outcome is to add another health care provider to help with the treatment, and management to improve primary care access in the emergency room to the patients in the community. Patients will see improved and faster access to appointments and emergency care. By DY4 we hope to recruit another provider within that year don't know in which month but we are expecting to see the provider to work half-time doing hospital rounds, ER and expecting to get 800 clinic visits. By DY5 we would like to see the provider working in a half-time status but we do understand that the provider will still be building their practice so we expect to see in DY5 clinic visits of 1000. In DY2, DY3 and/or DY4 we will start the recruiting process and before or within DY4 and DY5 we would like to have staffed a healthcare provider and staff.

**Starting Point/Baseline:**

At this time North Runnels County Hospital has two healthcare providers. The baseline is to add another healthcare provider. Starting baseline will be to start recruitment in DY2, DY3 and/or DY4. Our goal is to have another healthcare provider and nursing staff before or within DY4 or DY5. This will be a challenge. DY4 clinic visits 800 and admissions 15 and DY5 clinic visits 1000 and admissions 20.

**Rationale:**

North Runnels County Hospital is a designated Health Professional Shortage Area when it comes to primary care. The community residents residing in North Runnels County and the surrounding areas are underserved by physicians that provide primary care services. In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in a primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Low-income, self-pay and indigent Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. That is why the expanding primary care project was selected. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction appropriate utilization and reduced cost of services.

### **Project Components: 1.1.2 - Expand Existing Primary Care Capacity**

This project will address the core requirements of this project option in the following by expanding the existing primary care capacity:

- Expand primary care clinic space
- Expand primary care clinic staffing.
- Expand primary care capacity.
- Provide ER Coverage to relieve the other Health care providers.
- The North Runnels County hospital and clinic are eager to expand staffing, in that the provider will be a new addition, and equipped to handle primary care for our residents in the community.

### **Milestones and Metrics:**

The following milestones and metrics were chosen for the expansion of the existing primary care capacity project based on the core components and the needs of the target population: This milestone will be used when another healthcare provider is hired hopefully on or before DY4 or DY5.

P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. This will be maintained once another Physician or Physician Assistant is staffed we also will need to hire nursing staff for the clinic.

P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. We are looking to hire one more health provider and one more nursing staff.

a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation: All required documentation will be obtained once staff is put into place.

b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care.

### **Improvement Milestone:**

I-15. Milestone: Increase access to primary care capacity. The following metrics are suggested for use with an innovative project option to increase access to primary care capacity. By recruiting another healthcare provider this will increase access of care to the patient.

I-15.1. Metric: Increase percentage of target population reached.

a. Numerator: Number of individuals of target population reached by the innovative project. We are looking to target the population of North Runnels County and the surrounding areas.

b. Denominator: Number of individuals in the target population: Winters, TX population 2562.

c. Data Source: Documentation of target population reached, as designated in the project plan. This will be tracked monthly.

d. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching its targeted population.

### **Unique community needs identification numbers:**

Ties to Region 13 unique community needs: CNA-001- Primary Care shortage, CNA-008 – Patient Satisfaction and CNA-009 Improve Cost effectiveness of care

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

OD-9 Right Care, right setting; IT-9.2 ED appropriate utilization

**Reasons/rationale for selecting the outcome measures:**

North Runnels County Hospital chose this Category 3 Outcome domain because one of the main goals in recruiting a new provider to the area is to improve patient satisfaction with patient access to primary care. If patients feel they are able to receive timely care, appointments, and information, they are more likely to seek treatment and maintain best health practices. This project will tie in with giving patients improved access to primary care so they will be less inclined to use the ED for non-emergent treatment, and will allow additional patient satisfaction.

**Relationship to other Projects:**

This project relates to the following projects that we are submitting in Pass 3-B for cost containment. In relation to North Runnels County Hospital Category 3 project 020989201.3.1

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

North Runnels County Hospital to Expand existing primary care capacity is in relation with the following RHP13 participants; Coleman, Runnels, Kimble, Pecos and Tom Green County.

**Plan for Learning Collaborative:**

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 valuation that North Runnels County Hospital takes into account is the degree to which the project accomplishes the community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project will accomplish these goals by increasing access to primary care through additional staffing, hours, and space. This project will take much investment in recruiting, training, and compensation for a new provider, as well as providing additional perks or benefits to incentivize a provider to relocate to a rural area. North Runnels County Hospital understands that as health care costs rise that we will strive to find better ways to stay increasingly interested in developing accurate ways to measure outcomes. This will be done by offering the patients in the community faster diagnosis time, management and treatment of specific clinical conditions.

North Runnels Hospital ultimate challenge is to try to reduce health care costs for the patients in our community. North Runnels County Hospital will develop cost-of-care measures by achieving high value for patients that will help those who get, give and pay for care. Value is our overall goal of health care delivery, with value defined as the health outcomes achieved per dollar spent. This goal is what matters for our patients

served in our community. By adding another primary care physician, this will alleviate the problem of not having enough staff on hand, this will accommodate the patients that can't be seen in the clinic because lack of staff. The patient will be seen in the clinic with a faster response time and the patient will not have to go to another facility to be seen by another physician. This has been a problem due to the impact of cost to the patient and decreased response time for immediate care. This will benefit the patient and will improve the overall health to the patient, including the Medicaid and/or indigent patients. By DY4, we hope to recruit another provider within that year but month of hire unknown. We are expecting the provider to help out more in the ER and work half-time doing hospital rounds and 800 clinic visits. By DY5 we would like to see the provider working more than a half-time status but we do understand that the provider will still be building their practice. We expect to see in DY5 clinic visits of 1000. In DY2, DY3 and/or DY4 we will start the recruiting process and before or within DY4 and DY5 we would like to have staffed a healthcare provider and staff.

Our hospital covers the northern district population which covers Winters TX population of 2562 and also the population of the surrounding northern district. Our goal is to be the preferred provider for our community. With the ability to provide quicker, better service, to be more efficient in an effective way and lower cost to the patient, we can meet any new challenges that may arise.

020989201.1.1	1.1.2	I-15	1.1.2 Expand existing primary care capacity	
North Runnels County Hospital			020989201	
OD-9	IT-9.2	020989201.3.2	Expand primary care capacity	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p>Milestone 1 I-15. Improvement Milestone: Increase access to primary care capacity.</p> <p>Metric: I-15.1. Increase % of target population reached. Baseline/Goal: 0 Data Source: Documentation</p> <p>Milestone 1 Estimated Incentive Payment : \$78,297.00</p>	<p>Milestone 2 I-15. Improvement Milestone: Increase access to primary care capacity.</p> <p>Metric: I-15.1. Increase % of target population reached. Baseline/Goal: TBD Data Source: Documentation</p> <p>Milestone 2 Estimated Incentive Payment: \$85,223.00</p>	<p>Milestone 3 P-5. Train/hire additional primary care providers and staff</p> <p>Metric: P-5.1. Documentation Baseline/Goal: 1 primary care health-provider &amp; 1 nursing staff Data Source: Documentation</p> <p>Milestone 3 Estimated Incentive Payment: \$41,927.50</p> <p>Improvement Milestone 3: I-15 Increase access to primary care capacity.</p> <p>Metric: I-15.1. Increase % of target population reached. Baseline/Goal: 800 Clinic visits &amp; 15 admissions Data Source: Documentation</p> <p>Milestone 2 Estimated Incentive Payment: \$41,927.50</p>	<p>Milestone 5 P-5. Train/hire additional primary care providers and staff</p> <p>Metric: P-5.1. Documentation Baseline/Goal: 1 primary care health-provider \$ 1 nursing staff Data Source: Documentation</p> <p>Milestone 4 Estimated Incentive Payment: \$37,497.50</p> <p>I Improvement Milestone 3: I-15 Increase access to primary care capacity.</p> <p>Metric: I-15.1. Increase % of target population reached. Baseline/Goal: 1000 Clinic visits &amp; 25 admissions Data Source: Documentation</p> <p>Milestone 2 Estimated Incentive Payment: \$37,497.50</p>	

020989201.1.1	1.1.2	I-15	1.1.2 Expand existing primary care capacity	
North Runnels County Hospital			020989201	
OD-9	IT-9.2	020989201.3.2	Expand primary care capacity	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Milestone Bundle Amount: \$78,297	Year 3 Estimated Milestone Bundle Amount: \$85,223	Year 4 Estimated Milestone Bundle Amount: \$83,855	Year 5 Estimated Milestone Bundle Amount: \$74,995	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over DY's 2-5): \$327,572</i>				

## Summary Information

*Performing Provider: Pecos County Memorial Hospital*

*Pass 3b Project (Pass 1)*

*Project Unique ID #: New 130616905.1.3 Pass 3b (Old 130616905.1.1)*

- Provider: Pecos County Memorial Hospital is a 27-bed hospital in Fort Stockton, Texas serving a 4,764 square mile area and a population of approximately 8,300. Our service area also includes Terrell County which covers 2,358 square miles.
- Intervention(s): This project will implement a primary care clinic to provide patient care to the residents of Terrell County, a neighboring county of Pecos County, with a population of approximately 1,000.
- Need for the project: Terrell County is one of the most remote counties in Texas. Access to healthcare for these residents can be limited or nonexistent. This often leads to unnecessary utilization of PCMH's Emergency Department as well as Pecos County's EMS for non-emergent, but urgent care as well as higher acuity for inpatient stays due to delays in preventive care.
- Medicaid and Uninsured Target population: The target population is approximately 1,000 Terrell County residents who need access to primary care. Approximately 50% of Terrell County patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the visits.
- Category 1 or 2 expected patient benefits: The project seeks to establish our clinic in DY2, and increase clinic visits by 20 from DY2 to DY3 and in each consecutive year for DY4 and DY5.
- Category 3 outcomes: IT-9.2 Our goal is to reduce the non-urgent PCMH ED visits by Terrell County residents in program years 3, 4 & 5 by 5 visits from each previous year for a total of 15 visits, thus, achieving Outcome Domain-9 Right Care, Right Setting.

### ***Category 1: Infrastructure Development***

- **Identifying Project and Provider Information:**

  - **Project Option 1.1.1** - Expand Primary Care Capacity (Sanderson Clinic)

  - **Unique Project ID:** 130616905.1.3 Pass 3b (130616905.1.1)

  - **Performing Provider Name/TPI:** Pecos County Memorial Hospital/130616905

- **Project Description:**

Pecos County Memorial Hospital (PCMH) is in Fort Stockton, Texas located 65 miles north of Sanderson, Texas, which is in Terrell County. Terrell County is one of the most remote counties in Texas. It has a population of around 1,000 people and expands over 2,300 square miles. Almost 60 percent of Terrell County residents were over 45 years of age (approximately 33 percent for the state) according to the 2009 Health Facts Profile on Terrell County by the Center of Health Statistics at the Department of State Health Services. Terrell and Pecos counties are both Health Provider Shortage Areas, which further exacerbates our ability to recruit primary care providers. The residents and our patients in Terrell County are continually at risk of having no access to primary and preventive care due to the constant struggle to recruit physicians and other primary care providers to make sure these patients are being seen regularly and have all their preventive treatments. Additional patient barriers to access including non-emergent transportation and work schedules also can lead to unnecessary utilization of the Emergency Room and/or EMS for non-emergent, but urgent care as well as higher acuity for inpatient stays due to delays in preventive care.

As noted in many frontier communities, access to primary and preventive care can be limited or nonexistent. PCMH proposes to use this opportunity under the waiver to transform access to care by establishing a primary care clinic in Sanderson. We will recruit and hire mid-level primary care providers and physicians to rotate through the Sanderson Clinic to provide a local access point to primary and preventive care for these residents who might otherwise have access to any care. This will also increase the capacity within the health system to be able to provide patients with access to an available appointment in a more timely fashion. As recommended through the triple aim providing access to quality care will improve health outcomes. By DY 5 of the waiver, we expect to hire additional primary care providers to staff the Sanderson Clinic. We expect to expand hours on certain days to give patients who work the choice of afterhours care and to provide 1,000 visits over each of the next 4 years of the waiver. Our plans also include free physicals to athletes and to school bus drivers as well as a pilot program which will incorporate Electronic Health Record initiatives by using electronic patient bracelets uploaded with their health records.

- **Starting Point/Baseline:**

  - Terrell County has a population of approximately 1,000 residents. They are 65 miles from Fort Stockton, Texas, their closest hospital. We believe HPSA and claims data support the need to expand primary care into Sanderson, Texas.

- **Rationale:**

  - PCMH has identified project option

### 1.1.2 Expand existing primary care capacity

Required core project components:

- a) Expand primary care space
- b) Expand primary care clinic hours
- c) Expand primary care clinic staffing

As supported by 1.1.2, access to primary and preventive care in HPSA and frontier counties in Texas remains the greatest community need and priority to achieve the ability to reduce potentially preventable acute care costs. We see Sanderson and Terrell County as our first priority because 5% of our patients live in Terrell County. We had 75 admissions and 74 discharges for Terrell County residents in 2011. We have patients there that need to get preventive and post discharge care which will improve their health outcomes. Without access to primary care, we undermine the potential cost avoidance through the expansion of preventive care. Though the total population is low, the aging population is one of the fastest growing in costs. Access to annual health checkups for a full screening and administration of immunizations can prevent expensive episodic care for diabetes, pneumonia, the flu, and/or congestive heart failure. By providing additional primary care capacity, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with non-emergent care treatment in the ED. These objectives are identified in the RHP 13 Community Needs Assessment CN-005.

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

PCMH has selected OD-9 Right Care, Right Setting along with Improvement Target-9-2 Reduction of Emergency Department visits:

- Non-emergent utilization of the PCMH ED, as evidenced by PCMH 2011 ED statistics of over 50%, supports the need to address improper utilization of the ED.
- In 2011, 31% of ED visits from the Terrell County zip code were either Medicaid or self-pay.
- Terrell County is one of the most remote counties in Texas.
- By establishing primary care clinics in these underserved communities, RHP initiatives related to Category 1.1.2 will be achieved with the goal of increasing clinic visits annually as well as providing wellness initiatives to the residents.

- **Relationship to other Projects:**

PCMH projects interrelate with each other as shown in 1.1 and 2.2, expanding primary care capacity by establishing more clinics and by redesigning the outpatient delivery system to coordinate care for patients with chronic diseases. This will allow us to expand clinic space and hours (1.1 P-1) and implement a community/school-based clinics program (1.1 P-2) and expand the hours of a primary care clinic, including evening and/or weekend hours (1.1 P-4) which will result in increased primary care clinic volume of visits and evidence of improved access for patients seeking services (1.1.1). This, in turn, will help patients receive care for chronic conditions (2.2 P-9) as well as develop and implement programs to assist patients to better self-manage their chronic conditions (2.2 P-11). This will result in and improvement of the percentage of patients with self-

management goals (I18.1) as well as improvement in access to care of patients receiving chronic care management services (I21.1).

- **Project Valuation:**

By providing access to care we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings. We will provide the 1,000 Terrell County residents primary and preventive care. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. Valuation assumes the Sanderson primary care clinic will treat approximately 1,200 patients per year in the 79848 ZIP code. The plan projects a decrease in ED visits by 5 patients per year (or 5% per year). The result of the decrease in ED visits also assumes a corresponding decrease in Medicaid and/or other governmental funding sources for high-cost services in the ED. The average cost per ED visit, based on Pecos County Memorial Hospital's charges, is \$1,000 per visit. We estimate a decrease of 5 ED visits per year from the 79848 ZIP code. The project also assumes that increased access to primary care services will result in decreased hospital admissions. PCMH currently experiences an 11% ED crossed to admissions rate. Based on these statistics, we estimate a decrease of 4 inpatient admissions from the 79848 ZIP code. On average, a PCMH admission costs \$10,500. We propose a valuation of \$596,017 which is supported by the community need for access to quality primary care, the aging population served, the cost factors and barriers to find providers for frontier counties and local funding which will support this initiative.

NEW 130616905.1.3 OLD 130616905.1.1	1.1.2	1.1.2 A, B, C	1.1 Expand Primary Care Capacity				
<b>Pecos County Memorial Hospital</b>			130616905				
OD-9	New130616905.3.7 Old 130616905.3.1	IT-1.1.	IT-9.2 ED appropriate utilization (Standalone Measure)				
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)			
<b>Milestone 1</b> P-1. Milestone: Establish additional/expand existing/relocate primary care clinics. P-1.1. Metric: Number of additional clinics or expanded hours or space  Baseline/Goal: Establish or remodel clinic space to accommodate PCMH providers. Interlocal agreements between counties as required. Data Source: New primary care schedule or other Performing Provider document or other		<b>Milestone 4</b> P-4. Milestone: Expand the hours of a primary care clinic, including evening and/or weekend hours. P-4.1. Metric: Increased number of hours at primary care clinic over baseline.  Baseline/Goal: <i>To expand hours of operation by 4 hours per week by adding evening and/or weekend hours.</i>  Data Source: Clinic documentation.  Milestone 4 estimated		<b>Milestone 6</b> I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period  Baseline/Goal: <i>To increase underserved population by 20 visits from Year 3.</i>  Data Source: Registry, EHR,		<b>Milestone 8</b> I-15. Milestone: Increase access to primary care capacity. I-15.1. Metric: Increase percentage of target population reached.  Baseline/Goal: <i>To increase underserved population by 20 visits from Year 4.</i>  Data Source: Documentation of target population reached, as designated in the project plan.  Milestone 8 Estimated Incentive Payment: \$360,155	

<p>NEW 130616905.1.3 OLD 130616905.1.1</p>	<p>1.1.2</p>	<p>1.1.2 A, B, C</p>	<p>1.1 Expand Primary Care Capacity</p>	
<p><b>Pecos County Memorial Hospital</b></p>			<p>130616905</p>	
<p>OD-9</p>	<p>New130616905.3.7 Old 130616905.3.1</p>	<p>IT-1.1.</p>	<p>IT-9.2 ED appropriate utilization (Standalone Measure)</p>	
<p><b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b></p>				
<p>plans as designated by the Performing Provider.</p> <p>Milestone 1 Estimated Incentive Payment (maximum amount): \$132,824</p> <p><b>Milestone 2</b> P-2. Milestone: Implement/expand a community/school-based clinic program. P-2.1. Metric: One primary care clinic. a. Documentation of detailed expansion plans.</p> <p>Baseline/Goal: Establish</p>	<p>Incentive Payment (maximum amount): \$217,357</p> <p><b>Milestone 5</b> I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period</p>	<p>claims or other Performing Provider source</p> <p>Milestone 6 Estimated Incentive Payment: \$217,989</p> <p><b>Milestone 7</b> I-13. Milestone: Enhanced capacity to provide urgent care services in the primary care setting. I-13.1. Metric: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic</p>		

NEW 130616905.1.3 OLD 130616905.1.1	1.1.2	1.1.2 A, B, C	1.1 Expand Primary Care Capacity	
<b>Pecos County Memorial Hospital</b>				130616905
OD-9	New130616905.3.7 Old 130616905.3.1	IT-1.1.	IT-9.2 ED appropriate utilization (Standalone Measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p>program to offer free physicals to referenced population-10 physicals.</p> <p>Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.</p> <p>Milestone 2 Estimated Incentive Payment: \$132,824</p> <p><b>Milestone 3</b> P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the</p>	<p>Baseline/Goal: <i>To increase the number of patients seen in the clinic by 20 visits from the previous year of the underserved population.</i></p> <p>Data Source: Registry, EHR, claims or other Performing Provider source</p> <p><b>Milestone 5 Estimated Incentive Payment: \$217,357</b></p>	<p>Demonstrate improvement over baseline rates.</p> <p>Baseline/Goal: <i>To decrease the number of patients seen in our ED from Terrell County by 5 patients from previous year.</i></p> <p>Data Source: Registry, EHR, claims or other Performing Provider scheduling source.</p> <p>Milestone 7 Estimated Incentive Payment: \$217,989</p>		

<p>NEW 130616905.1.3 OLD 130616905.1.1</p>	<p>1.1.2</p>	<p>1.1.2 A, B, C</p>	<p>1.1 Expand Primary Care Capacity</p>	
<p><b>Pecos County Memorial Hospital</b></p>			<p>130616905</p>	
<p>OD-9</p>	<p>New130616905.3.7 Old 130616905.3.1</p>	<p>IT-1.1.</p>	<p>IT-9.2 ED appropriate utilization (Standalone Measure)</p>	
<p><b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b></p>				
<p>number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites.</p> <p>Baseline/Goal: 1 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</p> <p>Milestone 3 Estimated Incentive Payment: \$132,284</p>				

NEW 130616905.1.3 OLD 130616905.1.1	1.1.2	1.1.2 A, B, C	1.1 Expand Primary Care Capacity	
<b>Pecos County Memorial Hospital</b>				130616905
OD-9	New 130616905.3.7 Old 130616905.3.1	IT-1.1.	IT-9.2 ED appropriate utilization (Standalone Measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$398,474	<b>Year 3 Estimated Milestone Bundle Amount: \$434,714</b>	Year 4 Estimated Milestone Bundle Amount: \$435,978	Year 5 Estimated Milestone Bundle Amount: \$360,155	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$1,629,321</b>				

## Summary Information

Performing Provider: Pecos County Memorial Hospital

Pass 2 Project

Project Unique ID #: 130616905.1.2

- Provider: Pecos County Memorial Hospital is a 27-bed hospital in Fort Stockton, Texas serving a 4,764 square mile area and a population of approximately 8,300.
- Intervention(s): This project will implement an Emergency Room Fast Track Clinic to provide patient care to the residents of Pecos County for non-emergent services.
- Need for the project: PCMH ED is utilized by Pecos County patients as a clinic for their healthcare needs, many times for non-urgent services. This happens primarily because of the hours of operation of our regular clinics and because of a lack of ability to pay for office visits.
- Medicaid and Uninsured Target population: The target population is Pecos County patients that need non-urgent care. Approximately 50% of Pecos County patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the visits.
- Category 1 or 2 expected patient benefits: The project seeks to increase the number of non-urgent PCMH Fast Track Clinic visits by Pecos County residents by 5% from the previous year of the ED target of 6,633 visits which would be app. 330 visits in DY4 and by 4% from the previous year in DY5 which would be 252 visits.
- Category 3 outcomes: IT-9.2 Our goal is to reduce the non-urgent PCMH ED visits by non-urgent Pecos County residents in program years 4 & 5 by 330 visits and 252 visits, respectively, thus, achieving Outcome Domain-9 Right Care, Right Setting.

## Pass 2

### Category 1: Infrastructure Development

#### Pecos County Memorial Hospital Fast Track Program

- **Identifying Project and Provider Information:**

- **Project Option 1.1.1** - Expand Primary Care Capacity

- **Unique Project ID:** 130616905.1.2

- **Performing Provider Name/TPI:** Pecos County Memorial Hospital/130616905

- **Project Description:**

As a provider within a Health Professionals Shortage Area (HPSA) and a Medically Underserved Area (MUA), Pecos County Memorial Hospital (PCMH) in Fort Stockton, Texas plans to establish an Emergency Department Fast Track Program to provide services to non-emergent patients. In our current system, many patients utilize our emergency department as a clinic for their healthcare needs, many times for non-emergent services. Usually, this is because of the hours of operation of our regular clinics or because of lack of ability to pay for office visits. Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time thus providing patients with access to quality care and improving health outcomes. Our project fits right in to that vision. We will divert those non-emergent patients from our emergency department for conditions that could be managed in a primary care setting or fast track setting. We will also implement a sliding scale fee schedule to ensure indigent patients have access to affordable health care. By expanding our primary care system, our patients' care will result in better outcomes, patient satisfaction and reduced cost of services. We will recruit and hire mid-level primary care providers and physicians to rotate through the Fast Track Program to provide an access point to health care in a primary care setting. By DY 5 of the waiver, we expect to hire additional primary care providers to staff the Fast Track Clinic, have expanded hours of operation, and ensure that the Fast Track Program is seen as a viable option to our community for health care services. We expect to increase patient flow for non-emergent conditions annually, and thus, decrease non-emergent ED visits. Since ED visits are much more expensive than clinic visits, our project will provide cost containment results as well.

- **Challenges:**

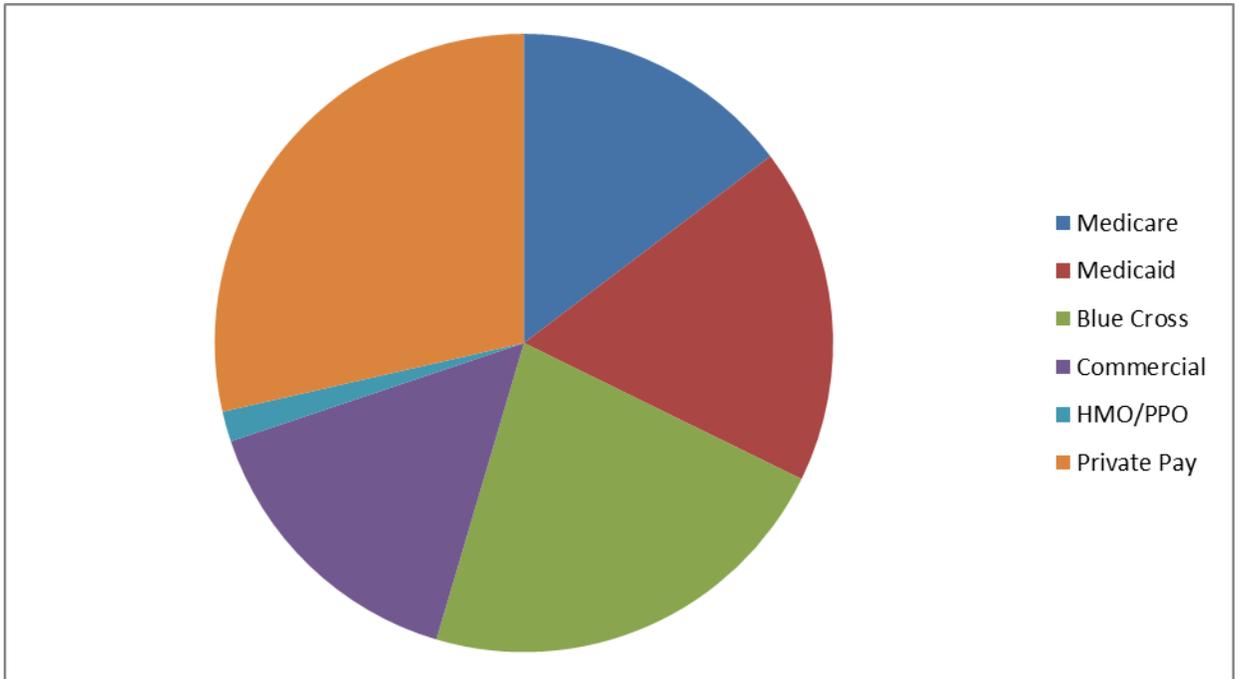
- Limited healthcare providers in area.
  - Limited mind-set of local community of county hospital.
  - Limited space in facility.
  - Increasing healthcare costs.

Being located in such a remote area of Texas, access to healthcare is always a challenge to small communities such as the Pecos County region. Recruiting and hiring providers is very expensive and it just adds to the ever increasing costs of healthcare. Add to this

the mentality of our community of PCMH's ED being a 'free' service, our bad debt is disproportionately high in this cost center.

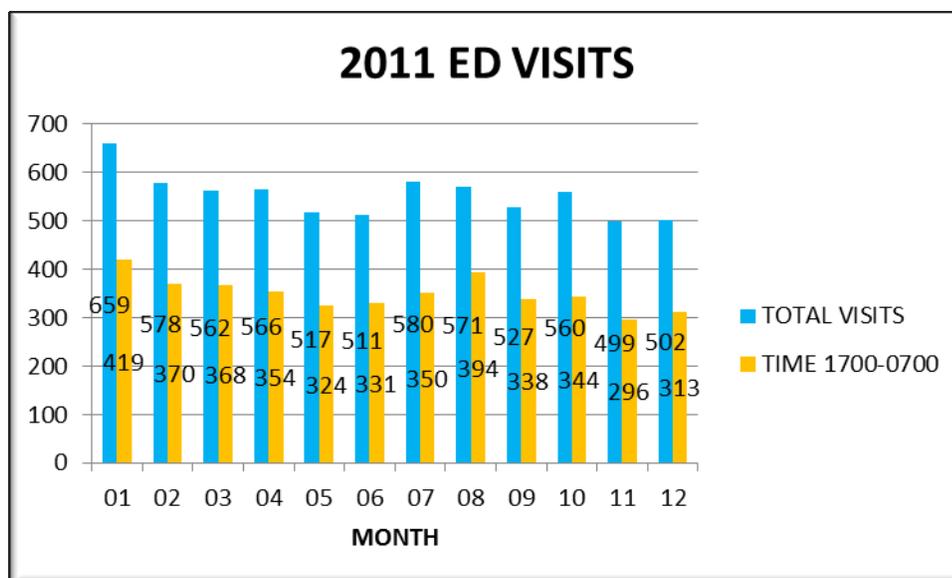
**Starting Point/Baseline:**

PCMH ED saw 6,633 patients in 2011. 28.6% of these visits were from uninsured patients. In addition, of the 6,633 treated, non-urgent patients averaged 73% for the year and 63% on average were seen between 5:00pm-8:00am.



**ED VISITS BY PAYOR CLASS 2011**

Private Pay=Self-insured (no insurance)



- **Rationale:**

PCMH has identified project option

1.1.1 Establish more primary care clinics

Required core project components:

- d) Establish more primary care clinics
- e) Expand primary care clinic hours
- f) Expand primary care clinic staffing

As supported by 1.1.1, access to primary and preventive care in HPSA and frontier counties in Texas remains the greatest community need and priority to achieve the ability to reduce potentially preventable emergency care costs. Pecos County Memorial Hospital currently has two clinics, Family Care Center (FCC) and the George Rural Health Center (GRHC). The FCC has three full-time physicians, one part-time surgeon, and two full-time mid-levels. GRHC has one full-time physician and a full-time midlevel. In October 2012, we added another full-time physician. In 2011, the clinics saw a combined 24,555 patients. In 2012, clinic visits have already increased by 12.6% through October. Since our physicians also cover our Emergency Department, it would, therefore, be imperative that we add providers for the Fast Track Program. This would alleviate the burden and the need identified by the RHP 13 Community Needs Assessment CN-005 and CN-007. By providing additional primary care capacity through this Fast Track Program, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with non-emergent care treatment in the ED. These objectives are identified in the RHP 13 Community Needs Assessment CN-005.

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

PCMH has selected OD-9-Right Care, Right Setting, IT-9.2:

- Non-emergent utilization of the PCMH ED, as evidenced by PCMH 2011 ED statistics, supports the need to address improper utilization of the ED.
  - A Fast Track Program will provide a greater access to care, save patients time and money by treating them in a primary care setting.
  - By establishing a Fast Track Program in this underserved community, RHP initiatives related to Category 1.12 will be achieved with the goal of decreasing ED visits annually as well as providing wellness initiatives to the residents.
  - We will measure this target population by zip code 79735 for Pecos County residents.
- **Relationship to other Projects:**  
 PCMH projects interrelate with each other as shown in Pass 1 1.1 and 2.2, expanding primary care capacity by establishing more clinics and by redesigning the outpatient delivery system to coordinate care for patients with chronic diseases. The Region 13 Performing Providers have projects focusing on learning collaboratives by choosing to focus on expanding primary care capacity. This will allow us to apply best practices in continuous quality improvement as a region.
- **Project Valuation:**  
 By providing access to care we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings. We will provide the residents of the Trans Pecos Region primary and preventive care. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier, which is often more likely in the uninsured/private pay population. The project seeks to increase the number of non-urgent PCMH Fast Track Clinic visits by Pecos County residents by 5% from the previous year of the ED target of 6,633 visits which would be app. 330 visits in DY4 and by 4% from the previous year in DY5 which would be 252 visits. We propose a valuation of \$1,292,483 which is supported by the community need for access to quality primary care, the aging population served, the cost factors and barriers to find providers for frontier counties and local funding which will support this initiative.

130616905.1.2	1.1.2	1.1.2.A, B, C	1.1 Expand Primary Care Capacity	
Pecos County Memorial Hospital			130616905	
OD-9	130616905.3.5	IT-9.2	IT-9.2 ED appropriate utilization (Standalone Measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1</b> P-5. Milestone: Train/hire additional providers and staff and establish a fast track program for existing providers. P-5.1. Metric: Documentation of increased number of providers and staff and fast track program.</p> <p>Baseline/Goal: Establish or remodel clinic space to accommodate fast track clinic. New schedule or other Performing Provider document or other plans as designated by the Performing Provider.</p> <p>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</p>	<p><b>Milestone 2</b> P-4. Milestone: Expand the hours of a fast track program, including evening hours and weekend hours. P-4.1. Metric: Increased number of hours at fast track program over baseline.</p> <p>Baseline/Goal: To expand hours of operation by 8 hours per week by adding evening and weekend hours.</p> <p>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</p> <p>Milestone 2 Estimated Incentive Payment: \$340,720</p>	<p><b>Milestone 3</b> I-12. Milestone: Increase fast track program volume of visits and improve access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.</p> <p>Baseline/Goal: To increase the number of patients seen in the clinic by 5% of the ED target population from previous year; 330 visits in DY4.</p> <p>Data Source: Registry, EHR, claims or other Performing Provider source</p> <p>Milestone 3 Estimated Incentive Payment: \$342,654</p>	<p><b>Milestone 4</b> I-13. Milestone: Enhanced capacity to provide urgent care services in the fast track program setting. I-13.1. Metric: Percent of patients receiving care in the fast track program as opposed to the ED. Demonstrate improvement over baseline rates.</p> <p>Baseline/Goal: To decrease the number of patients seen in the ED by 4% of the ED target population from previous year; 252 visits in DY5.</p> <p>Data Source: Registry, EHR, claims or other Performing Provider source</p> <p>Milestone 4 Estimated Incentive Payment: \$298,905</p>	

130616905.1.2	1.1.2	1.1.2.A, B, C	1.1 Expand Primary Care Capacity	
Pecos County Memorial Hospital			130616905	
OD-9	130616905.3.5	IT-9.2	IT-9.2 ED appropriate utilization (Standalone Measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
documentation  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$310,201				
Year 2 Estimated Milestone Bundle Amount: ( <i>add incentive payments amounts from each milestone</i> ): \$310,201	Year 3 Estimated Milestone Bundle Amount: \$340,720	Year 4 Estimated Milestone Bundle Amount: \$342,654	Year 5 Estimated Milestone Bundle Amount: \$298,905	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add milestone bundle amounts over Years 2-5</i> ): \$1,292,480				

## RHP 13

### Category 1: Infrastructure Development

#### ***Summary Information***

**Performing Provider:** Permian Basin Community Centers (PBCC) 138364812

#### **Pass 1 Project**

**Project Title/Option:** Expand Specialty Care Capacity 1.9.2

**Unique Category 1 Identifier:** 1383648121.1

**Provider:** Permian Basin Community Centers (PBCC) is one of 39 community centers in the state that contracts with DSHS as the Local Mental Health Authority. Its service area covers one county in RHP, Pecos, with a population of 17,932. PBCC also serves 7 additional counties in two other RHP's.

**Intervention:** This project will expand the provider network of psychiatrists and licensed behavioral therapists to provide services to individuals who do not currently have access to those services. This will be accomplished through either on-site providers or through telemedicine.

**Target Population:** DSHS primarily funds services to individuals with a diagnosis of Bipolar, Major Depression or Schizophrenia. Of those served by PBCC, 34% are Medicaid eligible and 44% are indigent. This project would serve individuals with mental health disorders other than those just listed, and who have limited access to community providers because of the same issue of Medicaid eligibility or indigent status.

**Need for Project:** Behavioral health services for indigent or Medicaid eligible individuals is limited in RHP 13 due to shortages of licensed providers willing to serve these individuals at the Medicaid rate or without other funding.

**Category 1 expected benefits:** This project intends to provide Behavioral Health services to approximately 20 new patients in DY 4, and 40 persons in DY 5 in Pecos County not currently receiving these services.

**Category 3 Outcomes:** 3.IT 6.1 goal is to improve Patient Satisfaction by 40% over a baseline to be established.

**Identifying Project and Provider Information:**

**Project Title/Option:** Expand Specialty Care Capacity 1.9.2

**Unique Category 1 Identifier:** 1383648121.1

**Performing Provider:** Permian Basin Community Centers (PBCC) 138364812

**Project Description:** PBCC intends to increase the capacity to provide specialty care services, e.g., Behavioral Health Care capacity, primarily psychiatric and counseling services, to patients with psychiatric diagnoses such as anxiety, depressive, adjustment, obsessive compulsive and post-traumatic stress disorders who are primarily indigent or Medicaid eligible.

Currently, PBCC receives its mental health funding from the Department of State Health Services, which allows funding primarily only for “target” diagnoses, i.e. serious and persistent mental illness diagnoses of schizophrenia, bipolar disorder and major depression. This leaves a large gap in specialty services and weakens the safety net system for mental health. The current client base of PBCC is 34% Medicaid eligible and 44% indigent.

PBCC intends to open a new clinic physically located in the Pecos County Memorial Hospital in Ft. Stockton, the largest town in Pecos County. It will be in addition to the current PBCC mental health clinic serving the seriously and persistently mentally ill. This new clinic located inside Pecos County Memorial Hospital will be the treatment site for a part-time psychiatrist, licensed counselor and full-time case manager. The licensed counselor will also be available to provide services to current PBCC clients who do not meet the current funding diagnostic criteria for counseling services.

The primary challenge for PBCC will be recruiting, hiring (or contracting with), and training licensed staff to provide services in this rural area of West Texas. The clinic hours will depend on the availability of the psychiatrist and licensed counselor, who may either provide services face-to-face or via telemedicine.

The goal of this project is, by the end of DY 5, to have increased the availability of behavioral health services to 40 individuals who would not have previously had access to treatment for mental health conditions either from primary care providers or otherwise, thereby increasing patient satisfaction. The new clinic will be launched in DY 3 and will serve approximately 20 clients in DY 4.

A customizable Process Milestone will be used in DY 2: that of developing the project plan and timelines for opening a new clinic that will detail staff and recruitment needs, training materials, minor remodeling of space in the Pecos County Hospital, development of treatment protocols, etc. This milestone best reflects the tremendous amount of planning needed to ensure the success of this project with the local hospital and other community partners.

PBCC intends to collaborate with private providers, private inpatient psychiatric facilities, and tele-psychiatry providers to expand provider infrastructure in an effort to expand the availability of psychiatric and counseling services to individuals who would not have previously had access to these services. Individuals suffering from non-target population diagnoses are forced to go without treatment due to a shortage of specialty care providers or behavioral health providers in a primary care setting. Left untreated, these patients’ symptoms worsen, leading to utilization of costly local emergency department treatment, utilization of hospital district funded contracts beds with private for profit inpatient psychiatric facilities, and/or inpatient State Mental Health Facility (SMHF) resources.

PBCC receives no federal funds for any similar project.

Continuous Quality Improvement (CQI) is a concept that is fully integrated into PBCC operations as outlined in its Quality Management (QM) Plan, and implemented by 3 full-time QM Coordinators. The QM staff will conduct regular meetings with the IT, Fiscal and Data Management staff to develop plans, reports, project data, etc., to inform the process of Plan, Do, Study, Act. These CQI activities are reflected as milestones in the attached tables. A customizable Process Milestone for these efforts will be a milestone in DY 2 -4 and is consistent with CQI efforts for other proposed projects and current practice.

Protocols will be established to ensure that providers have access to reports of utilization of services and healthcare outcomes. These reports will be reviewed at the already regularly scheduled meetings of PBCC's Utilization Management Committee that includes the PBCC Medical Director.

Region 13 seeks to transform healthcare in the total population and further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions, which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community, including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational in ensuring that patients receive quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients, as well as the total population.

**Starting Point/Baseline:** PBCC currently turns away approximately 32% of individuals screened for Behavioral Health services at the time of screening due to individuals not meeting the strict target population diagnostic criteria promulgated by DSHS; however, the majority of these individuals do suffer from mental health disorders, and would benefit from treatment of those disorders. PBCC conducts an average of 1,261 screenings annually. As stated, approximately 32% of those persons screened do not meet DSHS diagnostic criteria, and 80% of those are conservatively estimated to have mental health disorders. PBCC is unable to provide any services to them at this time.

Insufficient state funding for non-target diagnosis population, lack of available specialty care providers in PBCC's catchment area, especially for the indigent care population, and a rapidly expanding population as a result of the strength of the local oil economy are all factors that exacerbate the access barriers for people suffering from mental illness in RHP 13.

**Rationale:** Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed. **See Community Needs Assessment number CNA-006 "Mental Health issues related to access, shortage of mental health professionals, lack of insurance and transportation"**

With regard to specialty areas of greatest need, the recent report of the Committee on Physician Distribution and Health Care Access cites psychiatry, general/preventive medicine, and child and adolescent psychiatry where the ratios per 100,000 populations are 56.7%, 60.2% and 67% of the U.S. ratios, respectively.

Low reimbursement rates and administrative burdens are driving physicians away from Medicaid and Medicare patients in Texas according to findings from a recent Texas Medical

Association survey. According to results from the recent survey of more than 1,000 Texas physicians, thirty-one percent currently accept Medicaid patients; that is down from 42 percent in 2010. Texas physicians are also cutting back on Medicare patients. According to the biennial survey, the percentage of physicians in the state accepting new Medicare patients dropped from 66 percent in 2010 to 58 percent this year. (Becker's Hospital Review, "Fewer Physicians Accepting Medicare, Medicaid Patients", July 09, 2012).

Of the clients that PBCC currently serves, 44% are indigent and 34% are Medicaid eligible. Time Magazine published "Tallying Mental Illness' Costs" by Kathleen Kingsbury, May 09, 2008 and stated the following: "More than one in four American adults suffers from shorter-term, but clinically diagnosable mental disorders in a given year – including depression or an eating disorder – and such disorders are the leading cause of disability among U.S. workers under age 45."

According to the Mentor Research Institute in its January 17, 2007 article "The Impact of Untreated Mental Health Problems on Medical Care", "at least 50% of all unnecessary medical care is sought by people with untreated mental disorders."

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the "Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas" as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. **See Attachment 1 in the Addendum.**

*\* PBCC intends to fulfill core components a-d identified in project option 1.9.2 of the planning protocol.*

**Related Category 3 Outcome Measures:** This project is related to Category 3, OD-6, "Patient Satisfaction". Patient satisfaction surveys are designed to produce comparable data on the patients' perspectives of care that allows for objective and meaningful comparisons between institutions on domains that are important to individuals. Public reporting and sharing of survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for the public investment. A recent study reported the association between patient satisfaction and mortality rates after adjusting for clinical quality. Higher patient satisfaction was associated with lower mortality even after controlling for adherence to evidence-based practice guidelines, demonstrating that patients can judge the quality of clinical care they receive. Patient satisfaction is not about making patients "happy". It is about improving the patients experience to facilitate health and medical outcomes. When patients are satisfied, trust is enhanced. When patients trust their physician, they are more likely to disclose information, follow advice and adhere to treatment plans. Improving patient satisfaction also helps to ensure that people don't avoid getting the care they need which could prevent larger health issues in the future. (Press Ganey, "How Patient Satisfaction Correlates with Clinical Quality" by Maxwell Drain, MA, April 12, 2010).

As explained above for the rationale for this project, the individuals that will benefit from this project are historically indigent or underfunded (i.e. Medicaid), and would not have access to these services and outcomes without funding available through the 1115 waiver.

**Relationship to other Projects:** The expansion of behavioral health specialty services will be expanded via utilization of technology and expansion of available capacity. The following category projects relate: Category 1.7, 1.10, 1.11, 1.12.

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

Other RHP 13 projects related to this are 1.9 Specialty Care in other geographic areas, 2.1 Medical Home in other geographic areas.

**Plan for Learning Collaborative: See Category 3** – for collaboration with other Community Centers to select a set of outcome measures with a strategy for data collection through HIE's.

**Project Valuation:** Permian Basin Community Centers (PBCC) proposes to increase Behavioral Health Care capacity, primarily psychiatric and counseling services, to individuals who do not currently qualify for eligibility for Department of State Health Services (DSHS) funding. The following valuation is based on work prepared by H. Shelton Brown, Ph.D., A. Hasanat Alamgir, Ph.D., UT Houston School of Public Health and Thomas Bohman, Ph.D., UT Austin Center for Social Work Research.

It uses the method of cost-utility analysis (a type of cost-effectiveness research), as well as additional information on potential future costs saved.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The number of life-years added is based on a review of the scientific literature. See Attachment 3 in the Addendum – Rationale for Economic Valuation.

Since integrated healthcare is synonymous with collaborative healthcare, the term “collaborative healthcare” will be used in this valuation to be consistent with the literature referenced. **See Attachment 3 in Addendum – “Rationale for Economic Valuation”.**

**Cost-Utility Analysis**

One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.018 incremental life years gained. After quality-adjusting, .335 quality-

adjusted life-years were added. Assuming the program would serve 40 persons in a year, the following formula shows the total valuation:

$$\begin{aligned}
 & 40 \text{ (persons served)} \\
 & \times 0.335 \text{ (QALY gained)} \\
 & \times \underline{\$50,000} \text{ (life year value)} \\
 & = \$670,000 \text{ (annually)} \\
 & \times \underline{4} \text{ (years)} \\
 & = \underline{\$2,680,000}
 \end{aligned}$$

**Cost-Effectiveness and Cost Savings**

Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. Simon et al. (2012) found that collaborative care yielded 47.7 additional depression-free days per year at a cost of \$52 per depression-free day. Based on this CEA,

$$\begin{aligned}
 & 40 \text{ (persons served)} \\
 & \times 47.7 \text{ (depression-free days)} \\
 & \times \underline{\$52} \\
 & = \$99,216 \text{ (annually)} \\
 & \times \underline{4} \text{ (years)} \\
 & = \$396,864
 \end{aligned}$$

Data published by the Center for Health Statistics of the Texas Department of State Health Services (DSHS) lists the “Percent of Secondary Diagnosis of Mental Illness/Substance Abuse in Adult Potentially Preventable Hospitalizations in Texas” as anywhere from 20.3% of Long Term Diabetes hospitalizations to 44.4% of the hospitalizations for COPD. (**See Attachment 1 in Addendum**). Based on the average hospital cost of \$18,852 (**See Attachment 2 in Addendum**), the cost savings would be:

40 persons served x \$18,852 = \$754,080 annually or \$3,016,320

**Summary and Total Valuation**

This valuation analysis shows that the intervention will have a positive value for participants who receive the interventions. The total valuation is between \$2,680,000 and \$3,016,320, but no less than the \$719,259 projected value. There is additional supporting evidence that the intervention will lead to increased depression-free days.

**References**

Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch. Gen Psychiatry*, 69(5), 506-514.

Simon, G. E., Manning, W. G., Katzelnick, D. J., Pearson, S. D., Henk, H. J., & Helstad, C. S. (2001). Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. *Arch Gen Psychiatry*, 58(2), 181-187.

138364812.1.1	1.9.2	1.9.2. A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Permian Basin Community Centers (PBCC)			138364812	
<b>Related Category 3 Outcome Measure(s):</b>	138364812.3.1	3-IT-6.1.5	Patient Satisfaction	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Milestone 1 (P-X)</b> Engage Partners in developing a plan for equipping a specialty behavioral health clinic  <b>Metric 1: (P-X.1)</b>  Documentation of Plan and timeline detailing staff and operational needs, training materials, preparing clinic space and equipment  Goal: Complete project plan</p> <p>Data Source: Project Plan  Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$75,760</p> <p><b>Milestone 2: (P-X)</b> Evaluate and continuously improve services.</p> <p><b>Metric 1 (P-X.1)</b> Project planning and implementation</p>		<p><b>Milestone 3: (P-11)</b> Launch new Behavioral Health clinic</p> <p><b>Metric 1: (P-11.1)</b> Establish new clinic</p> <p>Goal: Clinic is open and providing services</p> <p>Data Source: Documentation of new clinic established and patients served</p> <p>Milestone 3 Estimated Incentive Payment: \$79,035</p> <p><b>Milestone 4: (P-X)</b> Evaluate and continuously improve services</p> <p><b>Metric 1 (P-X.1)</b> Project planning and implementation</p>	<p><b>Milestone 5: (I-23)</b> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services</p> <p><b>Metric 1: (I-23.2)</b>  Documentation of increased number of unique patients over prior reporting period - DY 3</p> <p>Goal: Increase number of patients to 20 patients served</p> <p>Data Source: Registry, EHR, claims, encounters or other Performing Provider Source</p> <p>Milestone 5 Estimated Incentive Payment: \$84,561</p> <p><b>Milestone 6: (P-X)</b> Evaluate</p>	<p><b>Milestone 7: (I-23)</b> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services</p> <p><b>Metric 1: (I-23.2)</b>  Documentation of increased number of unique patients over prior reporting period DY 3</p> <p>Goal: Increase number of patients to 40 patients served</p> <p>Data Source: Registry, EHR, claims, encounters or other Performing Provider Source</p> <p>Milestone 7 Estimated Incentive Payment: \$81,689</p> <p><b>Milestone 8: (P-X)</b> Evaluate</p>

138364812.1.1	1.9.2	1.9.2. A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Permian Basin Community Centers (PBCC)			138364812	
Related Category 3 Outcome Measure(s):	138364812.3.1	3-IT-6.1.5	Patient Satisfaction	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
demonstrate plan, do, study, act quality improvement cycles.  Goal: N/A (QI Milestone)  Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement.  Milestone 2 Estimated Incentive Payment: \$75,760	demonstrate plan, do, study, act quality improvement cycles.  Goal: N/A (QI Milestone)  Data Source Project reports including examples of how real-time data is used for rapid cycle improvement.  Milestone 4 Estimated Incentive Payment: \$79,036	and continuously improve services  <u>Metric 1 (P-X.1)</u> ) Project planning and implementation demonstrate plan, do, study, act quality improvement cycles.  Goal: Goal: N/A (QI Milestone)  Data Source: Project reports including examples of how real-time data is used for rapid cycle improvement.  Milestone 6 Estimated Incentive Payment: \$84,562	and continuously improve services  <u>Metric 1 (P-X.1)</u> ) Project planning and implementation demonstrate plan, do, study, act quality improvement cycles.  Goal: (QI Milestone)  Data Source: : Project reports including examples of how real-time data is used for rapid cycle improvement.  Milestone 8 Estimated Incentive Payment: \$81,688	
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive</i>	Year 3 Estimated Milestone Bundle Amount: \$158,071	Year 4 Estimated Milestone Bundle Amount: \$169,123	Year 5 Estimated Milestone Bundle Amount: \$163,377	

<b>138364812.1.1</b>	<b>1.9.2</b>	<b>1.9.2. A, B, C, D</b>	<b>EXPAND SPECIALTY CARE CAPACITY</b>	
<i>Permian Basin Community Centers (PBCC)</i>			<i>138364812</i>	
<b>Related Category 3 Outcome Measure(s):</b>	138364812.3.1	3-IT-6.1.5	Patient Satisfaction	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<i>payments amounts from each milestone): \$151,520</i>				
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5): \$642,091</i>				

**Reagan Memorial Hospital TPI 121806703**  
**1.1 Expand Primary Care Capacity RHP Project 121806703.1.1**  
**1.1.1 Establish more primary care clinics**

*Summary Information*

*Performing Provider: Reagan Memorial Hospital*

*Pass 1 Project*

*Project Unique ID #: **New ID 121806703.1.2***

***Old ID 121806703.1.1***

- Provider: Reagan Memorial Hospital is a 14-bed Critical Access Hospital serving all of Reagan County along with northern Crockett and western Irion Counties. The area has a large number of temporary residents, but a conservative estimate is that there are approximately 6,000 people in our service area.
- Intervention(s): This project will increase the number of Primary Care providers and the hours that these providers are available through the development of a hospital-based Primary Care clinic.
- Need for the project: The hospital's service area currently is covered by two physicians. There is no weekend or after-hours coverage, so many patients must seek treatment in the hospital's emergency department.
- Medicaid and Uninsured Target population: The target population is all residents of Reagan County who need primary care. The Medicaid and Uninsured utilization of the hospital's Emergency Room is currently 40.7% and the clinic utilization is expected to closely follow this trend.
- Category 1 or 2 expected patient benefits: The project seeks to provide additional Primary Care providers Monday through Friday, with some evening and possible weekend hours. In DY5, we expect to increase the clinic's visits by 1,500 additional patient visits over baseline.
- Category 3 outcomes: IT 6.1- The projects goal is to establish Baseline data in DY3 for:
  - Patients get timely care, appointments, and information
  - How well patients' physicians communicate
  - Patients' access to a Primary Care provider
  - Patients' involvement in shared decision making
  - Patients' overall health status/functional status
  - The hospital's goal is to increase patient satisfaction scores above the DY3 baseline by 2% in DY4 and a further 3% in DY5.

## Reagan Memorial Hospital TPI 121806703

### 1.1 Expand Primary Care Capacity RHP Project New ID 121806703.1.2 Old ID 121806703.1.1

#### 1.1.1 Establish more primary care clinics

- **Project Description:** Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients receive quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

Reagan Memorial Hospital Address RHP 13's Critical Needs Assessment item number CAN-005 by expanding primary care capacity in Reagan County by opening a primary care clinic under its own name. This will provide physicians and midlevel practitioners to meet the needs of the population that typically does not have access to primary care. Initially, we will identify the services that are most critical to our population. We will then develop a clinical schedule that will increase the number of hours they are available to care for our patients. We will implement transparent, standardized referral processes across the system and conduct quality improvement activities that will identify project impacts, "lessons learned" and opportunities to expand the project to a broader population. We will provide better access to our patients so they can avoid costly trips to physicians located outside the county or the emergency room and improve the health of our community.

The county has increased in population from 2,500 during the last census to an estimated 11,000 persons. Many of these are workers in the area's oil fields and do not have their family members with them. The county is reacting by encouraging the private sector to build permanent housing. If this happens, the county will see a further influx of mothers and children. These families will need primary care which does not exist at this time. The two current physicians are almost at their capacity. To improve the situation, Reagan Hospital District intends to recruit a Nurse Practitioner to take some of the patient load off of our two existing primary care physicians as early as August 2013. This should allow us to offer extend hours, weekends, and perhaps holiday hours.

The current Primary Care Providers see, on average, 65 patients a day. This equates to 14,600 visits annually. The hospital's Emergency Room sees an estimated 1,800 patients as well. Having a third provider and extended hours will enable the hospital to treat emergent patients quickly and will insure that patients

with less intense symptoms will have Primary Care available when they need it. The Nurse Practitioner should increase volume by at least 5,000 per year on a part time basis. If volumes continue to increase, and we believe they will, Reagan Hospital District will recruit a third physician and/or a second mid-level practitioner.

As a result of increased availability of and access to Primary Care, patients should experience greater confidence in taking the time to communicate more fully with their Primary Care Provider. Concerns will be addressed in a timely manner, and greater understanding of overall health issues will result in increased patient satisfaction.

- **Starting Point/ Baseline:** We will assess current needs beginning with baseline data established in August DY2.
- **Rationale:** There is a shortage of primary care providers in the Region (reference CAN-005). Inadequate access to primary care contributes to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed.
- **Performance Milestones selected:**
  - P-1 - Establish additional primary care clinic
  - P-4 - Expand the hours of primary care clinic, including evening and/or weekend
  - P-5 – Train/hire primary care providers and staff
- **Improve Milestones selected:**
  - I-12 – Increase primary care clinic volume of visits and evidence of improved of improved access for patients seeking services
- **Related Category 3 Outcome Measure(s):** Patient Satisfaction
- **Relationship to other Projects:** None
- **Relationship to other Performing Providers' Projects in the RHP:** None
- **Plan for Learning Collaborative:** TBD

**Project Valuation:** Reagan County is located in a medically underserved area including severe lack of local specialty care. The current Medicaid population, low number of available physicians and predominant chronic conditions would benefit from additional local primary care services. The goal is to increase 1,500 additional patient visits over baseline.

New:121806703.1.2 Old:121806703.1.1	1.1	1.1.1	<b>ESTABLISH MORE PRIMARY CARE CLINICS</b>	
Reagan Hospital District			121806703	
<b>Related Category 3 Outcome Measure(s): OD-6</b>	New:121806703.3.2 Old:121806703.3.1	IT-6.1	Patient Satisfaction	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p><b>Milestone 1 P-1:</b> Establish additional/expand existing/relocate primary care clinics</p> <p><u>Metric 1 P-1.1:</u> Number of additional clinics or expanded hours or space</p> <p><u>Baseline/Goal:</u> Baseline - None/Goal – Documentation of detailed expansion plans</p> <p><u>Data Source:</u> Detailed expansion plans</p> <p>Milestone 1 P-1 estimated incentive payment: \$189,595.00</p>	<p><b>Milestone 2 P-4:</b> Expand the hours of a primary care clinic, including evening and/or weekend</p> <p><u>Metric 1 P-4.1:</u> Increased hours of primary care clinic over baseline</p> <p><u>Baseline/Goal:</u> Baseline –0900-1700 Monday through Thursday/Goal – Clinic open at least Monday through Friday with the possibility of evening hours; 500 additional patient visits over baseline</p> <p><u>Data Source:</u> Clinic documentation</p> <p>Milestone 1 P-4 estimated incentive payment:</p>	<p><b>Milestone 3 P-5:</b> Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers</p> <p><u>Metric 1 P-5.1:</u> Documentation of increased number of providers and staff</p> <p><u>Baseline/Goal:</u> Baseline – None/Goal – Mid-level provider and 1 physician; 1,000 additional patient visits over baseline</p> <p>Data Source: Documentation of completion of all items described by the expansion plans. Hospital report, policy, contract or other documentation</p>	<p><b>Milestone 4 I-12:</b> Increase primary care clinic volume of visits and evidence of improves access for patients seeking services</p> <p><u>Metric 1 I-12.1:</u> Documentation of increased number of visits. Demonstrate improvement over prior reporting period</p> <p><u>Goal:</u> 1,500 additional patient visits over baseline</p> <p>Data Source: EMR</p> <p>Milestone 4 I-12 estimated incentive payment: \$190,235.00</p>	

New:121806703.1.2 Old:121806703.1.1	1.1	1.1.1	<b>ESTABLISH MORE PRIMARY CARE CLINICS</b>	
Reagan Hospital District			121806703	
<b>Related Category 3 Outcome</b> Measure(s): OD-6	New:121806703.3.2 Old:121806703.3.1	IT-6.1	Patient Satisfaction	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
	\$219,766.00	Milestone 3 P-5 estimated incentive payment: \$222,037.00		
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$189,595	Year 3 Estimated Milestone Bundle Amount: \$219,766	Year 4 Estimated Milestone Bundle Amount: \$222,037	Year 5 Estimated Milestone Bundle Amount: \$190,235	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$821,633				

## Summary Information

*Performing Provider: San Angelo-Tom Green County Health Department*

*Pass 1 Project*

*Project Unique ID #: 0227936-01.1.1*

☐ **Provider:** The San Angelo-Tom Green Health Department is a local health department run by the City of San Angelo. It is the only local health department in a 90 mile radius, serving approximately 112,000 residents of Tom Green County, as well as, the surrounding counties.

☐ **Intervention(s):** Three goals the project strives to achieve: 1) offer a lower cost STD Clinic, 2) establish the STD clinic in a central location, and 3) increase the number of patients seeking primary care and treatment for Chlamydia, Gonorrhea and Syphilis, thereby providing the right care, at the right place, and the right time.

☐ **Need for the project:** The San Angelo-Tom Green County Health Department, faced with budget shortfalls caused by decreases in revenue, had no option but to eliminate the STD Program during the budget process in the spring of FY12, for the start of FY13. The decrease in revenues experienced by the Health Department was due to policy changes made by the Department of State Health Services to its Immunization Programs in January 2012, which affected the way we conducted our business; additional losses of revenue came with the decrease in City funding during the Budget preparation process for FY13. The decision to eliminate the STD Program in FY13 (October 1, 2012) was made during the spring budget process. On average, the Health Department saw approximately 750-800 clients for STD related issues. More specifically, in 2011, the Health Department saw 791 patients for initial STD screens for Chlamydia, Gonorrhea and Syphilis, and 414 follow-up visits, with a total of 924 tests performed. Because the Health Department does not have an STD Clinic; these residents of Tom Green County are left without access to STD testing and treatment.

☐ **Medicaid and Uninsured Target population:** Socioeconomic Statistics estimate that roughly 30% of Tom Green County residents are uninsured or underinsured. The approximate population for Tom Green County is 112,000; therefore, it can be deduced that 30,000-35,000 residents have no insurance. Sixteen (16%) percent of the population lives below the poverty line, or about 16,000-18,000 residents.

☐ **Category 1 or 2 expected patient benefits:** By establishing a lower cost Sexually Transmitted Disease Clinic, the Health Department will fill a void in access to care for patients experiencing symptoms associated with a sexually transmitted disease, or have been in contact with someone who is infected with a sexually transmitted disease. With the establishment, and subsequent enhancements associated with a five year project, the Health Department believes the numbers of patients that will be served through the local health department, will decrease the costs assumed by the Emergency Room and its parent hospital. For example, currently, the approximate cost for

an ER visit at Shannon Medical associated with Gonorrhea and Chlamydia is \$133, and for a Syphilis and HIV issue, is approximately \$143. A low cost STD clinic would make visits more affordable and / or decrease the Hospital's assumption of unnecessary costs and unpaid debt. This will address CNA-007, Inappropriate Utilization of Emergency Room, on the Community Needs Assessment.

Therefore, by DY4, the San Angelo-Tom Green County Health Department projects to have 700 STD-related visits and 300 STD-follow-up visits, and in DY5, the Health Department expects to increase the STD related visits and follow-up visits by 5%, which amounts to 735 STD initial visits and 315 follow-up visits.

☐ Category 3 outcomes: OD-12 Primary Care and Primary Prevention, specifically, IT-12.5 Other USPSTF-endorsed screening outcome measures (3 non-standalone measure: measures including Chlamydia, Gonorrhea or Syphilis), was chosen based on the nature of the Sexually Transmitted Disease Clinic. There is a strong relationship between underinsured and uninsured patients and Emergency Room visits. With approximately 30% of residents of Tom Green County uninsured or underinsured, it stands to reason that approximately 30% of the positive confirmed cases may not be insured. Not to mention, the number of individuals seeking treatment that sought care but not counted in this proposal. \$133-\$143 makes the price of treatment unobtainable for some and certainly for many. With the establishment of the STD Clinic, an increase in patients being tested and treated at the San Angelo-Tom Green County Health Department will be observed. Based on historical figures, the Health Department was seeing 750-800 patients on average for STD related issues yearly.

#### ***D. Category 1: Infrastructure Development***

- **Identifying Project and Provider Information:**

Category 1: Infrastructure Development

Project Title: Sexually Transmitted Disease Clinic

RHP Project ID number: 0227936-01.1.1

Project Option: 1.1.1 Establish more primary care clinics

Performing Provider: San Angelo-Tom Green County Health Department (TPI-0227936-01)

- **Project Description:**

The San Angelo-Tom Green County Health Department Sexually Transmitted Disease (STD) Clinic project is designed for testing, treating and preventing the spread of Chlamydia, Gonorrhea, HIV and Syphilis. There is not a facility in place in Tom Green County providing such services; therefore, the need for such a clinic is evident. Based on an entire year of data, 2011, Tom Green County had the following confirmed positive cases: 3131 Chlamydia cases, 702 Gonorrhea cases, 38 HIV/AIDS cases and 23 Early Syphilis cases. Data is from the Department of State Health Services, Midland Regional Office. At the San Angelo-Tom Green County Health Department, again, in 2011 in which the last full data set is available, 791 patients were seen for an initial STD visit and an additional 414 were follow-up visits. A total of 924 patients samples were submitted for STD testing. Socioeconomic Statistics estimate that roughly 30% of Tom Green County residents are uninsured or underinsured. The approximate population for Tom Green County is 112,000; therefore, it can be deduced that 30,000-35,000 residents have no insurance. Sixteen (16%) percent of the population lives below the poverty line, or about 16,000-18,000 residents. In order to keep as many of the uninsured or underinsured residents experiencing Sexually Transmitted Disease symptoms out of the Emergency Department, the San Angelo-Tom Green County Health Department is proposing the establishment of the Sexually Transmitted Disease Clinic, where patients can be tested and treated for the above mentioned diseases, thereby enhancing their access to care, as well as, serve as a conduit to educational opportunities and awareness of Sexually Transmitted Diseases.

- **Project Goals:**

Three goals the project strives to achieve: 1) offer a lower cost STD clinic, 2) establishing the STD clinic in a central location, and 3) increase the number of patients seeking primary care and treatment for Chlamydia, Gonorrhea and Syphilis at the Local Health Department, thereby providing the right care, at the right place and at the right time.

- **5-Year expected outcome:**

Overall outcome expected is the establishment of a STD Clinic in a central location, accessible to all individuals, most especially, the uninsured or underinsured.

- **Starting Point/Baseline:**

There is no Sexually Transmitted Disease Clinic at the San Angelo-Tom Green County Health Department, nor any available space, and therefore, hundreds of patients needs are not being met. Therefore, the Starting Point/Baseline of this project is: there is no STD Clinic and no patients being seen for STDs at the San Angelo-Tom Green County Health Department as of October 1, 2012.

To reiterate the need for such a project, there currently is no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties, the number of confirmed positive STDs are relatively high, 3131 Chlamydia, 702 Gonorrhea, 38 HIV/AIDS, and 23 Early Syphilis in 2011, and the cost of an Emergency Room visit for a sexually transmitted disease related issue currently ranges from \$133-\$143, most specifically for an underinsured or uninsured individual.

- **Rationale:**

The San Angelo-Tom Green County Health Department, faced with budget shortfalls caused by decreases in revenue, had no option but to eliminate the STD Program during the budget process in the spring of FY12, for the start of FY13. The decrease in revenues experienced by the Health Department was due to policy changes made by the Department of State Health Services to its Immunization Programs in January 2012, which affected the way we conducted our business; additional losses of revenue came with the decrease in City funding during the Budget preparation process for FY13. The decision to eliminate the STD Program in FY13 (October 1, 2012) was made during the spring budget process. On average, the Health Department saw approximately 750-800 clients for STD related issues. Because the Health Department does not have an STD Clinic; these residents of Tom Green County are left without access to STD testing and treatment. Again, as noted earlier, 791 patients were seen in 2011, with 414 follow-up visits and 924 total STD tests performed. The establishment of an STD Clinic would greatly increase the chances of individuals to seek care at the Health Department. Currently housed in a one-room exam room space, the Health Department is removed from the core central district. By establishing a Clinic in a more central location, one block from Shannon Medical Center, and three blocks from a newly constructed multimillion dollar Multi-Modal Transportation HUB, individuals would have easier access to care. Along with a goal of preventing the spread of disease, the uninsured or underinsured residents who are most at risk and more likely to seek treatment in an Emergency Department, will have another option of care.

By establishing a lower cost Sexually Transmitted Disease Clinic, the Health Department will fill a void in access to care for patients experiencing symptoms associated with a sexually transmitted disease, or have been in contact with someone who is infected with a sexually transmitted disease. With the establishment, and subsequent enhancements associated with a five year project, the Health Department believes the numbers of patients that will be served through the local health department, will

decrease the costs assumed by the Emergency Room and its parent hospital. For example, currently, the approximate cost for an ER visit at Shannon Medical associated with Gonorrhea and Chlamydia is \$133, and for a Syphilis and HIV issue, is approximately \$143. A low cost STD clinic would make visits more affordable and / or decrease the Hospital's assumption of unnecessary costs and unpaid debt. This will address CNA-007, Inappropriate Utilization of Emergency Room, on the Community Needs Assessment.

In summary, by establishing a Sexually Transmitted Disease Clinic, the San Angelo-Tom Green County Health Department would provide another option for individuals seeking preventative care for sexually transmitted diseases, and keep them from seeking care in a more costly Emergency Department. In establishing a STD clinic in a central location, in close proximity to Shannon Medical and a multi-modal transportation facility, individuals seeking care for a sexually transmitted disease would have better access to the right care at the right place and when they need it the most.

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

OD-12 Primary Care and Primary Prevention, specifically, IT-12.5 Other USPSTF-endorsed screening outcome measures (3 non-standalone measure: measures including Chlamydia, Gonorrhea or Syphilis), was chosen based on the nature of the Sexually Transmitted Disease Clinic. There is a strong relationship between underinsured and uninsured patients and Emergency Room visits. With approximately 30% of residents of Tom Green County uninsured or underinsured, it stands to reason that approximately 30% of the positive confirmed cases may not be insured. Not to mention, the number of individuals seeking treatment that sought care but not counted in this proposal. \$133-\$143 makes the price of treatment unobtainable for some and certainly for many. With the establishment of the STD Clinic, an increase in patients being tested and treated at the San Angelo-Tom Green County Health Department will be observed. The Health Department anticipates that by Year 4, we will see 700 patients for initial STD screening visits and 300 follow-up visits.

- a. Numerator: Number of patients aged 16 and older that seek treatment for each of the three main STDs: Chlamydia, Gonorrhea or Syphilis
- b. Denominator: Number of residents ages 16 and above living in Tom Green County that are seen for on follow-up visits.
- c. Date Source: Data Logs, Scheduled visits
- d. Rationale: By testing, treating and providing education at the STD Clinic of the San Angelo-Tom Green County Health Department, numbers served at the Health Department are potential cost savings to the ER and parent hospital. A low cost STD Clinic is also a more affordable option for uninsured or underinsured individuals seeking primary care and preventative treatment for sexually transmitted diseases.

- **Relationship to other Projects:** We have only one Category 1 Project

- **Relationship to Other Performing Providers' Projects in the RHP:** N/A. No other provider is proposing a Sexually Transmitted Disease Clinic.
- **Plan for Learning Collaborative:** N/A
- **Project Milestones and Metrics:** See chart below.
- **Project Valuation:**  
The project was chosen based on the fact that the City of San Angelo is the major medical HUB for at least a 13 county region. As being the only Local Health Department in a 100 mile radius, the San Angelo-Tom Green County is the option of last resort for individuals, specifically for the uninsured or underinsured. With no STD Clinic, the City of San Angelo, Tom Green County and the surrounding communities' residents are left with a void, an option, for testing, treatment and education. With the cost of an ER visit for related STDs hovering at least within \$133-\$143, a lower cost STD Clinic is an option to pursue to try and keep individuals out of the ER and the parent hospital.
- **RHP Planning Protocol Reference:**  
Year 2 = Milestone 1, P-1; Metric P-1.1  
Year 3 = Milestone 2, P-4, Metric P-4.1 Milestone 3 = P-5, Metric 5.1  
Year 4 = Milestone 3, I-12, Metric 1-12.1  
Year 5 = Milestone 4, I-12, Metric I-12.1
- **Incentive Payment Amount:** Year 2=\$237,500, Year 3=\$250,000, Year4=\$250,000, Year 5=\$200,000 TOTAL = \$887,500

<b>0227936-01.1.1</b>	<b>1.1</b>	<b>1.1.1</b>	<b>SEXUALLY TRANSMITTED DISEASE CLINIC</b>	
San Angelo-Tom Green County Health Department			0227936-01	
<b>Related Category 3 Outcome Measure(s): OD-12</b>	0227936-01.3.1, 0227936-01.3.2, 0227936-01.3.3	IT-12.5	Other USPSTF-endorsed screening outcome measures (non-standalone measures)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone 1</b> P-1. Establish additional/expand existing/relocate primary care clinics  <u>Metric 1:</u> P-1.1 Number of additional clinics or expanded hours or space:  Documentation of detailed establishment/expansion plans  Baseline/Goal: Currently, there is no Sexually Transmitted Disease (STD) Clinic available. Goal is to establish one STD Clinic.  Data Source: Department of State Health Services Reports of Sexually	<b>Milestone 2</b> P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours  <u>Metric 1:</u> P-4.1 Increased number of hours of primary care clinic over baseline  Baseline/Goal: Number of hours offered for STD Clinic increased over Year 2 baseline  Documentation: Work schedules, payroll other documentation showing completion  Data Source: Schedules, daily logs  Milestone 1 Estimated	<b>Milestone 4 :</b> I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  <u>Metric 1:</u> I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period  Goal: Increase the number of visits for <i>Chlamydia, Gonorrhea and Syphilis</i> screening to 700 Initial Visits and 300 Follow-Up Visits based on Year 3 figures.  Data Source: Schedules, daily logs  Milestone 4 Estimated	<b>Milestone 5:</b> I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  <u>Metric 1:</u> I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period  Goal: Increase the number of <i>Chlamydia, Gonorrhea and Syphilis</i> visits by 5% based on Year 4 figures. This quantifies to 735 Initial Visits and 315 follow-up visits.  Data Source: Schedules, daily logs  Milestone 5 Estimated	

<b>0227936-01.1.1</b>	<b>1.1</b>	<b>1.1.1</b>	<b>SEXUALLY TRANSMITTED DISEASE CLINIC</b>	
<i>San Angelo-Tom Green County Health Department</i>			<i>0227936-01</i>	
<b>Related Category 3 Outcome Measure(s): OD-12</b>	<i>0227936-01.3.1, 0227936-01.3.2, 0227936-01.3.3</i>	<i>IT-12.5</i>	<i>Other USPSTF-endorsed screening outcome measures (non-standalone measures)</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Transmitted Disease Rates in Tom Green County. Number of STD visits to the ER.  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$237,500.	Incentive Payment: \$112,500  <b>Milestone 3:</b> P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  <b>Metric 1:</b> P-5.1 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  Baseline/Goal: Hire/Train Staff  Data Source: Schedules, daily logs, other payroll documentation	Incentive Payment: \$ 250,000	Incentive Payment: \$ 200,000	

<b>0227936-01.1.1</b>	<b>1.1</b>	<b>1.1.1</b>	<b>SEXUALLY TRANSMITTED DISEASE CLINIC</b>	
<i>San Angelo-Tom Green County Health Department</i>			<i>0227936-01</i>	
<b>Related Category 3 Outcome Measure(s): OD-12</b>	<i>0227936-01.3.1, 0227936-01.3.2, 0227936-01.3.3</i>	<i>IT-12.5</i>	<i>Other USPSTF-endorsed screening outcome measures (non-standalone measures)</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
	Milestone 3 Estimated Incentive Payment: \$ 112,500			
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$237,500	Year 3 Estimated Milestone Bundle Amount: \$ 250,000	Year 4 Estimated Milestone Bundle Amount: \$250,000	Year 5 Estimated Milestone Bundle Amount: \$200,000	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$887,500				

## Summary Information

**Performing Provider: Shannon Medical Center**

**Pass 1 Project: North Urgent Care Clinic**

**Project Unique ID #: 137226005.1.1**

Provider: Shannon West Texas Memorial Hospital, a non-profit health system established in the 1930's, is the only safety net hospital in Region 13, and provides the communities of West Central Texas with a variety of medical services. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust. Dedicated to the region's health and well-being, the medical center offers diverse clinical services, including a nationally-recognized cardiac care program, nationally-recognized ICU, the region's only Level III Trauma Facility and AirMed 1 air ambulance serving a 200-mile radius of San Angelo, and a dedicated Women's & Children's Hospital which is home to the Children's Miracle Network. Shannon Medical Center is a 409-bed safety net hospital located in Tom Green County. Shannon Clinic is a Physician Group made up of more than 250 Physicians. The estimated population for Shannon's service area as of 2011 including Tom Green County, is 288,304. (*U.S. Census Bureau, State & County Quickfacts*)

Intervention(s): The expansion of the North Urgent Care Clinic and the addition of a pediatric primary care physician will provide expanded access, coverage and services to meet the unmet health needs of Region 13. The clinic will be open 7 AM to 8 PM seven days a week and at least two providers will be added. Also, there will be a primary care Pediatrician working Monday-Friday 8 AM to 5 PM, at the new location centrally located in the zip code 76903.

Need for the project: Shannon Medical Center seeks to expand primary care by opening the North Urgent Care Clinic to decrease gaps between primary care and Emergency Department utilization. Current barriers to primary care consist of inconvenient hours, lack of appointments available, and long wait times.

Medicaid and Uninsured Target population: The target population for this project is all patients seeking non-emergent care that either do not have a primary care provider or are unable to get an appointment in a timely manner. Many of these patients are currently seeking care through the Emergency Department, and our aim is to redirect these patients to reduce inappropriate ED utilization. Medicaid and uninsured patients make up 18.7% of Shannon Clinic's patient volume, and of those patients 25% reside in 76903 (approximately 16,000 patient encounters). Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon Clinic had approximately 330,000 patient encounters of which 61,000 were Medicaid and uninsured patient encounters.

Category 1 or 2 expected patient benefits: With the addition of expanded hours, Shannon will increase overall access to timely care, reduce ED utilization by promoting right care, right setting, and improve patient satisfaction. Shannon seeks to increase the Urgent Care Clinic volume by 70% by demonstration year 5 (7,760 patient encounters) by redirecting non-emergent patients to utilize the North Urgent Care Clinic instead of the ED. Also, Shannon plans to assist 300 patients

that receive care at the Urgent Care Clinic with establishing a primary care provider.

Category 3 outcomes: IT-9.3 The goal is to reduce non-emergent emergency department visits for patients with pediatric/young adult asthma by a percent that is to be determined.

## **Category 1: Infrastructure Development**

### **Project Option: 1.1 Expand Primary Care Capacity**

- Project Title: North Urgent Care Clinic
- Unique Project ID Number: 137226005.1.1
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Project Description:**

Shannon Medical Center proposes to expand primary care by opening North Urgent Care Clinic. As the safety net hospital for RHP 13, Shannon's goal is to improve access to comprehensive, quality healthcare services. In order to meet demand, the expansion of the North Urgent Care Clinic will enhance accessibility to providers, offer additional hours of operation, and enhance coordination between urgent care and primary care placement. At least two providers will be added, the clinic will be open 7 AM to 8 PM seven days a week, with the addition of a primary care pediatrician working Monday-Friday 8 AM to 5 PM, and a new location centrally located in the community. The new clinic will feature pediatric and adult primary care, a staff of family practice providers, on-site labs, and x-rays.

#### **Project Goals:**

Region 13 has both Health Professional Shortage Areas (HPSA) designations and Medically Underserved Areas/Populations (MUA/P) designations in every county it represents, whether for the entire county or for special populations, as is the case for Tom Green County. In particular, a shortage of primary care providers and mental health providers exists throughout the region. The Henry J. Kaiser Foundation states that nearly one in five Americans lack adequate access due to a shortage of primary care providers in their communities. A major need for Region 13 is access to quality comprehensive care. As the safety net hospital for the region, Shannon treats a number of patients that travel to Tom Green County for care. Lack of health resources and healthcare professionals is an ongoing concern for Shannon and other providers in Region 13. Shannon is constantly recruiting for physicians to increase access to primary care.

The expansion of the North Urgent Care Clinic and the addition of a pediatric primary care physician will provide expanded access, coverage and services that are so greatly needed to meet the unmet health needs of Region 13. In our Region, it is difficult for a patient to get a primary care appointment in a timely manner due to traditional office hours and the practice of medicine structured around the physician, not around the patient. This is a major need for improvement in order to provide the right care at the right place at the right time. Shannon seeks to provide expanded primary and preventative care by increasing hours for patients with clearly defined medical needs that would otherwise seek medical treatment in the Emergency Department. An additional goal is to put a system in place to coordinate with patients that frequently seek care in the Urgent Care Clinic and/or Emergency Department and do not have a primary care provider. Follow up will take place to ensure the patient is established as a new patient with a primary care provider.

The North Urgent Care Clinic will serve as a primary care facility that does not require an appointment for patients. This will benefit Shannon's service area because it will allow patients to receive care in a timelier manner when they are unable to schedule an appointment with their primary care provider. In many circumstances, patients are discharged from the hospital and need to schedule a follow-up appointment. If there is not an available appointment with their primary care physician or they do not have a primary care physician, the clinic allows them to receive a follow-up appointment to improve the continuation of care and potentially reduce readmissions.

### **Relationship to Regional Goals:**

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, projects support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting healthcare resources in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

### **Challenges:**

A major challenge is changing the mentality of the patient/family that is accustomed to going to the Emergency Department for non-emergent care. In addition, due to Medicaid expansion there may be an increase in ED visits that might negatively impact outcomes.

Educating patients and families on the concept of right care at the right place at the right time is important to understand when it is appropriate to utilize the ED. To address this, Shannon plans to use public communication to send information about the availability and accessibility of the North Urgent Care Clinic to provide non-emergent care.

A potential challenge, related to all projects, is the impact of the Cline Shale oil boom. The impact to our area is expected to significantly hit hospitals, though no one has been able to project the actual magnitude of the growth we will experience. For this reason, Shannon cannot predict how this will impact patients, staff, and other factors that could influence this project but we anticipate this will be a challenge to some degree.

### **5 Year Expected Outcomes:**

The overall expected outcome is to reduce non-emergent ED visits for patients, particularly with Pediatric Asthma. Shannon plans to redirect non-emergent patients to utilize the North Urgent Care Clinic instead of the ED when the patient cannot schedule an appointment with their primary care physician within the next 48 hours for non-emergent care.

### **Starting Point/Baseline:**

The baseline for this project is Demonstration Year 1. Shannon will use data from 10/1/11-9/30/12 from the former Urgent Care Clinic location to develop a baseline for this project.

**Project Components:**

Shannon has identified the following project option:

1.1.1 Establish more primary care clinics

**Unique Community Need Identification Number:**

Shannon Medical Center will address Inappropriate Utilization of Emergency Room, CN-007, related to care to meet the goals set by Texas Health and Human Services Commission to ensure the innovation of the healthcare delivery system will improve access to care for Medicaid patients, quality of care delivered, cost effectiveness of care, and coordination of care across providers and communities.

**Rationale:**

The prevalence of barriers to timely primary care for all Americans has increased during the past decade, and these barriers have been associated with emergency department utilization.<sup>14</sup> For example, currently in the United States, there are more than 25 million Emergency Department visits by children each year with an estimated 37%-60% of those visits are for non-emergent conditions.<sup>15</sup>

Shannon Medical Center seeks to expand primary care by opening the North Urgent Care Clinic to decrease gaps between primary care and ED utilization. Current barriers to primary care consist of inconvenient hours, lack of appointments available, and long wait times.<sup>16</sup> By opening the expanded North Urgent Clinic, patients will benefit from extended hours and increased access to providers that potentially eliminate barriers to primary care and reduce costly and non-emergent visits to the ED. The expanded North Urgent Care Clinic is centrally located and provides primary care to an area of Tom Green County in which there are higher rates of Medicaid and uninsured populations.

The target population for this project is all patients seeking non-emergent care that either do not have a primary care provider or are unable to get an appointment in a timely manner. In Fiscal Year 12, there was a total of 24,608 ED visits with a level 1, 2, or 3 (non-emergent) at Shannon and more than 50% (12,322) of those patients reside in 76903. With the location of the Urgent Care Clinic in zip code 76903, Shannon seeks to reduce the number of non-emergent ED visits throughout the waiver period.

Medicaid and uninsured patients make up 18.7% of Shannon Clinic's patient volume, and of those patients 25% reside in 76903 (approximately 16,000 patient encounters). Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon Clinic had approximately 330,000 patient encounters of which 61,000 were Medicaid and uninsured patient encounters.

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<sup>14</sup> (Cheung, Wiler, Lowe, & Ginde, 2012)

<sup>15</sup> (Brousseau, Hoffman, Nattinger, Flores, Zhang, & Gorelick, 2007)

<sup>16</sup> (Cheung, Wiler, Lowe, & Ginde, 2012)

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

An overall focus for Shannon, as the safety net provider hospital in the region, is to expand access to care for the residents of the area. Physician recruitment and primary care capacity is vital to meeting this goal. The addition of two providers will expand capacity, with the target expansion with a pediatrician available Monday-Friday 8:00 AM-5:00 PM. With the addition of expanded hours, Shannon will increase overall access to timely care, reduce ED utilization by promoting right care, right setting, and improve patient satisfaction. Through a focused effort, Shannon will initiate efforts to promote the North Urgent Care Clinic for non-emergent needs.

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

IT-9.3 Pediatric/Young Adult Asthma Emergency Department visits (standalone measure)

**Reasons/Rationale for Selecting Outcome Measure:**

For this project, Shannon is defining Pediatric/ Young Adult Asthma as less than 17 years of age. During Fiscal Year 12, 56% of the level 1, 2, or 3 ED visits related to Pediatric/Young Adult Asthma were from patients that reside in 76903. Shannon believes there is potential to improve this rate substantially with the addition of a pediatrician and the expanded hours at the North Urgent Care Clinic.

**Relationship to other Projects:**

The underlying theme of Shannon’s projects is patient centered care because it plays an important role in improving clinical outcomes, quality, and compliance. This project’s focus on expanding primary care by establishing the North Urgent Care Clinic has a direct relationship to 2.4 Redesign to Improve Patient Experience (137226005.2.1). Related Category 4 measures include:

- Potentially Preventable Admissions
- Potentially Preventable Readmissions – 30 days
- Patient Centered Healthcare

**Relationship to Other Performing Providers’ Projects in the RHP:**

There is a relationship between Shannon with many Performing Providers in Region 13. Shannon sees approximately 40% of all patient encounters within its service area. As the only safety net hospital in RHP 13, Shannon chose to not use their full Pass 1 allocation to allow these funds to move to Pass 3B for the Anchor to redistribute to support more robust projects for rural providers in RHP 13. This initiates regional transformation to best meet the needs of Region 13.

**Plan for Learning Collaborative:**

Shannon seeks to participate in learning collaboratives across the Region since other Performing Providers propose to expand primary care. Region 13 will collaborate to share best practices for expanding primary care throughout the Region to meet the regional goals.

As the safety net hospital for Region 13, Shannon looks forward to potentially hosting an annual face-to-face meeting to provide the opportunity for members of Region 13 to collaborate by sharing experiences and challenges regarding DSRIP projects. In addition, Region 13 plans to maintain the RHP 13 website with up-to-date information from HHSC and CMS, as well as, DSRIP project information.

**Project Valuation:**

Shannon used a valuation methodology that was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. Each project was weighted and compared to all of Shannon’s proposed projects to determine the valuation for each project.

This project consists of establishing a new clinic in a convenient location, with additional providers, and extended hours. This clinic will be available for patients seeking non-emergent care that either do not have a primary care provider or are unable to get an appointment in a timely manner. By educating the community and offering services, Shannon intends to have 7,760 patient encounters (70% increase over baseline) by demonstration year 5 at the North Urgent Care Clinic. Also, Shannon plans to assist 300 patients that receive care at the Urgent Care Clinic with establishing a primary care provider. Project investment for this project includes educating and marketing the new location and hours, as well as, adding the providers to the clinic to offer services. Also, Shannon will work to put protocols in place to implement a plan of proactive management for patients that seek care at the North Urgent Care Clinic and do not have a primary care provider.

Because Shannon is the safety net hospital for Region 13, the scope of each project reaches the broader regional population and addresses community needs related to RHP 13. The scope of this project includes the addition of providers, including a pediatrician, and expanded hours. The increased access to primary and preventative care offers community benefit. By patients seeking non-emergent care at the North Urgent Care Clinic instead of the ED, Region 13 will benefit from reducing unnecessary ED costs.

137226005.1.1	1.1.1		North Urgent Care Clinic	
Shannon Medical Center			137226005	
OD-9	137226005.3.1	IT-9.3	Right Care, Right Setting Pediatric/Young Adult Asthma Emergency Department visits – NQF 1381 (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)	
<p><b>Milestone 1</b> P-1: Establish additional/expand existing/relocate primary care clinics. <u>Metric 1</u> P-1.1 Number of additional clinics or expanded hours or space. <u>Baseline/Goal:</u> Establish 1 clinic <u>Data Source:</u> New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider, Shannon Clinic</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$ 691,985.00</p> <p><b>Milestone 2</b> P-5: Train/hire additional primary care</p>	<p><b>Milestone 3</b> I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. <u>Baseline/Goal:</u> Increase North Urgent Care Clinic volume by 35% over baseline (3,880 patient encounters) <u>Data Source:</u> Registry, EHR, claims or other Performing Provider source from Shannon Clinic</p> <p>Milestone 3 Estimated Incentive Payment: \$ 1,509,836.00</p>	<p><b>Milestone 4</b> I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. <u>Baseline/Goal:</u> Increase North Urgent Care Clinic volume by 55% over baseline (6,097 patient encounters) <u>Data Source:</u> Registry, EHR, claims or other Performing Provider source from Shannon Clinic</p> <p>Milestone 4 Estimated Incentive Payment: \$ 1,514,225.00</p>	<p><b>Milestone 5</b> P-9: Develop and implement/expand a plan for proactive management of adult medicine patient panels through a new Office of Panel Management, such that clinic and provider panel capacity is increased and optimized going forward. <u>Metric 1</u> P-9.1: Documentation of implementation/expansion of Office of Panel Management. Demonstrate improvement over prior reporting period (baseline for DY2). <u>Goal:</u> Establish 300 new patients, without a primary care provider that visit the Urgent Care Clinic in DY 3, with a primary care provider <u>Data Source:</u> Documentation of panel management dynamics</p>	

137226005.1.1	1.1.1		North Urgent Care Clinic	
Shannon Medical Center			137226005	
OD-9	137226005.3.1	IT-9.3	Right Care, Right Setting Pediatric/Young Adult Asthma Emergency Department visits – NQF 1381 (standalone measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>		<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>		<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>
<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>				
<p>providers and staff and/or increase the number of primary care clinics for existing providers. <u>Metric 1</u> P-5.1 Documentation of increased number of providers and staff and/or clinic sites. <u>Baseline/Goal:</u> Hire 2 providers at North Urgent Care Clinic <u>Data Source:</u> Documentation of increased number of providers and staff and/or clinic sites.</p> <p>Milestone 2 Estimated Incentive Payment (<i>maximum amount</i>): \$ 691,984.00</p>				<p>(counts of additions, deletions, and total paneled patients) and results of initial panel “cleaning”. Performing provider administrative records.</p> <p>Milestone 5 Estimated Incentive Payment: \$ 625,440.00</p> <p><b>Milestone 6</b> I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. <u>Baseline/Goal:</u> Increase North Urgent Care Clinic volume by 70% over baseline (7,760 patient encounters)</p>

137226005.1.1	1.1.1		North Urgent Care Clinic	
Shannon Medical Center			137226005	
OD-9	137226005.3.1	IT-9.3	Right Care, Right Setting Pediatric/Young Adult Asthma Emergency Department visits – NQF 1381 (standalone measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
			<u>Data Source:</u> Registry, EHR, claims or other Performing Provider source from Shannon Clinic  Milestone 6 Estimated Incentive Payment: \$ 625,441.00	
Year 2 Estimated Milestone Bundle Amount: \$ 1,383,969.00	Year 3 Estimated Milestone Bundle Amount: \$ 1,509,836.00	Year 4 Estimated Milestone Bundle Amount: \$ 1,514,225.00	Year 5 Estimated Milestone Bundle Amount: \$ 1,250,881.00	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over DYs 2-5): \$ 5,658,911.00				

## Summary Information

**Performing Provider: Shannon Medical Center**

**Pass 3B Project: Disease Management Registry**

**Old Project Unique ID #: 137226005.1.2**

**New Project Unique ID #: 137226005.1.4**

Provider: Shannon West Texas Memorial Hospital, a non-profit health system established in the 1930's, is the only safety net hospital in Region 13, and provides the communities of West Central Texas with a variety of medical services. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust. Dedicated to the region's health and well-being, the medial center offers diverse clinical services, including a nationally-recognized cardiac care program, nationally-recognized ICU, the region's only Level III Trauma Facility and AirMed 1 air ambulance serving a 200-mile radius of San Angelo, and a dedicated Women's & Children's Hospital which is home to the Children's Miracle Network. Shannon Medical Center is a 409-bed safety net hospital located in Tom Green County. Shannon Clinic is a Physician Group made up of more than 250 Physicians. The estimated population for Shannon's service area as of 2011 including Tom Green County, is 288,304. (*U.S. Census Bureau, State & County Quickfacts*)

Intervention(s): Implement infrastructure that supports patient population health and coordination of care by expanding a chronic disease management registry to provide patient-centered care for patients with diabetes.

Need for the project: Tom Green County's diabetes mortality rate is a staggering 33.0 (deaths per 100,000 population), significantly higher than the state of Texas (23.1). Currently, Shannon serves more than 70% of the target population's health care needs. This region continues to experience disproportionately higher rates of hospitalizations and deaths due to preventable chronic diseases such as diabetes.

Medicaid and Uninsured Target population: The target population for this project is all patients diagnosed with diabetes at Shannon Clinic. Shannon treats approximately 50% of the Medicaid and uninsured population of Tom Green County. Between July 2011 and June 2012, Shannon Clinic had approximately 330,000 patient encounters of which 60,000 were Medicaid and uninsured patient encounters.

Category 1 or 2 expected patient benefits: By tracking key patient information, a disease registry will help physicians and other members of a patient's care team identify and contact patients who may have gaps in their care in order to prevent further complications. By demonstration year 5, Shannon will offer education services to at least 250 Medicaid/uninsured patients identified by the disease registry. Shannon will initially register at least 4000 patients with diabetes diagnosis codes (250. and 648.) Of these patients, registry reports will be utilized to send reminders and identify patients that need additional follow-up.

Category 3 outcomes: IT-1.10 Shannon will use the registry to track and seek improvements in

patients with hbA1c's greater than 9.0%. Shannon will implement educational programs determined in demonstration year 2 to see improvements in diabetes care.

## **Category 1: Infrastructure Development**

### **Pass 3B**

#### **Project Option: 1.3 Implement a Chronic Disease Management Registry**

- Project Title: Disease Management Registry
- Old Unique Project ID Number: 137226005.1.2
- New Unique Project ID Number: 137226005.1.4
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Project Description:**

Chronic conditions, as well as, a lack of effective efforts to manage chronic conditions are becoming more prevalent within healthcare across the United States. As a result, healthcare providers need effective strategies to manage these patients. One strategy is implementing and utilizing a disease management registry to gather and track specific patient information that helps primary care providers proactively manage these patients.

A disease management registry consists of a database with clinical information about patients and selected chronic diseases. This database is used to assist primary care providers to more accurately manage patients with targeted chronic conditions by performing preventive screenings in a timely manner and monitoring these patients.

#### **Project Goals:**

The goal of this proposed project is to implement infrastructure that supports patient population health and coordination of care at Shannon Clinic. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust.

By expanding the chronic disease management registry, Shannon seeks to develop strategies that offer improved proactive, patient-centered care for patients with chronic conditions which lead to better outcomes for patients and populations with health disparities.

Our initial efforts will identify key elements of disease registries for chronic diseases using patients with diabetes as a model. Region 13 has higher rates of diabetes among adults (18 years and older) than the state of Texas. The utilization of the registry will assist providers and staff with the tools to provide long-term care for patients, as well as capture these patients with targeted conditions as soon as possible. The target population of this project is patients seen by a primary care provider that are diagnosed with diabetes.

Initially, the registry will be introduced and implemented by family practice and internal medicine providers with patients that have a diagnosis of diabetes. Through the registry, Shannon seeks to engage and educate patients, as well as facilitate more efficient clinic interactions to encourage more patient compliance.

#### **Relationship to Regional Goals:**

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, projects support primary and preventive care expansions which are the backbone for improved access and care coordination. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting

healthcare resources in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

### **Challenges:**

A challenge will be engaging patients to make lifestyle changes to improve their health and increase compliance to better self-manage their chronic condition. Not only do patients have to make lifestyle changes, but there are barriers including transportation, financial resources for medication and education classes, and access to care that could hinder improvements.

Staff training and actively using the new technology for the registry could also pose a challenge for some to reach optimal usage. Physicians are being trained on multiple electronic medical record systems, and adding an additional form of technology could take some additional time to adapt.

Physicians and other healthcare professionals sometimes fall short of achieving optimal clinical outcomes, despite the fact that they try to provide the best care possible. This can occur because of limited clinic staff and appointment times allotted per clinic visit. By implementing use of the registry, clinicians and staff will have the opportunity to more efficiently use the minimal time during the clinical visit to provide more optimal care.

A potential challenge, related to all projects, is the impact of the Cline Shale oil boom. The impact to our area is expected to significantly hit hospitals, though no one has been able to project the actual magnitude of the growth we will experience. For this reason, Shannon cannot predict how this will impact patients, staff, and other factors that could influence this project but we anticipate this will be a challenge to some degree.

### **5 Year Expected Outcomes:**

The outcomes of this proposed project include the development of the disease management registry. Physicians and staff will be trained and actively using the registry to facilitate the most efficient provider-patient interaction during clinical visits.

### **Starting Point/Baseline:**

Baselines will be determined in demonstration year 2 once planning has been completed and the target population data has been entered into the registry.

### **Project Components:**

Shannon has identified the following project option and all will participate in all of the required core components:

- 1.3.1 Implement/enhance and use chronic disease management registry functionalities
  - a) Enter patient data into unique chronic disease registry
  - b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
  - c) Use registry reports to develop and implement targeted QI plan

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

**Unique Community Need Identification Number**

Shannon Medical Center will address CNA-001, Adult Diabetes Rate, related to care to meet the goals set by Texas Health and Human Services Commission to ensure the innovation of the healthcare delivery system will improve the quality of care as well as, coordination of care across providers and communities.

**Rationale:**

The diabetes mortality rate for the state of Texas is 23.1 (deaths per 100,000 population). Coming in significantly higher, Tom Green County’s rate is a staggering 33.0 (deaths per 100,000 population). Currently, Shannon, as the only not-for-profit health care provider in the region, serves more than 70% of the target population’s health care needs. This region continues to experience disproportionately higher rates of hospitalizations and deaths due to preventable chronic diseases such as diabetes. Echoing diabetes mortality rates are the region’s hospitalizations with a primary or secondary diagnosis of uncontrolled diabetes. Much of this can be related to the populations’ lower educational attainment and socioeconomic status.

Shannon treats approximately 50% of the Medicaid and uninsured population of Tom Green County. Between July 2011 and June 2012, Shannon Clinic had approximately 330,000 patient encounters of which 60,000 were Medicaid and uninsured patient encounters.

To address the low-income population, Shannon will designate health professionals to case manage and offer education, as well as coordinate with existing resources to provide services. While specific diabetes management programs for the uninsured are sparse, the community does have a number of resources that, if coordinated, can help in managing the disease. These resources include organizations that provide low- and no- cost health care for individuals and families in need. The area also has a diabetes support group that could be expanded to serve a larger population.

By tracking key patient information, a disease registry can help physicians and other members of a patient’s care team identify and contact patients who may have gaps in their care in order to prevent further complications.

Chronic disease management and care coordination through disease registries will increase efficiency by allowing the limited number of primary care providers to use their clinical skills more appropriately during a clinic visit.

**Required Quality Improvement:**

As Shannon looks to track additional chronic conditions, this proposed project will allow Shannon to utilize diabetes as a model to gain expertise in disease registry implementation.

Through experience and lessons learned, Shannon will potentially track additional chronic conditions through this registry.

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

The disease management registry is a new initiative that implements a new technology that will be used at Shannon Clinic to drive this project. It is the goal of this technology to enhance existing care by ensuring transitions of care for the Medicaid, Medicare, and uninsured populations to better manage chronic conditions.

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

OD-1 Primary Care and Chronic Disease Management; IT-1.10 Diabetes Care: HbA1c poor control (>9%) – NQF 0059 (standalone measure)

**Rationale for Selecting Outcome measure:**

Providers, clinicians, and staff will be able to understand and track patients with chronic conditions more closely using the disease management registry. By implementing process milestone 8, creating protocols for registry-driven reminders and reports regarding key health indicator monitoring and management, Shannon will be able to drive change with clinicians and staff ensuring hemoglobin A1c's are ordered frequently and monitored to adjust medication as needed.

**Relationship to other Projects:**

The underlying theme of Shannon's projects is patient centered care because it plays an important role in improving clinical outcomes, quality, and compliance. This project's focus on implementing a disease management registry has a direct relationship to 2.4 Redesign to Improve Patient Experience (137226005.2.1). Related Category 4 measures include:

- Potentially Preventable Admissions
- Potentially Preventable Readmissions – 30 days
- Patient Centered Healthcare

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

There is a relationship between Shannon with many Performing Providers in Region 13. Shannon sees approximately 40% of all patient encounters within its service area. As the only safety net hospital in RHP 13, Shannon chose to not use their full Pass 2 allocation to allow these funds to move to Pass 3B for the Anchor to redistribute to support more robust projects for rural providers in RHP 13. This initiates regional transformation to best meet the needs of Region 13.

**Plan for Learning Collaborative**

There is no direct learning collaborative for this project. However, as the safety net hospital for Region 13, Shannon looks forward to potentially hosting an annual face-to-face meeting to provide the opportunity for members of Region 13 to collaborate by sharing experiences and challenges regarding DSRIP projects. In addition, Region 13 plans to maintain

the RHP 13 website with up-to-date information from HHSC and CMS, as well as, DSRIP project information.

**Project Valuation:**

Shannon used a valuation methodology that was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. Each project was weighted and compared to all of Shannon’s proposed projects to determine the valuation for each project.

The investment in this project includes implementing a new form of technology that will be functioning throughout the clinic over the next 5 years. This will require purchase of the software, training on the software, and training for the clinicians and staff to reach optimal implementation and use of the software. By implementing this registry, clinicians and staff will have the opportunity to be more efficient and track patients with chronic conditions more closely. However, there must be an additional piece to reach optimal change to better the health for the patients. For this reason, Shannon will also expand resources to proactively educate patients with uncontrolled diabetes. Expansion of services will consist of hiring and training additional staff, developing a diabetes management program, and extending hours to better accommodate patients in the evenings and/or weekends for education services. In addition, Shannon will consider relocation for the clinicians and staff that will provide education to the patients to best accommodate the patients in an individual and/or group setting.

By demonstration year 5, Shannon will offer education services to at least 250 Medicaid/uninsured patients identified by the disease registry. Shannon will initially register at least 4000 patients with diabetes diagnosis codes (250. and 648.) Of these patients, registry reports will be utilized to send reminders and identify patients that need additional follow-up.

Through the registry and education, Shannon seeks to engage and educate patients, as well as facilitate more efficient clinic interactions to encourage more patient compliance. In turn, this will address the community need of the high rates of adult diabetes by reducing barriers such as financial resources and lack of access to care.

Old ID: 137226005.1.2 New ID: 137226005.1.4	1.3.1	1.3.1.a, 1.3.1.b, 1.3.1.c, 1.3.1.d	Disease Management Registry	
Shannon Medical Center			137226005	
OD-1	Old ID: 137226005.3.5 New ID: 137226005.3.7	IT-1.10	Primary Care and Chronic Disease Management: Diabetes Care: HbA1c poor control (>9%) – 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)	
<p><b>Milestone 1</b> P-1: Identify one or more target patient populations diagnosed with selected chronic disease(s)</p> <p><b>Metric 1</b> P-1.1: Documentation of patients to be entered into the registry</p> <p><u>Numerator:</u> Number of patients entered into the registry with target condition</p> <p><u>Denominator:</u> Total number of patients with the target condition</p> <p><u>Goal:</u> Register 4000 patients with diabetes diagnosis codes (250. and 648.)</p> <p><u>Data Source:</u> Shannon Clinic providers records/documentation</p>	<p><b>Milestone 3</b> P-8: Create/ disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases</p> <p><b>Metric 1</b> P-8.1: Submitted protocols for the specified conditions and health indicators</p> <p><u>Goal:</u> Put protocol in place to follow-up with 4000 registry-driven reminders</p> <p><u>Data Source:</u> Shannon Clinic protocols</p> <p>Milestone 3 Estimated Incentive Payment:</p>	<p><b>Milestone 5</b> I-21: Increase the number of clinicians and staff using the registry</p> <p><u>Metric:</u> I-21.1: Number of clinicians and staff using the registry</p> <p><u>Numerator:</u> Number of clinicians and staff using the registry</p> <p><u>Denominator:</u> Total number of clinicians and staff</p> <p><u>Baseline:</u> Demonstration year 2</p> <p><u>Goal:</u> Increase by at least 23 clinicians and staff</p> <p><u>Data Source:</u> Shannon Clinic registry report</p> <p>Milestone 5 Estimated Incentive Payment: \$ 841,398.00</p>	<p><b>Milestone 7</b> P-9: Implement an electronic process to correctly identify number or percent of screening tests that require additional follow-up</p> <p><b>Metric 1</b> P-9.1: Documentation of an electronic process to correctly identify number or percent of screening tests that require additional follow-up</p> <p><u>Goal:</u> Run follow-up report for 4000 with a diabetes diagnosis code at least twice per year to identify patients that require additional follow-up</p> <p><u>Data Source:</u> Process or other reporting documentation from Shannon Clinic</p>	

Old ID: 137226005.1.2 New ID: 137226005.1.4	1.3.1	1.3.1.a, 1.3.1.b, 1.3.1.c, 1.3.1.d	Disease Management Registry	
Shannon Medical Center			137226005	
OD-1	Old ID: 137226005.3.5 New ID: 137226005.3.7	IT-1.10	Primary Care and Chronic Disease Management: Diabetes Care: HbA1c poor control (>9%) – 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 Estimated Incentive Payment: \$ 761,709.00  <b>Milestone 2</b> P-6: Conduct staff training on populating and using registry functions <b>Metric 1</b> P-6.1: Documentation of training programs and list of staff members trained, or other similar documentation Goal: Train the Director of Nursing and the Quality Reporting Coordinator on registry functionality Data Source: HR or training resource materials from Shannon Clinic	\$ 836,647.00  <b>Milestone 4</b> I-17: Use the registry to identify patients and families that would benefit from targeted patient education services. Develop and implement patient and family training programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management, nurse and/or therapist-based education in primary care sites,	<b>Milestone 6</b> I-17: Use the registry to identify patients and families that would benefit from targeted patient education services. Develop and implement patient and family training programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management, nurse and/or therapist-based education in primary care sites, group classes or patients'	Milestone 7 Estimated Incentive Payment: \$ 697,270.00  <b>Milestone 8</b> I-17: Use the registry to identify patients and families that would benefit from targeted patient education services. Develop and implement patient and family training programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management,	

Old ID: 137226005.1.2 New ID: 137226005.1.4	1.3.1	1.3.1.a, 1.3.1.b, 1.3.1.c, 1.3.1.d	Disease Management Registry	
Shannon Medical Center			137226005	
OD-1	Old ID: 137226005.3.5 New ID: 137226005.3.7	IT-1.10	Primary Care and Chronic Disease Management: Diabetes Care: HbA1c poor control (>9%) – NQF 0059 (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>		<b>Year 4 (10/1/2014 – 9/30/2015)</b>
<b>Year 5 (10/1/2015 – 9/30/2016)</b>				
Milestone 2 Estimated Incentive Payment: \$ 761,708.00	group classes or patients’ homes and standardized teaching materials available across the care continuum. <u>Metric 1</u> P-17.3: Establishment of training programs developed and conducted by clinicians <u>Numerator:</u> Number of patients of a certain target group involved in training and education programs <u>Denominator:</u> total number of patients in the target group or the clinic <u>Goal:</u> Educate 150 Medicaid and self-pay patients in the registry <u>Data Source:</u> Shannon Clinic documentation	homes and standardized teaching materials available across the care continuum. <u>Metric 1</u> P-17.3: Establishment of training programs developed and conducted by clinicians <u>Numerator:</u> Number of patients of a certain target group involved in training and education programs <u>Denominator:</u> total number of patients in the target group or the clinic <u>Goal:</u> Educate 200 Medicaid and self-pay patients in the registry <u>Data Source:</u> Shannon Clinic documentation	Milestone 6 Estimated	nurse and/or therapist-based education in primary care sites, group classes or patients’ homes and standardized teaching materials available across the care continuum. <u>Metric 1</u> P-17.3: Establishment of training programs developed and conducted by clinicians <u>Numerator:</u> Number of patients of a certain target group involved in training and education programs <u>Denominator:</u> total number of patients in the target group or the clinic <u>Goal:</u> Educate 250 Medicaid and self-pay patients in the registry <u>Data Source:</u> Shannon Clinic

Old ID: 137226005.1.2 New ID: 137226005.1.4	1.3.1	1.3.1.a, 1.3.1.b, 1.3.1.c, 1.3.1.d	Disease Management Registry	
Shannon Medical Center			137226005	
OD-1	Old ID: 137226005.3.5 New ID: 137226005.3.7	IT-1.10	Primary Care and Chronic Disease Management: Diabetes Care: HbA1c poor control (>9%) – NQF 0059 (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
	Milestone 4 Estimated Incentive Payment: \$ 836,647.00	Incentive Payment: \$ 841,398.00	documentation  Milestone 8 Estimated Incentive Payment: \$ 697,271.00	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$ 1,523,417.00	Year 3 Estimated Milestone Bundle Amount: \$ 1,673,294.00	Year 4 Estimated Milestone Bundle Amount: \$ 1,682,796.00	Year 5 Estimated Milestone Bundle Amount: \$ 1,394,541.00	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over Years 2-5): \$ 6,274,048.00				



## Summary Information

**Performing Provider: Shannon Medical Center**

**Pass 2 Project: Specialty Care in Rural Areas**

**Project Unique ID #: 137226005.1.3**

Provider: Shannon West Texas Memorial Hospital, a non-profit health system established in the 1930's, is the only safety net hospital in Region 13, and provides the communities of West Central Texas with a variety of medical services. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust. Dedicated to the region's health and well-being, the medical center offers diverse clinical services, including a nationally-recognized cardiac care program, nationally-recognized ICU, the region's only Level III Trauma Facility and AirMed 1 air ambulance serving a 200-mile radius of San Angelo, and a dedicated Women's & Children's Hospital which is home to the Children's Miracle Network. Shannon Medical Center is a 409-bed safety net hospital located in Tom Green County. Shannon Clinic is a Physician Group made up of more than 250 Physicians. The estimated population for Shannon's service area as of 2011 including Tom Green County, is 288,304. (*U.S. Census Bureau, State & County Quickfacts*)

Intervention(s): This project will work closely with the current primary care providers and staff located in the rural areas surrounding Tom Green County to set up a referral process and schedule patients to see specialty providers when they are in their community.

Need for the project: Because of the geographic isolation and smaller patient volume (six of the seventeen counties in Region 13 have no primary care physicians) there is not a great enough need for specialty providers to work full-time in these rural communities. By extending specialty care to rural communities surrounding Tom Green County, patients will have increased access to resources in a closer proximity.

Medicaid and Uninsured Target population: The target population for this project is patients from communities outside of Tom Green County seeking specialty care. Shannon Medical Center treats approximately 50% of the Medicaid/uninsured population of Tom Green County; therefore, we anticipate approximately half of the rural population that receives specialty care to be Medicaid or uninsured. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid/uninsured patient encounters. Also according to April 2012 Medicaid enrollment data, there are 9,833 residents enrolled in Medicaid and 25,642 uninsured residents that dwell in Region 13, excluding Tom Green County. On average, 10% of Shannon's population is Medicaid/uninsured.

Category 1 or 2 expected patient benefits: Shannon will extend specialty services and implement a referral process to improve access to care for rural communities within Shannon's service area. Shannon sees approximately 40% of all patient encounters within Shannon's service area; therefore, Shannon anticipates serving a minimum of 1000 patients in demonstration year 3 with at least 10% Medicaid/uninsured patients. By demonstration year 5,

Shannon expects to increase the number of referrals by 5% over baseline (50 referrals) for specialty care.

Category 3 outcomes: IT-6.1 Shannon plans to improve patient satisfaction indicators for timely care, appointments, and information for all patients.

## **Category 1: Infrastructure Development**

### **Pass 2**

#### **Project Option: 1.9 Expand Specialty Care Capacity**

- Project Title: Expand Specialty Care in Rural Areas
- Unique Project ID Number: 137226005.1.3
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Project Description:**

According to the United States Department of Agriculture, there are three critical factors contributing to health outcomes: 1) access to healthcare resources (including proximity, affordability, and quality), 2) the community and occupational environment, and 3) personal behavior, such as smoking and diet. In addition, these three factors are mediated by age, geography, and socioeconomic status.<sup>17</sup> Considering accessibility declines as population density declines and geographic isolation increases, smaller patient volumes do not support full-time specialty services. Therefore, primary care providers generally refer patients to often distant specialty care providers. This results in rural residents incurring higher financial and travel time costs for specialized treatment. Sometimes as an alternative, rural residents may substitute local generalists for specialists, or reduce their usage of healthcare.<sup>18</sup>

#### **Project Goals:**

The goal of this proposed project is to offer specialty care services locally for the identified specialty care needs determined by the needs assessment conducted in demonstration year 2. By extending specialty care to rural communities surrounding Tom Green County, patients will have increased access to resources in a closer proximity instead of having to travel long distances for the targeted specialty care needs. Because of the geographic isolation and smaller patient volume, there is not a great enough need for specialty doctors to work full-time in these rural communities; therefore Shannon will send selected specialty providers on rotation to offer specialty services with the addition of 3 specialty services over baseline in demonstration year 4. This project will work closely with the current primary care providers and staff located in the rural areas to set up a referral process and schedule patients to see the specialty doctors when they are in their community. With the implementation of the referral process Shannon anticipates a 5% increase in referrals (50 referrals) in demonstration year 5. The target population will be determined based on the needs assessment in demonstration year 2. Special attention will ensure that the uninsured and Medicaid population will be a priority and referred to the specialists as needed. Shannon sees approximately 40% of all patient encounters within Shannon's service area; therefore, Shannon anticipates to serve a minimum of 1000 patients in demonstration year 3 with at least 10% being Medicaid/uninsured patients.

#### **Relationship to Regional Goals:**

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<sup>17</sup> (Jones, 2009)

<sup>18</sup> (Jones, 2009)

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, projects support primary and preventive care expansions which are the backbone for improved access and care coordination. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting healthcare resources in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

### **Challenges:**

The initial challenge for expanding these specialty services is lack of space and resources to offer services. A challenge we face as a Health Professional Shortage Area (HPSA) is recruiting and staffing specialists to adequately serve Tom Green County. In addition, there is an additional need of specialists that have available time to travel to meet the needs of the surrounding counties served. Shannon foresees workforce development as a potential challenge for this project. To address these challenges, Shannon offers a comprehensive compensation model and benefits package that differentiates us from other healthcare facilities in our area, as well as the larger metropolitan areas.

A potential challenge, related to all projects, is the impact of the Cline Shale oil boom. The impact to our area is expected to significantly hit hospitals, though no one has been able to project the actual magnitude of the growth we will experience. For this reason, Shannon cannot predict how this will impact patients, staff, and other factors that could influence this project but we anticipate this will be a challenge to some degree.

### **5 Year Expected Outcomes:**

At the end of the waiver period, Shannon expects to extend specialty services to improve access to care for rural communities and eliminate extensive travel times for patients seeking specialty services. In addition, Shannon plans to have an improved referral process which in turn improves patient satisfaction of timely care, appointments, and information. Shannon plans to serve 1000 patients by demonstration year 3 by sending specialists to rural locations identified through the needs assessment. By demonstration year 5, Shannon expects to increase the number of referrals by 5% over baseline (50 referrals) for specialty care.

### **Starting Point/Baseline:**

The baseline for this project is demonstration year 2. There is some form of specialty care offered in most rural hospitals but there is still a significant shortage of specialty care throughout Region 13, as well as Shannon's service area. In Demonstration year 2, Shannon Medical Center will conduct a physician needs assessment based on Intellimed forecasting module data from Fiscal Year 11 (to date this is the most current market share data) in addition to qualitative data from rural providers to determine the areas of specialty needed to best serve the community. At the conclusion of the assessment, the determined specialty doctors will begin traveling to specialty clinics in determined areas of Shannon's service area.

### **Project Components:**

Shannon has identified the following project option. At this time, Shannon will not extend hours as stated in component (a) since this will be new services with the specialists. There will be traditional operating hours at this time because Shannon will be increasing service availability by adding additional specialist provider access.

1.9.2 Improve access to specialty care

- a) Increase service availability with extended hours
- b) Increase number of specialty clinic locations
- c) Implement transparent, standardized referrals across the system
- d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Unique Community Need Identification Number**

Shannon Medical Center will address CNA-009, access to specialty care, related to care to meet the goals set by Texas Health and Human Services Commission to ensure the innovation of the healthcare delivery system will improve the quality of care as well as, coordination of care across providers and communities.

**Rationale:**

Six of the seventeen counties in Region 13 have no primary care physicians. Additionally, while all rural hospitals offer some specialty clinics, there are shortages throughout the rural areas for specialty care. The U.S. Department of Health and Human Services, defines Region 13 as having both Health Professional Shortage Area (HPSA) designations and Medically Underserved Areas/Populations (MUA/P) designations in every county it represents, whether for the entire county, or for special populations, as is the case for Tom Green County.

As the only safety net hospital in RHP 13, Shannon plans to initiate regional transformation through expanding specialty care in rural areas that make up Shannon’s service area. Shannon sees approximately 40% of all patient encounters within Shannon’s service area. There is not a need to recruit full-time specialists to these designated areas; however, sending specialists on a determined rotation transforms healthcare by expanding access and care coordination in these areas. In turn, this will improve health outcomes by eliminating extensive travel times and increasing access to care. Expanding specialty care will be a project that is fully carried out by Shannon, but Shannon will work with rural area providers to expand specialty services and implement referral processes to meet the healthcare needs of the community. Even though collaborative efforts will take place to implement services, this project is not a formal collaboration under the defined 1115 waiver guidelines with another Performing Provider.

Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County; therefore, we anticipate approximately half of the rural population that receives specialty care to be Medicaid or uninsured. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid and uninsured patient encounters. Also according to April 2012 Medicaid enrollment data,

there are 9,833 residents enrolled in Medicaid and 25,642 uninsured residents that dwell in Region 13, excluding Tom Green County.

Shannon will target this population and potentially additional rural areas that reside in the Shannon service area. Shannon plans to expand specialty care to outlying areas by sending specialists periodically to hold clinic days to meet the needs of the rural communities. With limited access to specialty care, there is an increased likelihood of chronic diseases among at-risk populations in Region 13, as well as across Texas. Healthy People 2020 addresses the barrier to services as a lack of available resources, cost, and lack of insurance coverage. Those who lack coverage are less likely to get care, and more likely to experience poor health status and pre-mature death.

Patients and families are required to travel long distances to access the care they need, particularly if it involves specialists. For example, Ozona, located in Crockett County, is located approximately 1.5 hours from Shannon Medical Center of San Angelo. The next closest centers are located in Midland and Del Rio, which are approximately 2 hours away from Ozona. Such travel can be difficult for the elderly and the poor, whose numbers are significant in rural Texas. According to the Journal of American Medical Association, inadequate outpatient care including lack of access to ongoing care, post hospitalization follow-up, rehabilitation, and home-based care may also contribute to poorer health outcomes.

**Required Quality Improvement:**

Through the specialty care gap assessment and referral process development, Shannon seeks to identify lessons learned to improve accessibility to specialty care. By adopting a standardized referral process for identified specialty care treatments, Shannon can extend this process to the broader population of existing clinics at Shannon. Through this quality improvement, Shannon can identify the population impacted and potentially expand services and processes to additional rural areas with Shannon’s service area.

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

By offering specialty services on a rotation to rural communities, Shannon will participate in expanding services and increasing access to specialty care. The purpose of this initiative is to develop a partnership with health care systems that will provide on-site rotations of specialty care services determined by the specialty care needs assessment. This partnership will allow patients to access these specialty services more conveniently and reduce long distance travel times for patients, particularly Medicaid and self-insured populations.

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

OD-6, Patient Satisfaction: IT-6.1 Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)

**Rationale for Selecting Outcome measure:**

Evidence based patient centered care demonstrates improved patient compliance with follow up chronic treatment needs. By focusing on the needs of the patient, as well as

increasing access to specialty care that will offer additional resources to eliminate long distance travel and increase patients receiving specialty treatment in a timely, more affordable manner. The community need for specialty services will be greatly impacted by rotating specialists as needed. This will improve patient satisfaction as well as increase patient compliance and appropriate follow up care.

**Relationship to other Projects:**

The underlying theme of Shannon’s projects is patient centered care because it plays an important role in improving clinical outcomes, quality, and compliance. This project’s focus on increasing access to specialty care has a direct relationship to 2.4 Redesign to Improve Patient Experience (137226005.2.1). Related Category 4 measures include:

- Potentially Preventable Admissions
- Potentially Preventable Readmissions – 30 days
- Patient Centered Healthcare

**Relationship to Other Performing Providers’ Projects in the RHP:**

There is a relationship between Shannon with many Performing Providers in Region 13. Shannon sees approximately 40% of all patient encounters within its service area. As the only safety net hospital in RHP 13, Shannon chose to not use their full Pass 2 allocation to allow these funds to move to Pass 3B for the Anchor to redistribute to support more robust projects for rural providers in RHP 13. This initiates regional transformation to best meet the needs of Region 13.

**Plan for Learning Collaborative:**

There is no direct learning collaborative for this project. However, as the safety net hospital for Region 13, Shannon looks forward to potentially hosting an annual face-to-face meeting to provide the opportunity for members of Region 13 to collaborate by sharing experiences and challenges regarding DSRIP projects. In addition, Region 13 plans to maintain the RHP 13 website with up-to-date information from HHSC and CMS, as well as, DSRIP project information.

**Project Valuation:**

Shannon used a valuation methodology that was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. Each project was weighted and compared to all of Shannon’s proposed projects to determine the valuation for each project.

The valuation of this project is based on the community need for specialty services in the surrounding rural counties. As the tertiary hospital in RHP 13, Shannon plans to initiate regional transformation through expanding specialty care in rural areas that make up Shannon’s service area. Shannon sees approximately 40% of all patient encounters within its service area. According to April 2012 Medicaid enrollment data, there are 9,833 residents enrolled in Medicaid and 25,642 uninsured residents that dwell in Region 13, excluding Tom Green County. Shannon will continue to assess specific community needs and work in a joint effort with rural communities to create an atmosphere that promotes working relationships and mutual benefit.

Shannon plans to expand specialty care to outlying areas by sending specialists periodically to hold clinic days to meet the needs of the rural communities. Travel costs, equipment, and space will be additional expenses associated with this project.

Shannon plans to serve 1000 patients by demonstration year 3 by sending specialists to rural locations identified through the needs assessment. By demonstration year 5, Shannon expects to increase the number of referrals by 5% over baseline (50 referrals) for specialty care.

Shannon will use the Physician Needs Assessment Intellimed Forecasting Module to determine specialty care gaps to determine provider demand in target specialty groups such as, Cardiology, Neurology, Nephrology, and Orthopedics.

As the only safety net hospital in Region 13, honing the referral process will result in a mutual benefit for patients and providers because implementing a more standardized process will improve timely care, appointments, and information.

137226005.1.3	1.9.2	1.9.2.b-1.9.2.d	Expand Specialty Care in Rural Areas	
Shannon Medical Center			137226005	
OD-6	137226005.3.6	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (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)	
<p><b>Milestone 1</b> P-1 Conduct specialty care gap assessment based on community need <u>Metric 1</u> P-1.1 Documentation of gap assessment. Demonstrate improvement over prior reporting period Goal: Determine areas to best build up supply of at least 2 specialists and improve specialty care access Data Source: Needs assessment</p> <p>Milestone 1 Estimated Incentive Payment: \$ 609,367.00</p>	<p><b>Milestone 2</b> P-11 Launch/expand a specialty care clinic <u>Metric 1</u> P-11.1 Establish/expand specialty care clinics Goal: Offer at least 2 specialty areas identified through gap assessment to serve a minimum of 1000 patients Data Source: Documentation of Shannon Clinic</p> <p>Milestone 2 Estimated Incentive Payment: \$ 669,318.00</p>	<p><b>Milestone 3</b> P-6 Develop and implement standardized referral and work-up guidelines <u>Metric 1</u> P-6.1 Referral and work-up guidelines Goal: Adopt a standardized referral process for specialty areas identified in needs assessment Data Source: Shannon Clinic referral and work-up policies and procedures documents</p> <p>Milestone 3 Estimated Incentive Payment: \$336,560.00</p> <p><b>Milestone 4</b> I-22 Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical</p>	<p><b>Milestone 5</b> I-29 Increase the number of referral of targeted patients to the specialty care clinic <u>Metric 1</u> I-29.1 Targeted referral rate Goal: Increase the number of referrals by 5% over baseline (50 referrals) Data Source: Registry and/or paper documentation as designated by Performing Provider, Shannon Clinic</p> <p>Milestone 5 Estimated Incentive Payment: \$ 557,816.00</p>	

137226005.1.3	1.9.2	1.9.2.b-1.9.2.d	Expand Specialty Care in Rural Areas	
Shannon Medical Center			137226005	
OD-6	137226005.3.6	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
			specialties <u>Metric 1</u> I-22.1 Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or number of specialist providers in targeted specialties at baseline Goal: Increase by 3 specialty areas over baseline Data Source: HR documents or other documentation demonstrating employed/contracted	

137226005.1.3	1.9.2	1.9.2.b-1.9.2.d	Expand Specialty Care in Rural Areas	
Shannon Medical Center			137226005	
OD-6	137226005.3.6	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
		specialists at Shannon Clinic  Milestone 4 Estimated Incentive Payment: \$ 336,559.00		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$ 609,367.00	Year 3 Estimated Milestone Bundle Amount: \$ 669,318.00	Year 4 Estimated Milestone Bundle Amount: \$673,119.00	Year 5 Estimated Milestone Bundle Amount: \$ 557,816.00	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$ 2,509,620.00</b>				

**Summary Information (RHP 13):** Category: 1.11 Telemedicine Expansion  
**Project Number:** 130725806.1.1

**Provider:** West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, Serving as the designated local authority for mental health for the established service area through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services to two very rural counties in the RHP 13 area.

**Intervention:** WTC will increase its telemedicine service capacity by purchasing and installing additional equipment, software and bandwidth in Runnels County, one of the 2 very rural counties in RHP 13 where WTC operates a mental health clinic serving approximately 100 patients each month. Equipment increases will provide additional hours of provider time to WTC consumers in RHP 13 counties. Additional provider availability will be established once the hardware infrastructure to expand the telemedicine network has been completed. This will increase physician availability across the very rural area, decreasing appointment wait times and inappropriate law enforcement incarcerations and emergency room admissions. This project will be an expansion of West Texas Centers' current telemedicine network.

**Need for the Project:** Current wait times for psychiatric appointments in these areas are from 15 to over 30 days, with physician clinics scheduled weekly or even less often due to the lack of telemedicine infrastructure. Delays in obtaining psychiatric appointments often result in consumers experiencing preventable crisis situations, which frequently require costly hospitalizations. Telemedicine is the only mechanism available in most cases to provide behavioral health care to this large geographic area. Once the network expansion has occurred additional physician and nursing hours can be procured which will increase available appointments and decrease consumer wait times.

**Target Population:** West Texas Center's patient population is 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years and it is estimated this percentage will be similar throughout the project.

**Category 1 expected patient benefits:** It is expected WTC through this project expansion will in DY 4 increase the total number of telemedicine visits by 10% from DY 2 baseline for an annual total of 815 psychiatric slots/appointments or 815 persons. In DY 5 this will increase by an additional 5% from DY 2 baseline to an annual total of 852 psychiatric slots/appointments or 852 persons. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

**Category 3 outcomes:** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.

## **RHP 13**

### **Identifying information**

- **RHP Performing Provider:** West Texas Centers
- **TPI:** 130725806
- **RHP Project Number:** 130725806.1.1
- **DSRIP Category/Project Area:** 1.11 Implement technology assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services.
- **Project Option:** 1.11.3-Other
- **Project Title:** West Texas Centers Telemedicine Expansion
- **Project Description:** West Texas Centers will expand access to behavioral health care through expansion of our current telemedicine network in Runnels County, Texas. Runnels County is a designated Health Professional Shortage Area (HPSA), with a very rural population. The closest major medical center or any behavioral health care other than West Texas Centers is sixty miles. Runnels County is a remote site provider receiving telemedicine services from West Texas Centers in Winters, Texas, Hub site providers for the Winters Clinic are located in Big Spring, Texas or Sweetwater, Texas. Acquisition of additional broadband capacity for Runnels County, hardware, software, office space and addition of remote site support staff will occur. Increased access to hub site providers will increase Runnels County appointment availability, decrease consumer wait times, improve response time for psychiatric assessments in crisis situations, provide additional opportunity for education and training of Runnels county providers, and provide a cost effective, evidence based mechanism for the delivery of services to this very rural area. Goals will include increase in available psychiatric appointments for medication reviews and assessments as well as decreased time for emergency departments and law enforcement personnel to be involved in crisis response activities. West Texas Center's patient population is 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years. This population will be the target population for the project.
- **Project Goals:** Goals will include reduced patient wait times, decreased time for emergency departments and law enforcement personnel to be involved in crisis response activities. Reduction of response times for West Texas Centers to crisis call situations. Projects will increase patient access to psychiatric services through shorter waiting times for appointments. It is expected WTC through this project expansion will in DY 4 increase the total number of telemedicine visits by 10% from DY 2 baseline for an annual total of 815 psychiatric slots/appointments or 815 persons. In DY 5 this will increase by an additional 5% from DY 2 baseline to an annual total of 852 psychiatric slots/appointments or 852 persons. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

This project relates to RHP 13 goals of improving overall healthcare access in the region by expanding access to behavioral health care services.

Challenges will include limited access to behavioral health care professionals and paraprofessionals. West Texas Centers will expand its current professional contracts to enable faster project development during DY 3, while performing intensive recruitment activities through DY 4 and 5. As expanded broadband and technology becomes available provider availability should be secured. An additional challenge will include procurement times associated with broadband expansion, as providers of these services are currently close to capacity due to the exceptionally robust economy in the West Texas area. West Texas Centers enjoys long time relationships with technological providers in the area which should assist with achieving some priority in procurement negotiations. Additionally, experience in the acquisition of such equipment should facilitate faster procurement and installation.

- **Five Year Expected Outcome:** Goals will include reduced patient wait times, decreased time for emergency departments and law enforcement personnel to be involved in crisis response activities. An overall reduction of response times for West Texas Centers to crisis call situations should also occur. Project will increase patient access to psychiatric services through shorter waiting times for appointments as well as provide additional access through increase appointment slots for new patients. It is expected WTC through this project expansion will in DY 4 increase the total number of telemedicine visits by 10% from DY 2 baseline for an annual total of 815 psychiatric slots/appointments or 815 persons. In DY 5 this will increase by an additional 5% from DY 2 baseline to an annual total of 852 psychiatric slots/appointments or 852 persons. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.
- **Relationship to regional goals:** Project will assist in transforming the health care delivery system to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of our existing health care system; and will continue to enhance and contribute to a regional approach to health care delivery that leverages and improves on existing programs and infrastructure and is responsive to patient needs throughout the entire region.
- **Starting Point/Baseline:** Baseline encounter data will be obtained from WTC fiscal year 2012 records as well as other data relevant to this project. Data sources will include the Avail Solutions Crisis Hotline data, Anasazi data which is the Centers current behavioral health software provider and Department of State Health Services Encounter data. WTC will continue to identify and refine baseline data with the final baseline being established no later than the end of DY 2.
- **Rationale:** RHP 13 Community Needs Assessment numbers CNA-006: Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, and the need for coordination between providers and CNA-008: Measuring patient satisfaction will be addressed through this project. West Texas Centers currently operates telemedicine in the project counties. West Texas Centers

primarily serves a population eligible for services only if 200% or less below the Federal Poverty Guidelines; otherwise they are eligible as private pay only. The patient population served is on average 45% Medicaid and 54% indigent or persons with no pay source. Staff turnover, recruitment challenges, travel requirements, and training needs continue to increase. Even though West Texas Centers currently operates a robust telemedicine network in Runnels County, ongoing assessment of that network is necessary to insure the most up to date and cost effective technology, equipment and processes are in place. It is clear through review of appointment waiting times and crisis response times; the current network is unable to keep up with the increasing needs. The access problem is acutely demonstrated through the current availability of WTC psychiatrist appointments for new patients which is currently in excess of twenty-one days. As providers move from these rural locations to more urban sites, the availability of local providers is steadily decreasing, putting a heavier burden on the current systems. Additional broadband and equipment will provide the necessary infrastructure to recruit and train "distance" providers, who are in many cases, the only provider available for both non urgent and crisis services. This expansion of telemedicine will increase diversions from emergency rooms and law enforcement incarceration while providing faster more real time assistance to the consumer in crisis. In the non urgent situation, this expansion will provide additional psychiatric appointments where currently capacity is currently maximized. Existing technical infrastructure at this is inadequate to provide additional needed access to psychiatric assessment and medication management capacity. It was not possible to utilize project option 1.11.1 for this project as this is not an implementation of telemedicine but an expansion of our current telemedicine network, which will significantly enhance the existing delivery structure so in order to stay as close to the Category 1 protocol document as possible the decision was made to select "other" project option of 1.11.3(Cat 1, pg127) This project will be utilizing required core project components from project options 1.11.1 and 1.11.2. Required core project components include those from project option 1.11.1 pg 126: b) assessing the local availability of and need for expanded video equipment in Nolan and Mitchell Counties including expanded access to high speed broadband technology; and the following from project option 1.11.2 pg 126: a) development or adapt current administrative and clinical protocols that will serve as a manual of technology-assisted operations; c)engage in rapid cycle improvement to evaluate the processes and procedures in the expanded telemedicine project and make any necessary modifications; and 1.11.2 pg 126: c) identify and train qualified behavioral health providers and peers that will connect to provide expanded telemedicine, to primary care providers, specialty health providers, peers or behavioral health providers. Connections could be provider to provider, provider to patient or peer to peer; from 1.11.2 pg 127: d) identify modifiers needed to track encounters performed via expanded telehealth technology; from 1.11.2 pg 127 e) develop and implement data collection and reporting standards for expanded electronically delivered services; from 1.11.2 pg 127: h) assess impact on patient experience outcomes (e.g. preventable inpatient readmissions). West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project. This will be

accomplished through utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring. WTC does plan to utilize either the CAHPS Survey or the ECHO Survey instruments to perform Category 3 measurements.

**Milestones and Metrics:** This project is an expansion of *existing* telemedicine infrastructure so in order to stay as close to the Category 1 protocol document as possible Project Option of 1.11.3(Cat1, pg 127): Other was selected however; process milestones for this project were customized from Project options 1.11.1 and 1.11.2 (Cat 1 page 126-127) and identified as customized in the milestone/metric table.

Process milestones were selected to immediately begin assessment of the current systems and begin analysis of the best value, most cost effective decisions regarding equipment, broadband and technology upgrades and procurement.

DY 2 Milestones 1: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment and;

Milestone 2: Procurement of additional Broadband Connection, were selected to begin the process of upgrade and expansion of WTC's current telemedicine network.

DY 3 Milestone 3: Hire tele-presenters, as needed, for remote site equipment expansion operation and;

Milestone 4: Training for providers/peers on use of equipment/software will provide the staffing and training necessary for the expanded telemed capacity to be in place by end of DY 3 achieving an increase in psychiatrist time through recruitment by .20 FTE .

Improvement milestones for DY 4 and 5 were selected and customized using language from the protocol wherever possible. Improvement milestones were selected based upon information identified both in the RHP needs assessment sections CAN 3 and WTCS own needs assessment process.

The customized Improvement Milestone 5: I-X-1 in DY 4 and;

Milestone 6: I-X-2 in DY 5: "Increase access to behavioral health care" was used.

Metrics for this milestone were customized for behavioral health care from language in Cat 1 Improvement Target I-15.2 pg 22): "Increase number of primary care visits"(changed in this project to: "increase number of behavioral health care visits"). It is expected WTC through this project expansion will in DY 4 increase the total number of telemedicine visits by 10% from DY 2 baseline for an annual total of 815 psychiatric slots/appointments or 815 persons. In DY 5 this will increase by an additional 5% from DY 2 baseline to an annual total of 852 psychiatric slots/appointments or 852 persons. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

The project will also increase access to services through recruitment of additional providers utilizing the expanded telemedicine network. Increased access will occur through increasing available physician appointment times, which will be possible due to the increase/improvement of the telemedicine infrastructure.

- **Continuous Quality Improvement:** West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution. The associated category 3 outcome measures related to patient satisfaction and the corresponding survey instruments will also be used in establishing continuous quality improvement protocols.
- **New or Enhanced Initiative:** This project is an enhancement to the current telemedicine network West Texas Centers currently operates in this county. This is significant in that start up costs and time associated with an initial project of telemedicine installation is extremely significant. This project will have the primary structure and process in place to rapidly develop the enhanced technology components and decrease the amount of time necessary to begin actual service delivery utilizing the new systems.
- **Related Category 3 Outcome Measure(s):** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. During DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology. The patient satisfaction improvement target was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.
- **Relationship to other Projects:** This project will continue to expand access to behavioral health care in a community based setting, rural “underserved” setting. The project will increase service capacity and provide additional behavioral health resources to health care providers.
- **Relationship to Other Performing Providers’ Projects in the RHP:** The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). Part of this eligibility includes geographic locations limited to Runnels County within the West Texas Center catchment area. The target population for this project will be persons experiencing a non urgent mental health event and meet the eligibility requirements of

the Department of State Health Services. Any person experiencing a behavioral health crisis event will be considered the target population for urgent/emergency treatment. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. With defined target populations, this project will promote the RHP goal of seeking to improve the health outcomes for targeted patients as well as the total population. It will compliment, but not duplicate other regional projects which may also be focused on expanding the access to specialty care. Regional projects by other behavioral health providers which are related include Center for Life Resources' project 133339505.1.1, Implement technology assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services; Project 138364812.1.1 Expand Specialty Care Capacity by Permian Basin Community Centers and Project 109483102.1.2 Enhance, expand behavioral health services being done by MHMR Services for the Concho Valley. These projects cover different geographic areas within the RHP and concurrently support regional goals, but we do not believe this WTC project duplicates another provider's intervention for the same target population in the same geographic area.

- **Plan for Learning Collaborative;** West Texas Centers will partner with regional health care providers in the development of learning collaborative efforts.

**Project Valuation:** West Texas Centers considered the rural nature of behavioral health care delivery in the RHP in consideration of the valuation of this project. Access to providers for behavioral health services is so limited; telemedicine has and is providing a mental health "lifeline" to consumers living in these areas. Research continues to support the successful utilization of telemedicine in the diagnosis and treatment of mental illness. Videoconferencing is a proven viable solution to treating consumers who live too far away to regularly have access to professional care or were too embarrassed to seek it in conventional ways.<sup>1</sup> Research has identified provider satisfaction with telemedicine, noting in many cases increased openness from patients enabling them to obtain better information than from a face to face encounter.<sup>2</sup> Telemedicine not only brings access to care closer to the patient, it has capacity to significantly reduce the stigma often associated with mental illness. In the counties associated with this project there is currently no local access to a psychiatrist other than through West Texas Center's telemedicine network.

Due to limited provider capacity, delays in treatment often result in increased emergency department utilization, law enforcement involvement and increased potential for endangerment to the patient and/or the community. This project will provide a cost effective mechanism to improve current access to rural behavioral health care, significantly improve patient appointment wait times, decrease timeframes associated with physician access during crisis situations while continuing to provide effective, evidenced based care to the behavioral health consumer.

It is expected WTC through this project expansion will in DY 4 increase the total number of telemedicine visits by 10% from DY 2 baseline for an annual total of 815 psychiatric slots/appointments or 815 persons. In DY 5 this will increase by an additional 5% from DY 2 baseline to an annual total of 852 psychiatric slots/appointments or 852 persons. It is impossible to estimate the number of new

patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.

<sup>1</sup>Media HealthLeaders. Telemedicine Offers New Alternatives for Behavioral Healthcare Delivery, healthleadersmedia.com September 29, 2012

<sup>2</sup>David Surface. Country Comfort-Mental Health Telemedicine in Rural America  
*Social Work Today Vol7 No. 1 P.28*

130725806.1.1	1.11.3 OTHER	1.11.3 OTHER	West Texas Centers Telemedicine Expansion	
West Texas Centers			130725806	
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction IT-6.1 Percent Improvement over baseline of patient satisfaction scores		
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)
Year 5 (10/1/2015 – 9/30/2016)				
<u>Milestone 1</u> P-X-1(customized milestone and metric with language used from Cat 1 P-4-1; pg 128)  Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment. P-X.1 Metric: Inventory of new equipment purchased  Data Source: Review of inventory or receipts for purchase of equipment.  Baseline: 2012 Inventory of WTC telemedicine equipment.  Goal: Purchase all necessary equipment for the project	<u>Milestone 3</u> P-X-3 (customized from milestone and metric with language used from Cat 1, P-7; pg 128)  Hire tele-presenters, as needed, for remote site equipment expansion operation. P-X-3 Metric: Documentation of acquisition of proper staff/training to operate expanded equipment capacity at Provider locations.  Data Source: Interviews with staff, review of hiring or payroll records, contracts  Baseline: FY 2012 psychiatrist FTE count	<u>Milestone 5</u> I-X-1(customized measure and metric language used from Cat 1 Improvement Target I-15.2 pg 22) (see narrative above under milestones and metrics)  Increase access to behavioral health care capacity I-X-5 Metric: Increase number of behavioral health care visits. a. Total number of visits for reporting period. Data Source: Registry, claims or other Performing Provider source Baseline: WTC total 2012 telemed appointment slots for this project location. West Texas Center’s 2012 claims, encounter data and other	<u>Milestone 6</u> I-X-2 (customized measure and metric from Cat 1 Improvement Target I-15.2 pg 22) (see narrative above under milestones and metrics)  Increase access to behavioral health care capacity I-X-5 Metric: Increase number of behavioral health care visits. a. Total number of visits for reporting period. Data Source: Registry, claims or other Performing Provider source Baseline: West Texas Centers FY 2012 claims, encounter data and other internal data sources. Goal: Will increase the total number of telemedicine visits	

130725806.1.1	1.11.3 OTHER	1.11.3 OTHER	West Texas Centers Telemedicine Expansion		
West Texas Centers			130725806		
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction IT-6.1 Percent Improvement over baseline of patient satisfaction scores			
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	
<p>Milestone 1 Estimated Incentive Payment \$55,420.50</p> <p><u>Milestone 2</u> P-X-2(customized milestone and metric with language used from Cat 1 P-5; pg 128) Procurement of additional Broadband Connection</p> <p>P-X-2 Metric: Documentation of presence of active broadband connections</p> <p>Data Source: Review of purchase receipt or demonstration of equipment</p> <p>Baseline: FY 2012 WTC Broadband invoice data</p> <p>Goal: Procure and implement</p>		<p>Goal: Will increase psychiatrist by .10 FTE</p> <p>Milestone 3 Estimated Incentive Payment: \$57,816.00</p> <p><u>Milestone 4</u> P-X-4 (customized milestone and metric with language used from Cat 1, P-8, pg 128)</p> <p>Training for providers/peers on use of equipment/software</p> <p>P-X-4 Metric: Documentation of completions of training on use of equipment/software</p> <p>Data Source: Training roster</p>		<p>internal data sources.</p> <p>Goal: Will increase the total number of telemedicine visits by 10% from DY 2 baseline for an annual total of 815 psychiatric slots/appointments or 815 persons. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.</p> <p>Milestone 5 Estimated Incentive Payment: \$123,699.00</p>	<p>by 5% from DY 2 baseline for an annual total of 852 psychiatric slots/appointments or 852 persons. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.</p> <p>Milestone 6 Estimated Incentive Payment: \$119,516.00</p>

130725806.1.1	1.11.3 OTHER	1.11.3 OTHER	West Texas Centers Telemedicine Expansion	
West Texas Centers			130725806	
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction IT-6.1 Percent Improvement over baseline of patient satisfaction scores		
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)
expansion of all Broadband connections required for project.  Milestone 2 Estimated Incentive Payment \$55,420.50		Baseline: FY 2012 WTC Provider training records  Goal: Complete training on use of equipment/software for all providers utilizing telemedicine in the project.  Milestone 4 Estimated Incentive Payment: \$57,816.00		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$110,841.00		Year 3 Estimated Milestone Bundle Amount: \$115,632.00		Year 4 Estimated Milestone Bundle Amount: \$123,699.00
				Year 5 Estimated Milestone Bundle Amount: \$119,516.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD \$ 469,688.00				

**Summary Information Pass 2(RHP 13):** Category: 1.13

**Project Number:** 130725806.1.2

**Project:** West Texas Centers Mobile Crisis Outreach Team Expansion

**Provider:** West Texas Centers is a community center serving as the designated local authority for mental health through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in two counties in the RHP 13 area, operating a full time Mental Health Clinic in Runnels County.

**Intervention:** West Texas Centers will expand its current Mobile Crisis Outreach Team staff by a minimum of .50 additional qualified mental health providers. . These additional staffs will effectively double the current capacity of the Centers crisis response system in these counties. Additional crisis response staff will decrease crisis wait times and result in more appropriate less costly solutions including diversion from emergency departments and law enforcement settings through the delivery of additional “wrap around”, preventive and follow-up crisis services.

**Need for the Project:** WTC current crisis services are averaging over 150 calls annually for residents in these counties, with over one hundred of those calls “go mobile” calls. These calls are handled currently by a .50 clinical on call staff person. Crisis response requires extensive travel in this rural area, twenty-four hour on call capability, one hour response time and consistent coordination with law enforcement and emergency rooms. This project will effectively decrease wait times for crisis response, increase and improve crisis wrap around, preventive and support services to facilitate faster Diversions from more costly and inappropriate settings such as emergency departments and law enforcement facilities.

**Target Population:** West Texas Center’s serves a primary population of Medicaid and uninsured patients. This project is expected to serve roughly 44% Medicaid and 53% uninsured with the remaining percentage of patients having some form of third party insurance; however, because we are the public safety net for behavioral health, the target population for this project would include any person in the WTC service area who contacted the WTC crisis hotline.

**Category 1 patient benefits:** Process milestones for this project are those identified for project option 1.13.1. These will include conducting stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers to develop a gap analysis of WTC crisis response system. Improvement milestones were chosen to demonstrate an increase in the utilization of appropriate crisis alternatives. In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 annual diversions or 89 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 109 annual diversions or 109 persons diverted to more appropriate treatment options.

**Category 3 outcomes:** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.

## Pass 2

### RHP 13

#### Identifying information

- **Project Title:** West Texas Centers Mobile Crisis Outreach Team Expansion
- **Project Option:** 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
- **RHP Project Number:** 130725806.1.2
- **RHP Performing Provider:** West Texas Centers
- **TPI:** 130725806
- **Project Description:** This project will expand the capacity of West Texas Center's behavioral health services to better meet the needs of the patient population and the community. It will enable WTC to provide better coordinated care and to insure the patient is being treated as a whole person which research shows will potentially lead to better outcomes and experience of care. West Texas Centers will perform a gap analysis of its current crisis response system for the counties the Center serves in RHP 13. This analysis will identify barriers, potential cost savings, community needs and overall crisis response processes which may need refinement or expansion. Additionally community needs will be further met through public forums and stakeholder meetings to help identify specific West Texas Centers crisis response system needs. West Texas Centers will expand its current Mobile Crisis Outreach Team staff by a minimum of .50 FTE. This additional staff will effectively double the current capacity of the Centers crisis response system in these counties.
- **Project Goals:** Goals will include increasing access to West Texas Centers Mobile Crisis Outreach team by emergency room and law enforcement personnel as well as individuals in the communities West Texas Center serves in RHP 13. In FY 2012 West Texas Centers received over 150 crisis calls for the RHP 13 West Texas Center counties with over 100 being legitimate "go mobile" response situations. The current Mobile Crisis Outreach team is responding to calls throughout the very rural and vast coverage area of the West Texas Centers RHP 13 counties. Additional assessment of the West Texas Centers crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. West Texas Centers currently provides these crisis services with only one Mobile Crisis Outreach staff member shared between other West Texas Center service areas outside the RHP 13 WTC counties. This person is responsible for responding to the crisis call within one hour of notification on a 24/7 call rotation. This project would increase by .50 FTE the available Mobile Crisis Outreach Worker staff. West Texas Centers currently responds to every crisis, therefore this project will not necessarily increase the number of crisis services delivered, though it will increase the capacity should increased crisis requirements occur. What the project will accomplish with an additional

Mobile Crisis Outreach staff is the ability to improve our crisis response time, increase and improve crisis support services related to prevention, wrap around and follow-up from the crisis event. Increasing our ability to potentially intervene in a behavioral health crisis prior to the consumer being booked into the jail, admitted to the ED or taken to a psychiatric hospital for admission will have a significant impact on consumer quality of life, and quality of care as well as provide a much more cost effective treatment alternative. In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 annual diversions or 89 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 2 baseline representing 109 annual diversions or 109 persons diverted to more appropriate treatment options.

- **Target Population:** The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). Part of this eligibility includes geographic location limited to Runnels and Terrell counties within the West Texas Center catchment area. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. The crisis population served by this project will also include those persons with an unknown mental health diagnosis at the time of the crisis event. We do not believe the project duplicates another provider's intervention for the same target population. This project is expected to serve roughly 44% Medicaid and 53% uninsured with the remaining percentage of patients having some form of third party insurance; however, because we are the public safety net for behavioral health, the target population for this project would include any person in the WTC service area who contacted the WTC crisis hotline.
- **Project Challenges:** Challenges will include continued difficulty in recruitment of professionals and paraprofessionals to this very rural area. West Texas Centers will increase recruitment activities to include a sign on bonus if necessary and will widen its recruitment area. The addition of a Mobile Outreach Crisis staff member will improve the ratio of crisis calls to staff member which in turn will improve recruitment and retention of staff in this high stress, high travel, critical decision making position. Additional challenges will include administrative support cost associated with patient satisfaction survey instruments and assessment activities to determine current and future crisis system design needs. West Texas Centers plans to utilize highly qualified administrative personnel to design survey instruments and conduct the assessment activities in order to obtain the best most reliable information possible. Research of available crisis systems among other state and national providers will be done to identify progressive, innovative crisis management approaches which may be applied to West Texas Center's current crisis process. Also the Center will utilize professional software packages as needed to obtain the consumer data necessary for a complete crisis system gap analysis and assessment.
- **Five Year Expected Outcome:** West Texas Centers anticipates meeting all core component requirements as identified in Project Option 1.13.1; a-e, and achieving all milestones and metrics within the project by completion of demonstration year 5. It is expected this project will increase West Texas Center's capacity to provide cost effective and appropriate

behavioral health intervention, triage and intensive wraparound services for individuals experiencing a psychiatric crisis through increased availability of face to face 24 hour psychiatric consultation via telemedicine (closely related to another WTC project identified below). This project will also increase WTC ability to provide appropriate treatment alternatives to incarceration for individuals with low level charges and serious psychiatric impairment, reduce emergency department utilization and wait times for individuals experiencing a psychiatric crisis, ensure appropriate triage and maximization of psychiatric inpatient resources and maximize law enforcement time and resources by providing behavioral health crisis intervention services and assessment “real time” in the community. Utilization of appropriate crisis alternatives not only increases the patient’s quality of care, improves the patient outcome, but results in cost savings across multiple entities.

In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 annual diversions or 89 persons diverted. By DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 12 baseline representing 109 annual diversions or 109 persons diverted to more appropriate treatment options.

- **Relationship to Regional Goals:** This project will work to transform health care delivery from a disease focused model of episodic care to a patient centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services and builds on the accomplishments of the existing behavioral health care system; and infrastructure, is responsive to patient needs throughout the region and improves health care outcomes and patient satisfaction. This project relates to RHP 13 goals of transforming health care in the total population of the region and to further advance the goals of the Triple Aim: to provide right care, at the right place, and at the right time.
- **Starting Point/Baseline:** Baseline encounter data will be obtained from WTC fiscal year 2012 records as well as other data relevant to this project. WTC will continue to refine baseline data during DY 2.
- **Rationale:** West Texas Centers currently provides crisis services to the WTC counties in RHP 13 using only one Mobile Crisis Outreach staff member shared between other West Texas Center service areas outside the RHP 13 WTC counties. With over 100 FY 2012 “go mobile” crisis calls, the ongoing ability to provide timely intervention and assistance to consumers and community stakeholders is tenuous. Staff turnover, recruitment challenges, travel requirements, and training needs continue to increase. West Texas Centers, in another project is currently proposing an expansion of its telemedicine services to provide additional psychiatric support to its front line crisis staff but without increasing the number of front line staff this assistance will improve access to services but cannot fulfill the crisis needs of the community. Ongoing assessment of our crisis delivery system is necessary to insure the most up to date and cost effective processes are in place. Additional staffing increases will increase diversions from emergency rooms and law enforcement incarceration while providing faster more real time assistance to the consumer. Crisis services are high risk, high need situations. In these very rural areas providing that service must be done with well trained, well seasoned and extremely competent staff. This project will provide additional staffing and training resources to insure these needs are met. Required components of this project are(Cat 1, pg 141): a) convene community stakeholders who can

support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps; b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service; c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings; d) Explore potential crisis alternative service models and determine accept and determine feasible models for implementation; e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. CQI efforts will include problem identification and resolution and follow-up to insure effectiveness of performance improvement actions. Through the project descriptions, goals and rationale described in this document, West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project. This will be accomplished through utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring.

- **Continuous Quality Improvement:** West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution. The associated category 3 outcome measures related to patient satisfaction and the corresponding survey instruments will also be used in establishing continuous quality improvement protocols.
- **Milestones and Metrics:** Process milestones for this project are those identified for project option 1.13.1. West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. These will include conducting stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers to develop a gap analysis of WTC crisis response system. Improvement milestones were chosen to demonstrate an increase in the utilization of appropriate crisis alternatives. Process milestones for this project are those identified for project option 1.13.1. These will include conducting stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers to develop a gap analysis of WTC crisis response system. Improvement milestones were chosen to demonstrate an increase in the utilization of

appropriate crisis alternatives. In DY 4 this project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 annual diversions or 89 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 12 baseline representing 109 annual diversions or 109 persons diverted to more appropriate treatment options.

- **Community Needs Identification Number the Project addresses:** RHP 13 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lack of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP.
- **New or Enhanced Initiative:** This project is an enhancement to the current crisis service network West Texas Centers currently operates in these counties.
- **Related Category 3 Outcome Measure(s):** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.
- **Relationship to other Projects:** This project will be directly related to West Texas Center's RHP 13 West Texas Center Telemedicine Expansion project number 130725806.1. This project and the telemedicine expansion project are closely related in that they will work together to meet both the day to day access needs as well as the crisis needs of the consumer and the community.
- **Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.
- **Project Valuation:** This project will decrease the cost of care through increased diversion of consumers from emergency rooms and jails as well as decrease the cost of inpatient care through inappropriate admissions to psychiatric facilities. In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 annual diversions or 89 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 12 baseline representing 109 annual diversions or 109 persons diverted to more appropriate treatment options. The project will meet the waiver goals additionally through more right care, right setting and right time treatment provision. The project will increase access to crisis response services through additional Mobile Crisis Outreach team members. It will decrease response times for these staff to assist emergency rooms and law enforcement agencies with mental health

crisis situations. According to txpricepoint.org, the average cost for just one possible preventable admission, such as severe psychological disorders including Schizophrenia, among all Concho County hospitals(closest major medical facility to West Texas Centers RHP 13 counties) for Federal Year 2011 was \$13,943.00 per average length of stay for this diagnosis group.(excludes physician cost). If you consider diversions resulting in non hospitalization simply using this figure and the estimated improvement target from DY 4 to DY 5 of 20 persons, you would achieve a gross savings of \$278,860.00 annually. Further research shows the average cost to transport an individual to a local hospital by local EMS services is \$585.00. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, where an officer is on hand, can range from 1 to 3 hours, sometimes substantially more. A law enforcement officer's average pay can range from \$12.50 to \$18 per hour, so in an average situation this would be an additional \$30-\$45 cost per event. This number may vary from \$15,000-\$20,000 depending on hours of law enforcement time and travel time for EMS services. Additionally, the small rural police or sheriff's department, often employing due to lack of resources, a low ratio of officers to citizens, is left significantly understaffed while an officer is on duty at the emergency department. Even though these financial costs are significant, the human cost, which is much harder to measure, can be even more significant.

130725806.1.2	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	West Texas Center Mobile Crisis Outreach Team Expansion		
West Texas Centers				130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.2	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<u>Milestone 1</u> <u>P-1(Cat. 1, pg142)</u> Milestone: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. P-1.1. Metric: Number of meetings and participants. Data Source: Attendance lists Baseline: N/A Goal: Will conduct a minimum of 2 stake holder meetings.  Milestone 1 Estimated Incentive Payment \$43,143.00	<u>Milestone 2</u> <u>P-2(Cat 1, pg 142)</u> Milestone: Conduct mapping and gap analysis of current crisis system. P-2.1. Metric: Produce a written analysis of community needs for crisis services. Data Source: Written plan Baseline: N/A Goal: Will conduct a mapping and gap analysis of current crisis system to determine baseline and identify improvement strategies.  Milestone 2 Estimated Incentive Payment: \$22,657.50  <u>P-4 Milestone 3</u> Milestone: Hire and train staff to implement identified crisis stabilization services. Data Source: Staff rosters and	<u>Milestone 4</u> <u>I-12(Cat 1, pg 146)</u> Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 30% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there was an increase.	<u>I-12 Milestone 5</u> <u>I-12(Cat 1, pg 146)</u> Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 35% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured	

130725806.1.2	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	West Texas Center Mobile Crisis Outreach Team Expansion		
West Texas Centers				130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.2	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
	<p>training records, training curricula            Goal: Hire .and/or identify .50 FTE staff member to perform Mobile Crisis Outreach Team (MCOT) functions for project area.            Baseline: FY12 WTC Human Resource records for project area MCOT staffing</p> <p>Milestone 3 Estimated Incentive Payment: \$22,657.50</p>	<p>Data source: Claims, encounter, and clinical record data.            Baseline: West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources            Goal: Will increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 diversions annually or 89 persons diverted to more appropriate treatment options.</p> <p>Milestone 4: Estimated Incentive Payment: \$48,610.00</p>	<p>at specified time intervals throughout the project to determine if there was an increase.            Data source: Claims, encounter, and clinical record data.            Baseline: West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources            Goal: Will increase the utilization of appropriate crisis alternatives by 35% from DY 2 baseline for a total of 109 annual diversions or 109 persons diverted to more appropriate treatment options.</p>	

130725806.1.2	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	West Texas Center Mobile Crisis Outreach Team Expansion		
West Texas Centers				130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.2	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
			Milestone 5: Estimated Incentive Payment: \$ 47,116.00	
Year 2 Estimated Milestone Bundle Amount: \$43,144.00	Year 3 Estimated Milestone Bundle Amount: \$45,315.00	Year 4 Estimated Milestone Bundle Amount: \$48,611.00	Year 5 Estimated Milestone Bundle Amount: \$47,116.00	
Total Estimated DSRIP Funding for 4 Years :\$184,184.00				



## Category 2 Projects

*Performing Provider: Ballinger Memorial Hospital*

**Pass 3b**

**Ballinger Memorial Hospital Access to Care Initiative –  
RHP Project Old ID 130089906.2.1 New ID 130089906.2.2  
Ballinger Memorial Hospital District/130089906**

*Summary Information*

- Provider: The Ballinger Memorial Hospital District owns and operates Ballinger Memorial Hospital, a 25 bed critical access hospital and the Ballinger Hospital Clinic, a provider based rural health clinic located in Ballinger, Texas. The District services approximately 515 square miles and provides services to 4,000 people annually.
- Intervention(s): This project will implement diabetic management program care model in the rural health clinic.
- Need for the project: As per the RHP 13 community needs assessment, diabetes management is a need for the region.
- Medicaid and Uninsured Target population: The target population is our entire population of patients that need services from specialists. Approximately 11% of our patients in the rural health clinic are either Medicaid eligible or indigent, so we expect they will benefit from about the same percentage of the consults. In addition, we have a very large Medicare population of 36% which would also benefit from this service.
- Category 1 or 2 expected patient benefits: The project seeks to provide enroll diabetic patients into this program, however, as a new endeavor, the goal are to be determined later with approval of CMS and HHSC.
- Category 3 outcomes:
  - IT-3.2 Our goal is listed as to be determined with the approval of CMS and HHSC based on DY1 implementation metrics to benchmark future years.
  - IT-3.3 Our goal is listed as to be determined with the approval of CMS and HHSC based on DY1 implementation metrics to benchmark future years.

**Project Description:** As a provider within a Health Professionals Shortage Area (HPSA) and a Medically Underserved Area (MUA), Ballinger Memorial Hospital District (BMHD) in Runnels County, Texas plans to expand chronic care management models. BMHD will expand chronic care management models by expanding the a diabetes management program through the Ballinger Hospital Clinic (BHC) which is a designated rural health clinic (RHC). For FY 2012, BHC had 904 admissions from 309 distinct patients with a diagnosis of diabetes. The goals of the project include: 1. Expand chronic care management models by developing a diabetes management care model to ensure patients are receiving the appropriate care and 2. to ensure patients achieve full compliance to manage diabetes appropriately. The current challenge of reaching these goals include: 1. Lack of specialty services in the community and 2. limited patient education and compliance for management of diabetes. Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population. The goals of the project directly reflect the needs of the region by addressing the adult diabetes rate. The expected 5-year outcomes of the project would be improved access to care for diabetic patients; improved patient centered care; and improved overall health and wellbeing of patients.

- **Starting Point/Baseline:** The rural health clinic would develop a diabetic management care model and would implement this model. As this is a new model for BHC, the starting point will project the baseline to be 30 patients based on 10% of the current patients having a diagnosis of diabetes.

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

- ☐ Rushed practitioners not following established practice guidelines
- ☐ Lack of care coordination
- ☐ Lack of active follow-up to ensure the best outcomes
- ☐ Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible. To speed the transition, Improving Chronic Illness Care created the Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. Evidence on the effectiveness of the Chronic Care Model has recently been summarized.

**Project 2.2.2 – Apply evidence-based care management model to patients identified as having high-risk health care needs**

BMHD will implement a model for diabetic management at BHC

CNA-001 Adult Diabetes Rate is addressed through the success of this project. As RHP 13's community needs assessment states, the adult diabetes rate for the region is a need that requires addressing. This project would fulfill this need.

**Performance Milestones selected:**

- 2.2.2 P-5 Implement a risk-reduction program for patients with diabetes mellitus to target patients identified as at-risk
  - Metric: Increase the number of patients enrolled in risk-reduction program  
BMHD will increase the number of patients enrolled in the diabetes management program. The development of the program and the number of patients enrolled in the program will be measured. BMHD will enroll 30 patients in DY2.

**Improvement Milestones selected:**

- 2.2.2 I-21 Improvements in access to care of patients receiving chronic care management services using innovative project option
  - Metric: Increase percentage of target population.  
BMHD will increase the number of patients enrolled in the program. Baseline and goal are to be determined once program is in place for one year with approval from HHSC and CMS. BMHD will enroll an additional 15 patients a year in the program.

**Related Category 3 Outcome Measure(s):** OD-1 Primary Care and Chronic Disease Management 130089906.3.2 and 130089906.3.3

As per the RHP 13 Community Needs Assessment, the adult diabetes rate management is a need of the region. This measure fully addresses the issue by the following measures:

**IT-1.10 Diabetic care: HbA1c poor control (>9%) – NQF 0059 (standalone measure)**

**IT-1.11 Diabetic care: BP control (<140/60mm Hg) – NQF 0061 (standalone measure)**

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.

**Required QI:** The ultimate goal of quality measurement in diabetes care at Ballinger Hospital Clinic (BHC) is to motivate quality improvement and decrease long-term diabetes complications. Performance measures have been constructed so that the credit for achieving the measure corresponds with the likelihood of benefit to the patient and consistent with commonly accepted definitions of quality. Quality improvement activities are directed towards achieving goals or implementing clinical actions with maximum potential benefits in outcomes for the patient.

The advent of EHR technology opened new options for diabetes quality measurement at BHC. The EMR will be utilized to gather both administrative and clinical data for quality measurement and improvement using the “clinical action measure” model. Clinical action measures combine a “measurement” for an intermediate outcome with a “process of care” for those above a determined threshold, and then suggest an evidence-based clinical action in certain clinical circumstances. By focusing on the clinical treatment, rather than only an outcome value, these measures are less likely to motivate treatment with nonevidence-based treatments in order to reach a clinical threshold.

- **Relationship to other Projects:** BMHD will be doing an expansion of primary care by integrating telehealth into the RHC. The diabetes initiative will play in to the expansion of primary care by allowing diabetic patients a structured diabetes management plan. The goal of all plans for BMHD is to provide the right care, in the right place and at the right time and these projects accomplish this goal.
- **Relationship to Other Performing Providers’ Projects in the RHP:** There are no related projects in RHP 13 at this time.
- **Plan for Learning Collaborative:** N/A
- **Project Valuation:** The need for diabetic management programs are evident by the RHP 13 community needs assessment. By having a diabetic management program in place at BHC, patients will receive the proper care at the right time and right place. With proper monitoring, treatment, and compliance will healthcare improves for patients and as a

result diabetic patients will have lower complications and hospital admissions due to diabetes.

Old ID 130089906.2.1 New ID 130089906.2.2	2.2	<b>2.2.2</b>	<b>BALLINGER MEMORIAL HOSPITAL DIABETIC MANAGEMENT PROGRAM</b>	
<i>Ballinger Memorial Hospital District</i>			130089906	
<b>Related Category 3 Outcome Measure(s):</b>	OD-2- IT-3.2 OD-2 IT-3.3	Old ID 130089906.3.2 New ID 130089906.3.5 Old ID 130089906.3.3 New ID 130089906.3.6	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 Diabetes care: BP control (<140/80mm Hg) - NQF 0061	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>Milestone 1</b> P-5: Implement a risk-reduction program for patients with diabetes mellitus to target patients identified as at-risk  <b>Metric 1</b> P-5: Increase the number of patients enrolled in risk-reduction program  Baseline/Goal: Baseline - Goal – Plan development and enroll 30 patients  Data Source: Diabetes	<b>Milestone 2</b> I-21: Improvements in access to care of patients receiving chronic care management services using innovative project option  <b>Metric 1</b> I-21: Documentation of increased number enrollments in program. Demonstrate improvement over prior reporting period  Baseline/Goal: Goal – 45 patients enrolled	<b>Milestone 3</b> I-21: Improvements in access to care of patients receiving chronic care management services using innovative project option  <b>Metric 1</b> I-21: Documentation of increased number enrollments in program. Demonstrate improvement over prior reporting period  Baseline/Goal: Goal – 60 patients enrolled	<b>Milestone 4</b> I-21: Improvements in access to care of patients receiving chronic care management services using innovative project option  <b>Metric 1</b> I-21: Documentation of increased number enrollments in program. Demonstrate improvement over prior reporting period  Baseline/Goal: Goal – 75 patients enrolled	

Old ID 130089906.2.1 New ID 130089906.2.2	2.2	<b>2.2.2</b>	<b>BALLINGER MEMORIAL HOSPITAL DIABETIC MANAGEMENT PROGRAM</b>	
<i>Ballinger Memorial Hospital District</i>			130089906	
<b>Related Category 3 Outcome Measure(s):</b>	OD-2- IT-3.2 OD-2 IT-3.3	Old ID 130089906.3.2 New ID 130089906.3.5 Old ID 130089906.3.3 New ID 130089906.3.6	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 Diabetes care: BP control (<140/80mm Hg) - NQF 0061	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Management Program plan and protocol and number of initial enrollments  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$73,734.00	Data Source: EMR  Milestone 2 Estimated Incentive Payment: \$86,115.00	Data Source: EMR  Milestone 3 Estimated Incentive Payment: \$87,282.00	Data Source: EMR  Milestone 4 Estimated Incentive Payment: \$75,177.00	

Old ID 130089906.2.1 New ID 130089906.2.2	2.2	<b>2.2.2</b>	<b>BALLINGER MEMORIAL HOSPITAL DIABETIC MANAGEMENT PROGRAM</b>	
<i>Ballinger Memorial Hospital District</i>			130089906	
<b>Related Category 3 Outcome Measure(s):</b>	OD-2- IT-3.2 OD-2 IT-3.3	Old ID 130089906.3.2 New ID 130089906.3.5 Old ID 130089906.3.3 New ID 130089906.3.6	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 Diabetes care: BP control (<140/80mm Hg) - NQF 0061	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$73,734.00		Year 3 Estimated Milestone Bundle Amount: \$86,115.00	Year 4 Estimated Milestone Bundle Amount: \$87,282.00	Year 5 Estimated Milestone Bundle Amount: \$75,177.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$322,308				

## Summary Information

Performing Provider: COLEMAN COUNTY MEDICAL CENTER

Pass I Project

Project Unique ID #: NEW: 136144610.2.2 (OLD: 136144610.2.1), 2.1 Enhance/Expand Medical Homes

- Provider: CCMC will implement an evidence-based prenatal care model through a medical home initiative to provide prenatal care to improve prenatal health care the likeability that a mother carries the baby to 39 weeks, and therefore improves the health outcome for the child. Mothers under 18 years of age make up 10.5% in Coleman County, compared to 4.9% in the State. Pregnancies in women aged 13-17 is 47.3 (rate) in Colman County, compared to 26.1 (rate) in the State.
- Intervention(s): New project. Outreach program to school aged girls who are pregnant to enroll them into our medical home model for prenatal care. The medical home will be their "home base" for issues that arise during their pregnancy. The health care team will specifically look to address the pregnant girl's health care needs, coordinate their care and proactively provide the preventive and educational care to improve pregnancy health as well as birth outcomes. Program will also include all at-risk mothers who are identified through ER or Clinic encounters. Additionally, CCMC will establish referral process to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program for this at-risk population.
- Expected results are lower costs for Medicaid and uninsured patients by opening access to care.
- Need for the project: Prematurity is the leading cause of neonatal death. Those who survive face longer-term problems such as cerebral palsy, intellectual disabilities, visual and hearing impairments and learning difficulties. While only 6% of Texas Medicaid-funded newborns stay in a NICU, those infants consume 66% of a hospital's newborn care expenditure.
- Medicaid and Uninsured Target population: Medicaid births as a percent of all births is 74.1% for Coleman County. Low birth rates are 9.4% for the area compared to 8.4% in the State. Coleman County's deliveries are reflective of a high risk population of Medicaid (74.1%) and unmarried mothers (52.6%) who do not traditionally have economic access to prenatal care within the first tri-semester and through full term. In Texas, only 60% received prenatal care.
- Category 2 expected patient benefits: Providing a "home base" for usual care for high-risk pregnant women will focus on improved, organized care for the patient. We have also identified the need to educate school aged pregnant girls on the need for prenatal care. Outreach activities will promote overall health and wellness to change the culture within the community. With an estimated patient base of 125 by DY 5 we project enrolling approximately 50% of pre-natal patients, or 62 patients, in our medical home model.

Category 3 outcomes: IT-8.2 Percentage reduction of Low Birth-weight births.

- Our goal is to reduce low birth-weight births in Coleman County by 10% by DY5.

- 40% enrollment in patient centered medical home of pregnant women with first tri-semester by DY5.

## **Category 2: Program Innovation and Redesign**

- **Identifying Project and Provider Information:**

- 2.1 Enhance/Expand Medical Homes
- 136144610.2.2 (New) 136144610.2.1 (Old)
- Coleman County Medical Center/136144610.

- **Project Description:**

Mothers under 18 years of age make up 10.5% in Coleman County, compared to 4.9% in the State. Pregnancies in women aged 13-17 is 47.3 (rate) in Colman County, compared to 26.1 (rate) in the State. Medicaid births as a percent of all births is 74.1% for Coleman County. Low birth rates are 9.4% for the area compared to 8.4% in the State. CCMC will implement an evidence-based prenatal care model through a medical home initiative to provide prenatal care to improve prenatal health care the likeability that a mother carries the baby to 39 weeks, and the outcomes for the child. This will also improve cost effective care for this high risk population, though not the outcome used in Category 3. Prematurity is the leading cause of neonatal death. Those who survive face longer-term problems such as cerebral palsy, intellectual disabilities, visual and hearing impairments and learning difficulties. While only 6% of Texas Medicaid-funded newborns stay in a NICU, those infants consume 66% of a hospital's newborn care expenditure.

We will outreach to school aged girls who are pregnant to enroll them into our medical home model for prenatal care. The medical home will be their "home base" for issues that arise during their pregnancy. The health care team will specifically look to address the pregnant girl's health care needs, coordinate their care and proactively provide the preventive and educational care to improve pregnancy health as well as birth outcomes. This will result in improved labor and delivery and reduce lengths of stay associated with child birth. A core value and necessary enhancement includes a change to patient-centered interactions and checks and balances to ensure evidence-based protocols are implemented and followed by staff and patients. Additionally, CCMC will establish referral process to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program for this at-risk population.

By DY 5, we will determine steps to achieve the NCQA PCMH status and expect to have a medical home implemented and include pregnant women, specifically under 18 years of age, who reside in Coleman. This program will support and be incorporated in to the overall RHP 13 medical home initiative.

- **Starting Point/Baseline:**

Coleman County's deliveries are reflective of a high risk population of Medicaid (74.1%) and unmarried mothers (52.6%) who do not traditionally have economic access to prenatal care within the first tri-semester and through full term. In Texas, only 60% received prenatal care. Presently, over 50% of all pregnant women in the county are

presenting to the Clinic without pre-natal care during their first tri-semester. We currently don't have a medical home model established. Additionally, there is no Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program for this at-risk population.

- **Rationale:**

In Texas, only 60% received prenatal care. Predominantly lack of prenatal care and resulting low birth rate deliveries are due to the economic barriers of accessing health care. We currently don't have a medical home model established or a program for medical insurance/Medicaid advocacy assistance.

As supported by CN. 012., pregnant woman need a patient centered medical home model to provide tailored prenatal, labor and delivery and postnatal care. CCMC, with almost 50 percent of births to mothers age 13-17, has identified an even higher need for these young mothers. Providing a "home base" for usual care for high-risk pregnant women will focus on improved, organized care for the patient. We have also identified the need to educate school aged pregnant girls on the need for prenatal care. Outreach activities will promote overall health and wellness to change the culture within the community.

CCMC has identified project option 2.1.3 Implement medical homes in HPSA and other rural and impoverished areas using evidence-based change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative. Below are the required core project components with explanations of how they are addressed in this project.

a) Empanelment: Assign all patients to a primary care provider within the medical home. Understand practice supply and demand, and balance patient load accordingly. CCMC's clinic will enroll identified pregnant teams in the medical home in order to provide prenatal care in the medical home.

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.

CCMC's clinic staff will create a team approach to providing the need wraparound access to care specific to pregnant women. This might include ensuring prenatal appointments are made upon check out from all appointment and reducing no show rates with phone and email reminders.

c) Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.

CCMC will ensure that staff are aware of the patient assigned to them to improve access to non-emergent urgent care.

d) Assure that patients are able to see their provider or care team whenever possible. Increasing primary care capacity in 1.1 will also provide increased capacity for prenatal care and increase provider availability and access through phone and email communications.

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.

CCMC's clinic will seek to improve secure communication and reminders through phone, email and 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.

CCMC will evaluate the team approach and success of the patient centered medical home in order to make necessary modifications and improve continuation in the program by the pregnant woman as well as improved birth outcomes for the baby. CCMC will provide a safety net through medical insurance/Medicaid advocacy programs which will not only reduce barriers to access to care during pre-delivery, but also for post-delivery and children's long term health needs.

- **Related Category 3 Outcome Measure(s): IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (Standalone measure)**

CCMC will implement processes to improve low birth-weight births less than 2,500 grams at birth.

Low birth rate children statistically face long-term problems such as cerebral palsy, intellectual disabilities, visual and hearing impairments and learning difficulties. Among Texas Medicaid –funded newborns, low birth rate and resulting NICU admissions consume 66% of newborn care expenditure.

Development of a patient center medical home model, coupled with a medical insurance/Medicaid medical advocacy program will result in higher percentages of pre-natal care and reduce barriers to both pre-natal care and longer term infant health care.

Focusing on improving the low-birth weight outcomes will help improve the likelihood of lower pre-term deliveries and improve outcomes for high-risk deliveries.

- **Relationship to other Projects:**

CCMC will be building primary care capacity in 1.1 with additional Family Practitioners who will also deliver babies and provide needed prenatal care and improve

outcomes for mothers and babies. In category 4, PPCs and ED utilization should be impacted with increases in available clinic capacity and the medical home for pregnant women.

- **Relationship to Other Performing Providers' Projects in the RHP:** CCMC will coordinate patient center medical home prenatal care programs, best practice sharing of information and outcomes with Shannon Medical Center, which is a participating partner in RHP 13 as well as other rural area hospitals. RHP 13 members of a will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.
- **Plan for Learning Collaborative:** Collaborative area wide RHP collaborative meetings will be scheduled to coordinate development of best practices, EHR sharing & coordination of care for high risk deliveries. The learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects. RHP collaborative group will also be an evidence based research group to find innovative ideas and solutions.
- **Project Valuation:**

As noted above, CCMC's clinic seeks to identify pregnant women and tailor a care model to provide a home base for them early in pregnancy. In order to improve this rate, we will aggressively seek to educate and to identify additional pregnant women early and to enroll them in the medical home. We will also do a study to determine the steps needed to achieve the NCQH PCMH status. Approximately 114 live births occur each year in Coleman County. Our regional low birth weight rate was approximately 10 percent in 2008; which is significantly higher than the State of Texas rate of 8.4% and therefore, we additionally anticipate an improvement in this rate. As evidenced by the numerous healthy baby initiatives and the different prenatal programs, healthy pregnancies greatly reduce the costs, trauma and likelihood of unhealthy deliveries. CCMC has an expected 75% Medicaid and 12% uninsured deliveries at CCMC each year; which are the highest risk population of potential low-birth rate natality. The total cost for a birth depends on any complications you or the baby may have. On average, a vaginal birth, can cost between \$9,000 to \$17,000; depending on the particular hospital. A Cesarean birth (C-section) without any other complications ranges from \$14,000 to \$25,000. At CCMC the average cost for a delivery is \$ 3,000 and a C-section \$5,000 to \$7,000. Our expected results of reducing low-birth rate natality will produce a significant savings in pre-term delivery and C-section costs regionally. With an estimated patient base of 125 by DY 5 we project enrolling approximately 62 pre-natal patients in our medical home model.

<p>NEW: 136144610.2.2 (OLD: 136144610.2.1)</p>	<p><b>2.1.3</b></p>	<p><b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b></p>	<p>2.1 Enhance/Expand Medical Homes</p>	
<p>Coleman County Medical Center</p>			<p>136144610</p>	
<p><b>Related Category 3 Outcome Measure(s):</b></p>	<p>New: 136144610.3.4 (Old: 136144610.3.2)</p>	<p><i>IT-8.2</i></p>	<p>Percentage of Low Birth- weight births</p>	
<p><b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b></p>				
<p><b>Milestone 1</b> P-6. Milestone: Establish criteria for medical home assignment P-6.1. Metric: Medical home assignment criteria  Baseline/Goal: 15% enrollment in patient centered medical home of pregnant women within first tri-semester. Establishment of a referral program and process to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program.  Data Source: Submission of</p>	<p><b>Milestone 2</b> P-1. Milestone: Implement the medical home model in primary care clinics P-1.1. Metric: Increase number of primary care clinics using medical home model a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of primary care clinics  Baseline/Goal: 30% enrollment in patient centered medical home of pregnant women within first tri-semester. Referral of rate of 25% of</p>	<p><b>Milestone 5</b> P-11. Milestone: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population (must select at least one metric): P-11.1. Metric: Implement a patient registry that captures preventive services utilization. a. Numerator: Number of patients overdue for preventive services. b. Denominator: Total number of patients in the registry</p>	<p><b>Milestone 8</b> I-12. Milestone: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.  I-12.1. Metric: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients  Baseline/Goal: 50% enrollment</p>	

<p>NEW: 136144610.2.2 (OLD: 136144610.2.1)</p>	<p><b>2.1.3</b></p>	<p><b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b></p>	<p>2.1 Enhance/Expand Medical Homes</p>		
<p>Coleman County Medical Center</p>			<p>136144610</p>		
<p><b>Related Category 3 Outcome Measure(s):</b></p>	<p>New: 136144610.3.4 (Old: 136144610.3.2)</p>	<p>IT-8.2</p>	<p>Percentage of Low Birth- weight births</p>		
<p><b>Year 2 (10/1/2012 – 9/30/2013)</b></p>		<p><b>Year 3 (10/1/2013 – 9/30/2014)</b></p>		<p><b>Year 4 (10/1/2014 – 9/30/2015)</b></p>	<p><b>Year 5 (10/1/2015 – 9/30/2016)</b></p>
<p>medical home assignment criteria, such as patients with specified chronic conditions; patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high users of health care services; and patients with particular socio-economic, linguistic, and physical needs. Evidence of referral program process.</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$202,427</p>	<p>potential expectant mothers without insurance to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance.</p> <p>Data Source: Submission of data supporting the implementation of a patient centered medical home in the clinic space. Referral program data base.</p> <p>Milestone 2 Estimated Incentive Payment: \$73,612</p> <p><b>Milestone 3</b> P-11. Milestone: Identify</p>		<p>Baseline/Goal: 40% enrollment in patient centered medical home of pregnant women within first tri-semester. Referral of rate of 50% of potential expectant mothers, or approximately 50 patients, without insurance to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance.</p> <p>Data Source: Patient registry or EHR</p> <p>Milestone 5 Estimated Incentive Payment: \$73,826</p>	<p>in patient centered medical home of pregnant women within first tri-semester. With an estimated patient base of 125 by DY 5 we project enrolling approximately 62 pre-natal patients. Referral of rate of 75% of potential expectant mothers without insurance to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance.</p> <p>Data Source: Practice management system, EHR, or other documentation as designated by Performing</p>	

<p>NEW: 136144610.2.2 (OLD: 136144610.2.1)</p>	<p><b>2.1.3</b></p>	<p><b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b></p>	<p>2.1 Enhance/Expand Medical Homes</p>									
<p>Coleman County Medical Center</p>			<p>136144610</p>									
<p><b>Related Category 3 Outcome Measure(s):</b></p>	<p>New: 136144610.3.4 (Old: 136144610.3.2)</p>	<p><i>IT-8.2</i></p>	<p>Percentage of Low Birth- weight births</p>									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%; text-align:center;">Year 2 (10/1/2012 – 9/30/2013)</th> <th style="width:25%; text-align:center;">Year 3 (10/1/2013 – 9/30/2014)</th> <th style="width:25%; text-align:center;">Year 4 (10/1/2014 – 9/30/2015)</th> <th style="width:25%; text-align:center;">Year 5 (10/1/2015 – 9/30/2016)</th> </tr> </thead> <tbody> <tr> <td data-bbox="176 703 613 1398"></td> <td data-bbox="613 703 1050 1398"> <p>current utilization rates of preventive services and implement a system to improve rates among targeted population</p> <p>P-11.1. Metric: Implement a patient registry that captures preventive services utilization. a. Numerator: Number of patients overdue for preventive services. b. Denominator: Total number of patients in the registry</p> <p>Baseline/Goal: Registry in place in Clinic and Hospital. Coordinated care process for</p> </td> <td data-bbox="1050 703 1486 1398"> <p><b>Milestone 6</b> I-12. Milestone: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.</p> <p>I-12.1. Metric: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients</p> </td> <td data-bbox="1486 703 1923 1398"> <p>Provider</p> <p>Milestone 8 Estimated Incentive Payment: \$91,480</p> <p><b>Milestone 9</b> I-17. Milestone: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care</p> <p>I-17.1. Metric: Reminders for patient pre-natal care services a. Numerator: For select specific preventive pre-natal care service;</p> </td> </tr> </tbody> </table>					Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)		<p>current utilization rates of preventive services and implement a system to improve rates among targeted population</p> <p>P-11.1. Metric: Implement a patient registry that captures preventive services utilization. a. Numerator: Number of patients overdue for preventive services. b. Denominator: Total number of patients in the registry</p> <p>Baseline/Goal: Registry in place in Clinic and Hospital. Coordinated care process for</p>	<p><b>Milestone 6</b> I-12. Milestone: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.</p> <p>I-12.1. Metric: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients</p>	<p>Provider</p> <p>Milestone 8 Estimated Incentive Payment: \$91,480</p> <p><b>Milestone 9</b> I-17. Milestone: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care</p> <p>I-17.1. Metric: Reminders for patient pre-natal care services a. Numerator: For select specific preventive pre-natal care service;</p>
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NEW: 136144610.2.2 (OLD: 136144610.2.1)	<b>2.1.3</b>	<b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b>	2.1 Enhance/Expand Medical Homes	
Coleman County Medical Center			136144610	
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.4 (Old: 136144610.3.2)	<i>IT-8.2</i>	Percentage of Low Birth- weight births	
<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
	enrollment of eligible participants established.  Data Source: Patient registry or EHR  Milestone 3 Estimated Incentive Payment: \$73,612  <b>Milestone 4</b> P-X. Establish a baseline for I-12 improve the patients assigned to a Medical Home, in order to measure improvement over self  P-X.X. Report Baseline	Goal: 40% enrollment of eligible patients who are maintaining prenatal care visits as scheduled.  Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider  Milestone 6 Estimated Incentive Payment: \$73,826  <b>Milestone 7</b> I-17. Milestone: Medical home provides population health management by identifying	the number of patients in the registry needing the preventive service and who have been contacted to come in for service b. Denominator: Total number of patients in the registry needing the preventive service  Goal: 50% enrollment of eligible patients who are maintaining prenatal care visits as scheduled. Reminders or direct contact for 75% of pre-natal patients preventive services	

<p>NEW: 136144610.2.2 (OLD: 136144610.2.1)</p>	<p><b>2.1.3</b></p>	<p><b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b></p>	<p>2.1 Enhance/Expand Medical Homes</p>	
<p>Coleman County Medical Center</p>			<p>136144610</p>	
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<p><b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b></p>				
	<p>Goal:</p> <p>Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider</p> <p>Milestone 4 Estimated Incentive Payment: \$73,613</p>	<p>and reaching out to patients who need to be brought in for preventive and ongoing care</p> <p>I-17.1. Metric: Reminders for patient pre-natal preventive services</p> <p>a. Numerator: For select specific pre-natal care service , the number of patients in the registry needing the service and who have been contacted to come in for service</p> <p>b. Denominator: Total number of patients in the registry needing the service</p>	<p>Data Source: Registry, or other documentation as designated by Performing Provider</p> <p>Milestone 9 Estimated Incentive Payment: \$91,481</p>	

NEW: 136144610.2.2 (OLD: 136144610.2.1)	<b>2.1.3</b>	<b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b>	2.1 Enhance/Expand Medical Homes	
Coleman County Medical Center			136144610	
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.4 (Old: 136144610.3.2)	IT-8.2	Percentage of Low Birth- weight births	
<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
			Goal: Reminders or direct contact for 50% of pre-natal patients preventive services  Data Source: Registry, or other documentation as designated by Performing Provider  Milestone 7 Estimated Incentive Payment: \$73,827	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$202,427	Year 3 Estimated Milestone Bundle Amount: \$220,837	Year 4 Estimated Milestone Bundle Amount: \$221,479	Year 5 Estimated Milestone Bundle Amount: \$182,961	

NEW: 136144610.2.2 (OLD: 136144610.2.1)	<b>2.1.3</b>	<b>2.1.3.A</b> <b>2.1.3.B</b> <b>2.1.3.C</b> <b>2.1.3.D</b> <b>2.1.3.E</b> <b>2.1.3.F</b>	2.1 Enhance/Expand Medical Homes
Coleman County Medical Center			136144610
<b>Related Category 3 Outcome Measure(s):</b>	New: 136144610.3.4 (Old: 136144610.3.2)	IT-8.2	Percentage of Low Birth- weight births
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$827,704</b>			

Add additional projects using same format above

## Summary Information

*Performing Provider: Concho County Hospital*

*OLD Project Unique ID #: 091770005.2.1*

*NEW Project Unique ID #: 091770005.2.2*

☐ Provider: Concho County Hospital is a 16-bed hospital in Eden, Tx serving 1,885 square mile area including Menard county with a combined population of approximately 6,350.

☐ Intervention(s): This project will implement a Health and Wellness center to educate and understand patients with diabetes needs.

☐ Need for the project: Within the last year, 16% of all patients seen at CCH had Diabetes as their primary diagnosis. Currently, CCH does not provide hands-on treatment for diabetic patients

☐ Medicaid and Uninsured Target population: The target population is patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Approximately 25% of our patients are either Medicaid eligible or indigent. We expect they will benefit from the health and wellness promotion center

☐ Category 1 or 2 expected patient benefits: The Health and Wellness Center will provide further education, exercise, and one-on-one encounters for patients with diabetes. Within the last year, Concho County Hospital has seen 322 patients with Diabetes as the principle or secondary diagnosis. A majority of our diabetes population is uncontrolled. In the last quarter of DY3, a baseline will be established by running one cycle of 20 patients through our Health and Wellness program. Of these 20 patients we hope to improve 5% or one patient's Hgba1c levels. In each quarter of DY4 we will implement one cycle of 20 patients for a total of 60 patients in that year. Of these 60 patients, we hope to see improvements in 10% or six patients' Hgba1c levels. In the three cycles of 20 patients in DY5, we hope to see improvements in Hgba1c levels by 15% or nine patients.

☐ Category 3 outcomes: 3.1 - Implement Evidence-based Health Promotion Programs, Concho County Hospital, 091770005, 091770005.3.1 Our goal is to increase the number of patients' by 5% each year lower their HgBA1c.

**Narrative for each Category 2 Project shall include:**

**Concho County Hospital Health and Wellness Promotion**

- **Identifying Project and Provider Information:** 2.6 - Implement Evidence-based Health Promotion Programs, Concho County Hospital, New ID: 091770005.2.2 Pass 3B Old ID 091770005.2.1, 091770005
- **Project Description:** Concho County Hospital, as the go to place for healthcare in Concho County, recognizes the need for further education, exercise, and one-on-one encounters for patients with diabetes. We have developed a plan to address this life threatening disease. For the diabetic patient, Concho County Hospital's goal is to provide a comprehensive care-plan to include healthy living promotion, patient education, training by professionals (physical & dietary) and follow-up treatment. Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population. Our goal is to improve patients' HgbA1c's by 5% each year.

The challenges Concho County Hospital faces are as follows:

1. Funding for the remodeling of the current Hospital area designated for the Health and Wellness Center.
2. Full-time employees such as a registered nurse, a physical therapist, and/or dietician to facilitate the Health and Wellness Center Program.
3. Identifying new patients in need of the Health and Wellness Center Program.
4. Patient participation with diabetes.

Funding from the RHP will provide Concho County Hospital the resources it needs to initiate remodeling of our existing structure for the Health and Wellness Center. Funding will provide compensation for employees needed to maintain the Health and Wellness Center. CCH plans to identify new patients through advertisements using media such as postal mail, our local newspaper, and word of mouth. Participating patients will receive a free membership and all the benefits of the Health and Wellness program and its resources at no extra cost. Non-compliant patients will be excluded and replaced with new participants.

Within five years, CCH aspires to have patients with chronic diabetes in a state of health and wellness to improve their quality of life. CCH plans to give patients with diabetes the tools they need to rid themselves of the disease for the remainder of their lifetime. In the future, newly diagnosed patients will be aware of the resources available to them to treat their disease.

- **Starting Point/Baseline:** Currently the Health and Wellness Program is not being implemented due to lack of resources. Our goal is for the Health and Wellness Program to be initiated through this program. CCH has an existing structure that will need to be remodeled for the location of the program. When the Health and Wellness program is functional, a baseline will be established.
- **Rationale:**  
Project Options:

#### 2.6.2 Establish self-management programs and wellness using evidence-based designs

Within the last year, 16% of all patients seen at CCH had Diabetes as their primary diagnosis. Currently, CCH does not provide hands-on treatment for diabetic patients. Treatment is limited to medication therapy and consultations provided by medical staff. This Health and Wellness program will provide additional education on diet and exercise with the onsite staff. The patient will be instructed on the diabetic diet with adherence to their age and culture. A nutritionist will have one-on-one dietary consultation and will follow-up regularly to discuss dietary challenges to include cooking instructions.

#### Required Quality Improvement

Through education and testing, Concho County Hospital seeks to identify lessons learned to improve diabetics HgbA1c through diet, exercise and education. Through this quality improvement, Concho County Hospital can identify the impacted population and potentially improve the quality of life for our diabetic patients.

Community Needs CNA-001 Adults Diabetes rate is 10.3%; range is 9.0% to 11.8% For DY2-DY5, activities that will occur in the exercise space include cardio equipment and light strength training as it is related to physical therapy. Personnel space will be utilized for research and consultations. The education center will be operated on an as-needed basis. The assessments area will be utilized for checking vital signs. We will evaluate the program and broaden lessons learned by consulting with the patient population.

- **Milestones**

- P-1. Milestone: Conduct an assessment of health promotion programs that involve community health workers at local and regional level.

- P-1.1. Metric: Document regional assessment
  - a. Data Source: Documentation of Planning
  - b. Rationale/Evidence: The importance of this milestone is to identify, support and compliment already existing resources in the community for health promotion programs.
  
- P-3. Milestone: Implement, document and test an evidence-based innovative project for targeted population
  - P-3.1. Metric: Document implementation strategy and testing outcomes.
    - a. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider.
    - b. Rationale/Evidence: Documentation of implementation strategy and testing outcomes.
  
- P-4. Milestone: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned.
  - P-4.1. Metric: Document learning and diffusion strategic plan
    - a. Date Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider.
    - b. Rationale/Evidence: Documentation of learning and diffusion strategic plan and actions
  
- P-5. Milestone: Execution of evaluation process for project innovation.
  - P-5.1. Metric: Document evaluative process, tools and analytics.
    - a. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider
    - b. Rationale/Evidence: Documentation of evaluation process, tools and analytics.
  
- Improvement Milestone:
  - I-8. Milestone:: Increase access to health promotion programs and activities using innovative project option
    - I-8.1 Metric: Increase percentage of target population reached.
      - a. Data Source: Documentation of target population reached, as designated in the project plan.
      - b. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching it targeted population.

- **R1.1 Related Category 3 Outcome Measure(s):**
  - OD-1 Primary Care and Chronic Disease Management**
  - IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 (Standalone measure)**
    - 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)
    - c. Data Source: EHR, Registry, Claims, Administrative clinical data
    - d. Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly \$100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars
- **Relationship to other Projects:** Kimble County is addressing diabetes prevention for all of the surrounding area. Concho County Hospital is addressing diabetes after it has been diagnosed, and patients Hba1c is >9.0%. This project is for after care and treatment for diabetes. For example, If Kimble County, in their efforts to prevent diabetes, finds that certain patients are beyond prevention; these patients can be referred to CCH for treatment. The CCH service area will include Eden, Eola, Menard, Junction, Paint Rock, Ballinger, Brady, Melvin, Millersview, and Ft. McKavitt.
- **Relationship to Other Performing Providers' Projects in the RHP:** Other providers in RHP 13 are doing Primary Capacity Care, such as Kimble, Coleman, and Pecos Counties.
- **Plan for Learning Collaborative: N/A**
- **Project Valuation:** The Health and Wellness center will attempt to educate, embrace, and understand patients' individual needs. We understand the diabetic challenges will be continuous and varying from patient to patient. We plan to individualize each care plan accordingly. Within the last year, Concho County Hospital has seen 322 patients with Diabetes as the principle or secondary diagnosis. A majority of our diabetes population is uncontrolled. In the last quarter of DY3, a baseline will be established by running one cycle of 20 patients through our Health and Wellness program. Of these 20 patients we hope to improve 5% or one patient's Hgba1c levels. In each quarter of DY4 we will implement one cycle of 20 patients for a total of 60 patients in that year. Of these 60 patients, we hope to see improvements in 10% or six patients'

Hgba1c levels. In the three cycles of 20 patients in DY5, we hope to see improvements in Hgba1c levels by 15% or nine patients. Our goal of maintaining a healthy lifestyle for the diabetic patient will be constant and changing. We hope to keep the patient coming back because they want to live healthier and not because they have to. Non-compliant diabetic patients will lose free access to the program and will be replaced. CCH has a fully staffed laboratory, a receptionist, and an EHR system to collect data. These existing systems will help with cost avoidance.

**Milestones/Metric Table for each Category 2 Project shall include:**

- **Identifying Project and Provider Information:**

Concho County Hospital – 091770005

Health and Wellness Promotion Center – 091770005.2.6

Waiver 1115, Category 2

2.6 Implement Evidence-based Health Promotion Programs IT 1.10 Diabetes Care: HbA1c poor control (>9.0%)

- **RHP Planning Protocol Reference:** [see attached table]

- **Incentive Payment Amount:** [See Attached table.]

New ID 091770005.2.2 Pass 3B Old ID 091770005.2.1	<b>2.6.2</b>	<b>P1.1]</b>	<b>HEALTH AND WELLNESS PROMOTION</b>	
Concho County Hospita			091770005	
<b>Related Category 3 Outcome Measure(s):</b>	<i>IT 1.10</i>	091770005.3.2 OLD: 091770005.3.1	Diabetes Care: HbA1c poor control >10%	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>Milestone 1</b>  <b>P-1 Milestone:</b> Conduct an assessment of health promotion programs that involve community health workers at local and regional level.  <b>P-1.1. Metric:</b> Document regional assessment  <b>Milestone 1</b> Estimated Incentive Payment ( <i>maximum amount</i> ): \$189,595  <b>Data Source:</b> Documentation	<b>Milestone 2</b>  <b>P-3. Milestone:</b> Implement, document and test an evidence-based innovative project for targeted population  <b>P-3.1 Metric:</b> Document implementation strategy and testing outcomes  Goal: In the last quarter of DY3, a baseline will be established my running one cycle of 20 patients through our Health and Wellness program. Of these 20 patients we hope to improve 5% or one patient’s Hgba1c levels.  <b>Milestone 2</b> Estimated	<b>Milestone 3</b>  <b>P-4. Milestone:</b> Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned.  <b>P-4.1. Metric:</b> Document learning and diffusion strategic plan  Goal: In each quarter of DY4 we will implement one cycle of 20 patients for a total of 60 patients in that year. Of these 60 patients, we hope to see improvements in 10% or six patients’ Hgba1c levels. <b>Improvement Milestone:</b> I-8 Increase access to health	<b>Milestone 4</b>  <b>P-5. Milestone:</b> Execution of evaluation process for project innovation  <b>P-5.1. Metric:</b> Document evaluative process, tools and analytics  Goal: In the three cycles of 20 patients in DY5, we hope to see improvements in Hgba1c levels  <b>Milestone 4.1</b> Facility Functionality and Report Findings Estimated Incentive Payment	

New ID 091770005.2.2 Pass 3B Old ID 091770005.2.1	<b>2.6.2</b>	<b>p1.1]</b>	<b>HEALTH AND WELLNESS PROMOTION</b>	
Concho County Hospita			091770005	
<b>Related Category 3 Outcome Measure(s):</b>	<i>IT 1.10</i>	091770005.3.2 OLD: 091770005.3.1	<i>Diabetes Care: HbA1c poor control &gt;10%</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
of Planning	Incentive Payment: \$219,765  <b>Data Source:</b> EHR, Registry, Claims, Administrative clinical data	promotion programs and activities using innovative project option  <b>Milestone 3.1</b> Determine Best Practices and Baseline. Estimated Incentive Payment \$111,018.50 Practice Improvement Payment \$111,018.50  <b>Data Source:</b> EHR, Registry, Claims, Administrative clinical data	\$190,236  <b>Data Source:</b> EHR, Registry, Claims, Administrative clinical data	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$189,595	Year 3 Estimated Milestone Bundle Amount: \$219,765	Year 4 Estimated Milestone Bundle Amount: \$222,037	Year 5 Estimated Milestone Bundle Amount: \$190,236	

New ID 091770005.2.2 Pass 3B Old ID 091770005.2.1	<b>2.6.2</b>	<b>p1.1]</b>	<b>HEALTH AND WELLNESS PROMOTION</b>	
<i>Concho County Hospita</i>			<i>091770005</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<i>IT 1.10</i>	091770005.3.2 OLD: 091770005.3.1	<i>Diabetes Care: HbA1c poor control &gt;10%</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over DYs 2-5): \$821,633</i>				

## **Summary Information**

**Performing Provider: Heart of Texas Healthcare System**

**Pass 3 Project**

**Project Unique ID #: 138715115.2.1**

Provider: Heart of Texas Memorial Hospital is a 25-bed hospital in Brady, Texas serving an 80 square mile area and a population of approximately 15,000.

Intervention(s): This project will implement and support a Coordinated Approach to Child Health (CATCH) program to the students in McCulloch County at risk in the rising epidemic of childhood obesity. Childhood obesity can be effectively treated and reduced by learning healthier habits and daily routines. Children spend the majority of their day at school making school an ideal place for interventions targeting healthy behaviors to occur. By collaborating with children, families, schools, hospitals, and communities there is great potential to improve health outcomes and quality of life for children in Region 13.

Need for the Project: Obesity is a rising epidemic across the United States. According to the CDC, almost one in five children over the age of 5 is obese. Coordinated Approach to Child Health (CATCH®) is a Texas Education Agency (TEA) recognized, evidence-based program designed to promote physical activity and healthy habits. By integrating healthier habits as a child into everyday life, individuals are more likely to establish positive behavior changes that last a lifetime.

Medicaid and Uninsured Target Population: The target population is students residing within McCulloch County. This project will potentially serve up to 7 schools and approximately 1,500 students. The program will likely impact the students' families, as well. Roughly one-third (1/3) of the hospital patients in McCulloch County are either Medicaid eligible or indigent, so we expect approximately one-third of this population will benefit from this program.

Category 1 or 2 expected patient benefits: The overall goals of this program are to: 1) provide students, teachers, and parents with the equipment, training, and resources necessary for students to develop lifelong healthy habits, 2) for children to participate in at least 150 minutes amount of moderate to vigorous physical activity per week (MVPA), 3) develop healthy eating habits, and 4) maintain sustainability of the program after the waiver period.

Category 3 outcomes: IT-10.1 The expected outcome for this proposed project is to show improvements in Quality of Life (QOL) scores in the target population using a validated assessment tool.

### Pass 3

#### Category 2: Innovation and Redesign

#### Project Option: 2.6 Implement Evidence-based Health Promotion Programs

- Project Title: CATCH® in Motion
- Unique Project ID Number: 138715115.2.1
- Performing Provider Name/TPI: Heart of Texas Memorial Hospital/138715115

#### Project Description:

Obesity is a rising epidemic across the United States. According to the CDC, almost one in five children over the age of 5 is obese. Compared to the national average, one in three children is obese in Texas. Obesity can result in long-term health concerns considering most children that are obese grow up to be obese adults with serious health issues. Some of these health issues include high blood pressure, heart disease, diabetes and some cancers<sup>19</sup>. By focusing on interventions at an early age, children can be reached before becoming overweight or obese. For children that are already overweight or obese, these interventions could prevent them from becoming overweight or obese adults. These interventions can have a greater impact during childhood which would lead to a healthier and more productive future.

Heart of Texas Memorial Hospital will contract with Shannon Medical Center to perform the services under this proposed project. Heart of Texas Memorial Hospital is considered one of the piloted programs to determine best practices and lessons learned under this proposed project for Region 13. This project will be considered for regional expansion if potential funds become available under the 1115 waiver.

#### Project Goals:

Childhood obesity can be effectively treated and reduced by learning healthier habits and daily routines. Children spend the majority of their day at school making school an ideal place for interventions targeting healthy behaviors to occur. Coordinated Approach to Child Health (CATCH®) is a Texas Education Agency (TEA) recognized, evidence-based program designed to promote physical activity and healthy habits. By integrating healthier habits as a child into everyday life, individuals are more likely to establish positive behavior changes that last a lifetime.

Demonstration Year 2 will consist of planning processes to determine the needs in the schools and/or community-based organizations located in McCulloch County, so the program can be tailored to specifically meet the needs of the community. During this process, Shannon will speak with school administrators, school teachers and staff, community leaders, pediatricians, dieticians, and experts in childhood obesity on assessment tools and curriculum to determine the most adequate resources to use for implementation. CATCH® curriculum is available for pre-kindergarten, elementary, and middle school children, so the assessment will determine which age group has the greatest need and will benefit most from this intervention.

Based on the National Heart, Lung, and Blood Institute's research in the Child and Adolescent Trial for Cardiovascular Health, the CATCH® in Motion program was designed to assist elementary schools in coordinating complimentary school health efforts between physical

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<sup>19</sup> [www.dshs.state.tx.us](http://www.dshs.state.tx.us)

education teachers, classroom teachers, food and nutrition services staff, school counselors, and school nurses. The CATCH® in Motion program will potentially serve 7 schools and approximately 1,600 students in McCulloch County. In school, it is reported that obesity increases absenteeism, lowers academic performance, and takes an emotional toll on children. By collaborating with children, families, schools, hospitals, and communities there is great potential to improve health outcomes and quality of life for children in Region 13.

**Relationship to Regional Goals:**

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting healthcare resources in the healthcare system. With defined target populations, such as children, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

**Challenges:**

A challenge with this proposed project is engaging the secondary population consisting of parents, teachers, and staff. Parent involvement and support, as well as buy in from the teachers and staff has the potential to be a challenge since parents and teachers have a major influence on children’s health to make healthier, and more active decisions. Another challenge could be to show measurable improvement in behavior change over a short period of time (the 5 year waiver period).

**5 Year Expected Outcomes:**

Because health habits are established at an early age, it is essential to help students develop lifelong healthy habits. The overall goals of this program are to: 1) provide students, teachers, and parents with the equipment, training, and resources necessary for students to develop lifelong healthy habits, 2) for children to participate in at least 150 minutes amount of moderate to vigorous physical activity per week (MVPA), 3) develop healthy eating habits, and 4) maintain sustainability of the program after the waiver period.

**Starting Point/Baseline:**

Baselines will be determined in Demonstration Year 3

**Project Components:**

2.6.4 Other project option: Implement other evidence-based project to implement the project options above

**Unique Community Need Identification Number**

Heart of Texas Memorial Hospital will address CN-003, one in three Texas children is overweight or obese, to meet the goals set by Texas Health and Human Services Commission to

ensure the innovation of the healthcare delivery system will improve the cost effectiveness of care.

**Rationale:**

Childhood obesity is a preventable condition where prevention is significantly cheaper than the healthcare costs associated with children becoming obese adults. Individuals who are obese throughout childhood have a higher likelihood of remaining obese throughout adulthood which means these individuals suffer the consequences of obesity over many years of their lives. Research suggests that when children become obese adults their medical costs are 42% higher than for normal-weight adults.<sup>20</sup> According to Abigail Arons in Childhood Obesity in Texas: The Costs, The Policies, and a Framework for the Future, “upstream” interventions are more feasible approaches to reducing childhood obesity. “Upstream” interventions focus on the root cause of obesity compared to a “downstream” intervention such as medical treatment because it treats obesity after it has occurred. By focusing on the factors that cause obesity, upstream strategies implement effective use of resources to prevent and reverse obesity in the broader population of children<sup>21</sup>.

According to CATCH<sup>®</sup> research and development, a cost-effectiveness study reports the program cost-effectiveness ratio was \$889.68 and net benefit was \$68,125 (comparison of the present value of averted future costs with the cost of the CATCH<sup>®</sup> intervention). An independent review article in Health Affairs reports, the most cost-effective way to prevent obesity in youth is the Coordinated Approach to Child Health (CATCH<sup>®</sup>), a comprehensive intervention to promote healthy eating and physical activity in elementary schools, which costs \$900 per quality-adjusted life year (QALY) saved.<sup>22</sup>

During childhood, research suggests the most expensive obesity-related costs are due to hospitalization. In addition, the cost of hospitalizing children that are obese is higher than the cost of hospitalizing a normal-weight child. For example, children hospitalized with a secondary diagnosis of obesity have 29% higher costs for asthma and 26% higher costs for pneumonia than children with the same primary diagnosis but without a secondary diagnosis of obesity.<sup>23</sup>

**Required Quality Improvement (QI) Component:**

In forming a learning collaborative with Shannon Medical Center, HOT can apply best practices in continuous quality improvement with this project; especially, since Shannon already has a CATCH<sup>®</sup> program in place. This project will allow both providers in assisting our communities with achieving and sustaining success in battling childhood obesity.

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

This proposed project represents a new initiative of implementing CATCH<sup>®</sup> in Motion to McCulloch County. This program will address the rising epidemic of childhood obesity to

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<sup>20</sup> (Arons, 2011)

<sup>21</sup> (Arons, 2011)

<sup>22</sup> [www.catchinfo.org](http://www.catchinfo.org)

<sup>23</sup> (Arons, 2011)

educate children, parents, and the community of the importance of developing healthy habits at an early age. Considering obesity is preventable, this initiative can positively impact daily lifestyles and eliminate lifelong consequences for children and their families.

### **Related Category 3 Outcome Measure(s)**

OD-10 Quality of Life; IT-10.1 Quality of Life (standalone measure) 529-08-0236-00120

### **Rationale for Selecting Outcome measure:**

Considering this project will be implemented in the schools, Quality of Life will be assessed using a validated assessment tool that will be determined throughout the project planning in demonstration year 2. The importance of quality of life in children is essential to daily life as children grow older. By working with children, there is the opportunity to develop lifestyle and behavior changes that will impact the quality of their lifetime.

### **Relationship to other Projects:**

In an effort to reduce the number of patients suffering with chronic disease directly related to obesity and diabetes, Heart of Texas Hospital will initiate a childhood obesity program. Over a lifetime, obesity and its related complications result in necessary and costly medical treatment, such as dialysis treatment. Therefore, this project relates to 1.9, Expand Specialty Care Capacity, because it addresses the growing need for disease prevention and education by improving quality of life and reducing long-term healthcare costs.

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

This proposed project of CATCH® in Motion is Regional project within Region 13. Heart of Texas Memorial Hospital and Pecos County Memorial Hospital are the initial Performing Providers through a subcontract with Shannon Medical Center to assess, plan, and implement this evidence-based health promotion program. Heart of Texas Memorial Hospital will serve the students in McCulloch County only. There are approximately 1,499 students attending public school in McCulloch County. This project will be considered for expansion if potential funds become available under the 1115 waiver to additional Performing Providers in Region 13.

### **Plan for Learning Collaborative**

Because individuals, institutions, needs, and resources differ from community to community, no two approaches are expected to look exactly alike. Each new setting will bring together a unique group of people to determine the specific needs facing young people in their schools and build on the many resources that are already in place to support positive youth development and healthy behaviors.<sup>24</sup> A learning collaborative will take place between Heart of Texas Memorial Hospital and the school districts located in McCulloch County to determine the greatest needs and resources for program implementation. In addition, learning collaboratives will take place across Region 13 to determine best practices and lessons learned to reduce childhood obesity and related health complications.

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<sup>24</sup> [www.tea.state.tx.us](http://www.tea.state.tx.us)

**Project Valuation:**

Abigail Arons reviewed the following data in 2011 of hospital costs in Texas. According to her review, by 2005 obesity-related hospital costs for children were approximately \$237.6 million per year. One study estimates that the cohort of obese children in the U.S. who were twelve years old in 2005 would incur \$6.24 billion dollars over their lifetime, in direct medical expenditures alone.<sup>25</sup> This data suggests that a reduction in obesity among children has huge cost-saving potential for individuals facing obesity, as well as hospitals.

The valuation methodology for this proposed project was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. After considering the collaboration efforts of Heart of Texas and Shannon, the valuation methodology, and the needs of the community, the project value was determined based on the available pass 2 allocation.

By reviewing this data and taking the valuation methodology into account, Heart of Texas Memorial Hospital and Shannon determined the valuation for this proposed project. The valuation of this proposed project includes many factors including the significance of cost-savings for the hospital, training teachers, administration, and staff, possible incentives for program implementation, and the resources needed for implementation. Planning and an assessment will take place to determine the needs of McCulloch County. At this time, the assessment tool will be determined and the corresponding evaluation team from The University of Texas Health Science Center will assist in training for future implementation. CATCH® curriculum training will take place for all of the involved staff members that will be incorporating the intervention. The option of stipends for Campus Champions will be determined to incentivize the CATCH® in Motion representatives in the schools.

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<sup>25</sup> (Arons, 2011)

138715115.2.1	2.6.4 Other	CATCH® in Motion	
Heart of Texas Memorial Hospital			138715115
OD-10	138715115.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<p><b>Milestone 1</b> P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community</p> <p><u>Metric 1</u> P-2.1: Documentation of innovational strategy and plan</p> <p><u>Goal</u>: Determine the target population and needs of the community</p> <p><u>Data Source</u>: Performing Providers evidence of innovational plan</p> <p>Milestone 1 Estimated Incentive Payment: \$ 659,216</p>	<p><b>Milestone 2</b> I-8: Increase access to health promotion programs and activities using innovative project option</p> <p><u>Metric 1</u> I-8.1: Increase percentage of target population reached by the innovative project</p> <p><u>Numerator</u>: Number of individuals of target population reached by the innovative project</p> <p><u>Denominator</u>: number of individuals in the target population</p> <p><u>Baseline</u>: Demonstration Year 2; Determine target population based on greatest need; approximately 596 in Elementary-5<sup>th</sup> grade and 299 in 6<sup>th</sup>-8<sup>th</sup> grade.</p> <p><u>Data Source</u>:</p>	<p><b>Milestone 3</b> P-5: Execution of evaluation process for project innovation</p> <p><u>Metric 1</u> P-5.1 Document evaluative process, tools, and analytics</p> <p><u>Goal</u>: Implement assessment tool to survey children in target population</p> <p><u>Data Source</u>: Performing Provider contract or other documentation of implementation TBD by Performing Provider</p> <p>Milestone 3 Estimated Incentive Payment: \$390,563.50</p> <p><b>Milestone 4</b> I-8: Increase access to health promotion programs and activities using innovative project option</p> <p><u>Metric 1</u> I-8.1: Increase</p>	<p><b>Milestone 5</b> 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 agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</p> <p><u>Metric 1</u> P-8.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p><u>Goal</u>: Participate in 2 face-to-face meetings per year to</p>

138715115.2.1	2.6.4 Other	CATCH® in Motion	
Heart of Texas Memorial Hospital			138715115
OD-10	138715115.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
	Documentation of target population reached, as designated in the project plan  Milestone 2 Estimated Incentive Payment: \$ 769,777	percentage of target population reached by the innovative project <u>Numerator</u> : Number of individuals of target population reached by the innovative project <u>Denominator</u> : number of individuals in the target population <u>Goal</u> : 5% increase over baseline <u>Data Source</u> : Documentation of target population reached, as designated in the project plan  Milestone 3 Estimated Incentive Payment: \$390,563.50	discuss best practices <u>Data Source</u> : Documentation of semiannual meetings including meeting agendas, slides from the presentations, and/or meeting notes Milestone 5 Estimated Incentive Payment: \$ 334,955.50  <b>Milestone 6 I-8</b> : Increase access to health promotion programs and activities using innovative project option <u>Metric 1 I-8.1</u> : Increase percentage of target population reached by the innovative project <u>Numerator</u> : Number of individuals of target population reached by the innovative project <u>Denominator</u> : number of individuals in the target

138715115.2.1	2.6.4 Other		CATCH® in Motion	
Heart of Texas Memorial Hospital			138715115	
OD-10	138715115.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
			population <u>Goal:</u> 10% increase over baseline <u>Data Source:</u> Documentation of target population reached, as designated in the project plan  Milestone 6 Estimated Incentive Payment: \$ 334,955.50	
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$ 659,216	Year 3 Estimated Milestone Bundle Amount: \$ 769,777	Year 4 Estimated Milestone Bundle Amount: \$ 781,127	Year 5 Estimated Milestone Bundle Amount: \$ 669,911	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$ 2,880,031				

## Summary Information

Performing Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Pass 1 Project

Project Unique ID #: 133340307.2.1

- Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP13 (Kimble, Mason, Menard, Schleicher, and Sutton). Hill Country serves a 5,847 square mile area of RHP13 with a population of approximately 19,125 in 2012.
- Intervention(s): This project will implement Co-occurring Psychiatric and Substance Use Disorder Services within the 5 counties served by Hill Country in RHP13 in order to meet the needs of individuals with psychiatric and substance use issues within the community setting in order to reduce emergency department utilization, inpatient utilization, and incarceration
- Need for the project: Of the 197 individuals receiving mental health services through Hill Country in RHP13, 174 report substance use while 15 report substance use at a level that interferes with their daily lives and/or medications. In meeting with area hospitals, individuals with psychiatric disorders who also abuse substances end up in their emergency departments
- Medicaid and Uninsured Target population: The target population is individuals within Kimble, Mason, Menard, Schleicher, and Sutton counties who have a psychiatric diagnosis and abuse substances. Based on the population served in Hill Country's behavioral health program in RHP13, approximately 39% of our behavioral health patients within RHP13 have Medicaid and approximately 79% have income below \$15,000 per year.
- Category 1 or 2 expected patient benefits: The project aims to establish Co-occurring Psychiatric and Substance Use Disorder services within the 5 counties served by Hill Country in RHP13 which will provide psychiatric and substance use disorder services within the community setting in order to reduce emergency department utilization and incarceration. The project seeks to provide services to a minimum of 20 individuals from the 5 counties served by Hill Country in RHP13 by the end of DY5 (new enrollees 4 in DY3; 6 in DY4; and 10 in DY5).
- Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Co-occurring Psychiatric and Substance Use Disorder services showing improvement on the Activities of Daily Living (DLA-20)

which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, emergency department utilization and incarceration.

- **Identifying Project and Provider Information**

Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

TPI: 133340307

Title: Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder

Unique RHP ID#: 133340307.2.1

**Project Description:**

According to SAMHSA statistics on co-occurring disorders, 25.7 percent of all adults with serious mental illness also suffer from substance use dependence and 19.7 percent of adults with any mental illness also suffer from substance use dependence. Hill Country currently serves over 197 adults with Severe and Persistent Mental Illness on an annual basis within five counties of RHP 13 (Kimble, Mason, Menard, Schleicher, and Sutton). Of the 197 individuals served, 174 report substance use while 15 report substance use at a level that interferes with their daily lives and/or medication. Throughout the 22,000 square mile service delivery area of Hill Country MHDD Centers, there is one individual dedicated to Co-occurring service delivery. By expanding this service, Hill Country can better address the need of individuals with co-occurring psychiatric and substance use disorder. Services will be community based. If individuals are unable to reach services due to lack of transportation, transportation will be provided.

Hill Country MHDD Centers in planning to add Co-occurring Psychiatric and Substance Use Disorder services throughout the five county area served by Hill Country in RHP13.

**Challenges:**

The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

**Goals:**

The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services throughout the five county area in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population. By the end of five years, Hill Country will have established Co-occurring Psychiatric and Substance Use Disorder specialists which will have provided services to a minimum of 20 consumers within the community over the life of the project.

**Relationship to the Regional Goals:**

The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services based on each individual's needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way.

**Starting Point/Baseline:**

Hill Country MHDD Centers currently has one individual specializing in delivering Co-occurring Psychiatric and Substance Use Disorder services who serves forty individuals on an annual basis. Services are currently in Kerr and Gillespie counties which are located in RHP6. This project will expand the service to all 5 counties served by Hill Country in RHP13.

**Rationale:**

Hill Country will identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual. According to SAMHSA, integrated treatment or treatment that addresses mental and substance use conditions at the same time is associated with lower costs and better outcomes such as reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests, and improved quality of life.

**Project Components:**

Through the Co-occurring Psychiatric and Substance Use Disorder services, Hill Country MHDD Centers proposes to meet all required project components:

- A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on individuals who have co-occurring psychiatric and substance use disorder and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.
- B) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals co-occurring psychiatric and substance use disorder in order to provide targeted training for staff. Primary concentration will be based on SAMSHA's Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices Kit.
- C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment.
- D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Co-occurring Psychiatric and Substance Use Disorder specialists in the most appropriate interventions to address the needs of the individuals

and in connecting the individuals with other appropriate resources within the community.

- E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services. In addition, Hill Country will do follow up surveys with individuals who receive services to determine satisfaction with services and to help ensure stabilization of symptoms.

Unique community need identification number the project addresses:

CAN-006 Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers

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

Hill Country MHDD Centers currently has one individual specializing in delivering Co-occurring Psychiatric and Substance Use Disorder services who serves forty individuals on an annual basis. This individual is funded through the Texas Department of State Health Services contract which includes federal and state funds and currently operates within Kerr and Gillespie counties in RHP6. This project will expand the service to all five counties served by Hill Country in RHP13. No current federal funds will be utilized on the project.

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

OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:

Co-occurring Psychiatric and Substance Use Disorder impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those

functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

**Relationship to other Projects:**

Provision of Co-occurring Psychiatric and Substance Use Disorder services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 13 (133340307.2.2 Trauma Informed Care) by providing specialized services addressing Co-occurring Psychiatric and Substance Use Disorder for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 13: Kimble, Mason, Menard, Schleicher, and Sutton The other four local mental health authorities (Center for Life Resources, MHMR Services for the Concho Valley, Permian Basin Community Centers and West Texas Centers) provides mental health services to the remaining counties within Regional Healthcare Partnership 13 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects..

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by

professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). -The valuation on this project is based on 20 consumers over the life of the project (new enrollees 4 in DY3; 6 in DY4; and 10 in DY5)

<b>133340307.2.1</b>	<b>2.13</b>	<b>2.13.1(A-E)</b>	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder	
<i>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</i>			<i>133340307</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<i>133340307.3.1</i>	<i>3.IT-10.2</i>	<i>Activities of Daily Living</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
<b>Milestone 1 P-2:</b> Design community-based specialized intervention for target population <b>Metric 1 P-2.1:</b> Baseline: No intervention currently available Goal: Submission of project plan Data Source: Project documentation  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$53,334	<b>Milestone 2 [I-X]:</b> Number of individuals beginning service during demonstration year <b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder) <b>Baseline/Goal:</b> Baseline - 0 individuals served; Goal - 4 individuals beginning service during DY3 <b>Data Source:</b> Hill Country MHDD records/EHR <b>Milestone 2 Estimated Incentive Payment: \$55,639</b>	<b>Milestone 3 P-4:</b> Evaluate and continuously improve interventions <b>Metric 1 P4.1:</b> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records  Milestone 4 Estimated Incentive Payment: \$ 26,607	<b>Milestone 5 P-4:</b> Evaluate and continuously improve interventions <b>Metric 1 P4.1:</b> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records  Milestone 4 Estimated Incentive Payment: \$ 28,755	

		<p><b>Milestone 4 [I-X]:</b> Number of individuals beginning service during demonstration year</p> <p><b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder)</p> <p><b>Baseline/Goal:</b> Baseline - 4 individuals beginning service in DY3; Goal – 6 new individuals beginning services during DY4 (for a total of 10);</p> <p><b>Data Source:</b> Hill Country MHDD records/EHR</p> <p><b>Milestone 4 Estimated Incentive Payment: \$26,607</b></p>	<p><b>Milestone 6 [I-X]:</b> Number of individuals beginning service during demonstration year</p> <p><b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder)</p> <p><b>Baseline/Goal:</b> Baseline - 4 individuals beginning service in DY3; Goal – 10 individuals beginning services during DY5 (for a total of 20);</p> <p><b>Data Source:</b> Hill Country MHDD records/EHR</p> <p><b>Milestone 6 Estimated Incentive Payment: \$28,754</b></p>
Year 2 Estimated Milestone Bundle Amount: \$53,334	Year 3 Estimated Milestone Bundle Amount: \$55,639	Year 4 Estimated Milestone Bundle Amount: \$57,214	Year 5 Estimated Milestone Bundle Amount: \$57,509
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over Years 2-5): \$223,696			

## Summary Information

Performing Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Pass 1 Project

Project Unique ID #: 133340307.2.2

- Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP13 (Kimble, Mason, Menard, Schleicher, and Sutton). Hill Country serves a 5,847 square mile area of RHP13 with a population of approximately 19,125 in 2012.
- Intervention(s): This project will implement Trauma Informed Care Services within the 5 counties served by Hill Country in RHP13 in order to meet the needs of individuals who have experienced trauma that is impacting their behavioral health. The project will incorporate community education on the impact of trauma through Mental Health First Aid training and Trauma Informed Care training, and will provide trauma services through interventions such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced.
- Need for the project: Studies have shown that the majority of individuals who are incarcerated have suffered traumatic experiences and that individuals who suffer traumatic experiences are 300% more likely to develop ischemic heart disease. By treating trauma, individuals address the trauma in their life and reduce the chance of internalizing the trauma resulting in physical illnesses, a behavioral health crisis, or in reactions that may result in incarceration.
- Medicaid and Uninsured Target population: The target population is individuals within Kimble, Mason, Menard, Schleicher and Sutton counties who have suffered trauma. Based on the population served in Hill Country's behavioral health program in RHP13, approximately 39% of our behavioral health patients within RHP13 have Medicaid and approximately 79% have income below \$15,000 per year..
- Category 1 or 2 expected patient benefits: The project aims to establish Trauma Informed Care within the 5 counties served by Hill Country in RHP13. Trauma Informed Care will provide community education on identifying trauma symptoms and treatment for individuals who have suffered from trauma in an effort to identify trauma symptoms early and begin treatment to avoid emergency department utilization and incarceration. The project seeks to provide services to a minimum of 25 individuals from the 5 counties served by Hill Country in RHP13 by the end of DY5. (number anticipated beginning service by year, DY3 6; DY4 8 DY5 11)
- Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Trauma Informed Care showing

improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, emergency department utilization and incarceration.

## Identifying Project and Provider Information

**Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

**TPI: 133340307**

**Title: Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care**

**Unique RHP ID#: 133340307.2.2**

### Project Description:

According to Dr. Eric Kandel's New Intellectual Framework for Psychology, studies show that medication doesn't change molecular structure of the brain – experiences do. When an individual is exposed to trauma over long periods, it drastically effects their mental health. Further research indicates that many children diagnosed with ADD and ADHD are actually suffering from trauma and PTSD. In the article *Diagnosis: ADHS – or Is It Trauma?*, it is noted that seven of 10 children have been exposed to at least one potentially traumatic event and that preschoolers who had experienced multiple traumatic events were 16 times more likely to have attention problems and 21 times more likely to be overly emotionally reactive including showing symptoms of depression and anxiety than children who had not had such experiences.

Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. In the July-Sept. 2012 Youth Law New, *Trauma-Informed Care Emerging as Proven Treatment for Children, Adults with Behavioral, Mental Health Problems*, states, "Children who are physically or sexually abused, or who go through other trauma-inducing experiences can develop mental health disorders and related problems. Indeed, trauma can fundamentally affect how a young person grows and develops." According to a study cited in *Trauma among Girls in the Juvenile Justice System*, A person traumatized in childhood may resort to criminal behavior. When a survey of all juvenile detainees nationwide was conducted, 93.2% per cent of males and 84% of females reported having had a traumatic experience. In Kaiser's Adverse Childhood Experiences (ACE) study researchers looked at patients with ACE scores of 7 or higher who didn't smoke, didn't drink to excess, and weren't overweight. The study revealed that the risk of ischemic heart disease (the most common cause of death in the United States) was 360 percent higher than for patients who scored a 0 on the ACE. (Paul Tough, "The Poverty Clinic: Can a Stressful Childhood Make You a Sick Adult?", The New Yorker, March 21, 2011).

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The National Center for Trauma Informed Care, a division of SAMHSA, facilitates the adoption of trauma-informed environments in the delivery of a broad range of

services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support.

**Challenges:**

The primary challenge for implementation of the project is recruiting behavioral health staff. Hill Country will address the challenge by offering incentive as necessary.

**Goals:**

The goal of this project is to establish Trauma Informed Care throughout the five counties served by Hill Country in RHP13. The project will consist of developing Healthy Communities through the use of Mental Health First Aid Training and Trauma Informed Care training as a means to help the community understand the impact of trauma and to help identify symptoms of trauma for earlier treatment. In addition, a system of trauma counseling will be developed including practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced. The primary challenge of the project will be recruitment and training of staff for initial implementation. By the end of five years, Hill Country's goal is to have trained at least 50 individuals in Mental Health First Aid and/or Trauma Informed Care and will have established Trauma Informed Care throughout the five county service area and provided services to at least 25 consumers within the community over the life of the project. (number anticipated beginning service by year, DY3 6; DY4 8 DY5 11)

**Relationship to the Regional Goals:**

The goal of this project is to provide Trauma Informed Care within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way.

**Starting Point/Baseline:**

Hill Country MHDD Centers currently provides Cognitive Behavioral Therapy to individuals suffering from Major Depression and Cognitive Processing Therapy for individuals who have experienced a crisis episode and suffer from Post Traumatic Stress Disorder. During fiscal year 2011, Hill Country MHDD Centers provided 1050 hours of Cognitive Behavioral Therapy and Cognitive Processing Therapy combined. This program would enable Hill Country to acquire and train additional clinicians to provide Cognitive Behavioral Therapy and Cognitive Processing Therapy to a broader population at an earlier stage to avoid the exacerbation of symptoms into a crisis episode resulting in utilization of Emergency Departments, potential psychiatric hospitalizations and utilization of the criminal justice system.

**Rationale:**

The approach Hill Country will take with this project will include building health communities by offering Mental Health First Aid Training and Trauma Informed Care training to schools, law enforcement, hospitals, physicians, and community organizations. The training will be aimed at helping individuals understand the role trauma plays in their lives and helping identify early

warning signs of mental health issues. In addition, Hill Country will design programs to offer trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced.

**Project Components:**

Through the implementation of Trauma Informed Care, Hill Country MHDD Centers proposes to meet all required project components:

- A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on individuals who have issues due to an experienced trauma and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to trauma in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for service providers.
- B) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals in Trauma Informed Care in order to provide targeted training for staff and to develop innovative wrap around services to help avert future impact of the trauma.
- C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the trauma, the services received, the number of individuals receiving follow up services, the number of individuals with recurring symptoms, and progression on the Activities of Daily Living assessment.
- D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Trauma Informed staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.
- E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of individuals receiving Trauma Informed Care. In addition, Hill Country will do follow up surveys with individuals who receive Trauma Informed Care services to determine satisfaction with

services and to help ensure stabilization of symptoms in order to avert additional recurrence of trauma symptoms.

Unique community need identification number the project addresses:

CAN-006 Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers

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

Hill Country does not currently have a Trauma Informed Care initiative within Regional Healthcare Partnership 13. The addition of the Trauma Informed Care would give committed staff to providing ongoing trauma services in order to reduce the number psychiatric hospitalizations and avert recurrence of the psychiatric crisis due to triggers related to past trauma.

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

OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:

Trauma impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

**Relationship to other Projects:**

Provision of Trauma Informed Care services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 13 (133340307.2.1 Co-occurring Psychiatric and Substance Use Disorder Services.) by providing specialized services addressing trauma experienced by individuals that if not addressed in the community may result in needing inpatient psychiatric services. Addressing trauma symptoms in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing trauma symptoms in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

**Relationship to Other Performing Providers’ Projects in the RHP:**

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 13: Kimble, Mason, Menard, Schleicher, and Sutton. The other four local mental health authorities (Center for Life Resources, MHMR Services for the Concho Valley, Permian Basin Community Centers, and West Texas Centers) provides mental health services to the remaining counties within Regional Healthcare Partnership 13 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects..

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). ~~The proposed program’s value is based on a monetary value of \$50,000 per QALY gained due to the intervention multiplied by number of participants.~~ The valuation on this project is based on 25 consumers over the life of the project (number anticipated beginning service by year, DY3 6; DY4 8 DY5 11)

<b>133340307.2.2</b>	<b>2.13</b>	<b>2.13.1 (A-E)</b>	Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care	
<i>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</i>			<i>133340307</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<i>133340307.3.2</i>	<i>3.IT-10.2</i>	<i>Activities of Daily Living</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
<b>Milestone 1</b> P-2: Design community-based specialized intervention for target population <b>Metric 1</b> P-2.1: Baseline: No intervention has been designed  Goal: Submission of project plan  Data Source: Project documentation  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$87,393	<b>Milestone 2</b> [I-X]: Number of individuals beginning service during demonstration year  <b>Metric 1</b> [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma Informed Care)  <b>Baseline/Goal:</b> Baseline - 0 individuals beginning services; Goal 6 individuals beginning services during DY3  <b>Data Source:</b> Hill Country MHDD records/EHR  <b>Milestone 2 Estimated Incentive Payment: \$91,171</b>	<b>Milestone 3</b> P-4: Evaluate and continuously improve interventions <b>Metric 1</b> P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records  Milestone 4 3 Estimated Incentive Payment: \$ 45,556  <b>Milestone 4</b> [I-X]: Number of	<b>Milestone 5</b> P-4: Evaluate and continuously improve interventions <b>Metric 1</b> P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records  Milestone 4 Estimated Incentive Payment: \$ 47,116  <b>Milestone 6</b> [I-X]: Number of	

		<p>individuals beginning service during demonstration year</p> <p><b>Metric 1</b> [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma Informed Care)</p> <p><b>Baseline/Goal:</b> Baseline - 6 individuals beginning services in DY3; Goal - 8 individuals beginning services during DY4 (Total of 14).</p> <p><b>Data Source:</b> Hill Country MHDD records/EHR</p> <p><b>Milestone 4 Estimated Incentive Payment: \$45,556</b></p>	<p>individuals beginning service during demonstration year</p> <p><b>Metric 1</b> [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma Informed Care)</p> <p><b>Baseline/Goal:</b> Baseline - 6 individuals beginning services in DY3; Goal -11 individuals beginning services during DY 5 (Total of 25).</p> <p><b>Data Source:</b> Hill Country MHDD records/EHR</p> <p><b>Milestone 4 Estimated Incentive Payment: \$47,115</b></p>
Year 2 Estimated Milestone Bundle Amount: \$87,393	Year 3 Estimated Milestone Bundle Amount: \$91,171	Year 4 Estimated Milestone Bundle Amount: \$91,112	Year 5 Estimated Milestone Bundle Amount: \$94,231
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over Years 2-5): \$363,907			

## Summary Information

Performing Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Pass 2 Project

Project Unique ID #: 133340307.2.3

- Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP13 (Kimble, Mason, Menard, Schleicher, and Sutton). Hill Country serves a 5,847 square mile area of RHP13 with a population of approximately 19,125 in 2012.
- Intervention(s): This project will implement Veteran Mental Health Services within the 5 counties served by Hill Country in RHP13 in order to meet the overall health needs of veterans dealing with behavioral health issues. The project will expand peer support services in an effort to identify veterans and their family members who need comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration and provide the community based wrap around behavioral health services - for these veterans and their family members in order to treat symptoms prior to the need for utilization of emergency departments, inpatient hospitalization or incarceration.
- Need for the project: Hill Country's service area within RHP13 has a veteran population of 1,342 and veterans seeking behavioral health services currently have to travel over 300 miles and take a full day off of work to receive behavioral health services. Based on an average family size for the counties of 2.25, the veterans and their families are a total target population base for the project of 3,019. In addition, a recent study of death certificates in Texas revealed that the percentage of deaths by suicide for Texas veterans was nearly double the same rate for civilians.
- Medicaid and Uninsured Target population: The target population is veterans within Kimble, Mason, Menard, Schleicher and Sutton counties who have behavioral health issues. Based on the population served in Hill Country's behavioral health program in RHP13, approximately 39% of our behavioral health patients within RHP13 have Medicaid and approximately 79% have income below \$15,000 per year.
- Category 1 or 2 expected patient benefits: The project aims to establish Veteran Mental Health Services within the 5 counties served by Hill Country in RHP13. Veteran Mental Health Services will provide wraparound behavioral health services to veterans within their local communities. The project seeks to provide services to a minimum of 20 veterans from the 5 counties served by Hill Country in RHP13 by the end of DY5. (number anticipated beginning service by year, DY3 4; DY4 6 DY5 10)

- Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Trauma Informed Care showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, emergency department utilization and incarceration.

## **Pass 2**

### **Identifying Project and Provider Information**

**Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

**TPI: 133340307**

**Title: Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services**

**Unique RHP ID#: 133340307.2.3**

### **Project Description:**

As the mental health authority for our service area, Hill Country is well aware of the challenges for Veteran's requiring mental health services. Currently Veteran's within the five counties served by Hill Country within RHP13 must travel to San Antonio to receive mental health services. For a majority of these veterans, this involves over 300 miles of travel and a full day off of work for a one hour appointment. Just this year, the Veteran's Administration contracted with Hill Country to offer Telemedicine services at the Del Rio Mental Health Clinic in order to help reduce this additional strain on the Veteran's in the far western portion of our service area.

According to 2012 population estimates from the Texas Department of State Health Services Population Data System for Texas Population Estimates Program and statistics from the Veteran's Administration 9/30/08 Projection of Veteran's by 110<sup>th</sup> Congressional District, Vet Pop 2012, the five counties served by Hill Country within RHP13 have a total population of 19,125 with a Veteran population of 1,342, or 7% of the total population.

Studies conducted by the Veterans Administration state that nearly 20% of the suicides that occur in the U.S. are committed by veterans. According to a study of death certificates completed by the Austin American Statesman, the percentage of deaths of Texas veterans caused by suicide from 2003 through 2011 was 21.5% compared to 12.4% for the overall Texas population. Of Texas Veterans with a primary diagnosis of post-traumatic stress disorder who died during this period, 80% died of overdose, suicide or a single-vehicle crash. During discussions Hill Country held with County Veteran Service Officers within the region, it was noted that there is a need for Mental Health services for Veterans due to the transportation and time commitment needed to access Veteran Administration services as well as the reluctance of veterans to acknowledge a potential mental health issue with the Veterans Administration.

Hill Country currently has two Veteran Peer Coordinators who recruit volunteer Veterans to provide peer support services throughout Hill Country's 19 county, 22,000 square mile service area. Through this project, Hill Country would acquire additional Veteran Peer Coordinators who can actively work to recruit and train veteran peer support providers in a concentrated area such as Kimble, Mason, Menard, Schleicher and Sutton counties. The Veteran Coordinators acquired through this project will create liaisons within the counties, seek out

veterans and establish drop-in centers, recruit volunteers, connect veterans with other community resources, create jail outreach and jail diversion for veterans involved with the criminal justice system, coordinate medical and behavioral health referrals as appropriate and serve as a liaison with the local National Guard and Reserve units. This project will also include provision of comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration for both Veterans and their families in Blanco and Llano counties, including reservists who only receive Veteran Administration benefits for a few months after active deployment. ~~clinical behavioral health services~~ Wrap around services will be delivered by ~~from~~ clinicians who have been trained in cultural competency for the military environment. Wraparound services provided through this project in the local community will complement the Psychiatrist and Counselor services provided by the Veteran Administration at the VA clinics. During the last 6 months, the Veteran Peer Support services have referred 60 individuals for mental health treatment.

Hill Country MHDD Centers will expand Veteran Peer and Mental Health services throughout the five county area served by Hill Country in RHP13. In establishing the project, Hill Country will review literature and experiences regarding Veteran Peer and Mental Health services to establish appropriate training for staff on the most effective interventions for veteran services. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for veteran peer and community based wrap around behavioral ~~mental~~ health services. As a means to determine the success of the interventions, a functional assessment (DLA-20) determining what impact the various stressors have on the individuals daily lives will be completed when a Veteran is referred for mental health services and at determined intervals during treatment. In order to track individuals receiving treatment in the program, Hill Country will establish specific units and subunits within its information technology system (Anasazi) that will enable reporting on Veteran Peer and Mental Health services delivered within the program as well as by location within the program.

#### Challenges:

The primary challenge for implementation of the project is recruiting dedicated staff. Hill Country will address the challenge by offering incentives as necessary.

#### Goals:

The goal of this project is to expand Veteran Peer and Mental Health services throughout the five counties served by Hill Country in RHP13 in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population.

#### Relationship to the Regional Goals:

The goal of this project is to expand Veteran Peer and Mental Health services throughout the eleven counties served by Hill Country in RHP13 in order to reduce emergency department

utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population.

**Starting Point/Baseline:**

Hill Country MHDD Centers currently has one two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the service to add a concentrated Veteran Peer Coordinators to serve two to three counties each of the five counties served by Hill Country in RHP13 in order to recruit and train veteran peer service providers and provide identified mental health services as needed. The DLA20 assessment will be performed on each individual referred from veteran peer services to veteran mental health services as their baseline and the percentage of individuals who have improved DAL20 scores on a subsequent assessment after treatment will be utilized to show improvement.

**Rationale:**

Hill Country will identify and train Veteran Peer Coordinators in the provision of veteran peer support services including identifying and seeking out veterans needing services, recruit veteran peer support providers, creating drop-in centers for veterans, identify and connecting with current resources, and incorporating jail diversion as appropriate for veterans in touch with the criminal justice system.

**Project Components:**

Through the Veteran Mental Health services project, Hill Country MHDD Centers proposes to meet all required project components:

- F) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on veterans with mental health issues and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.
- G) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving veteran mental health issues in order to provide targeted training for staff.
- H) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment(DLA-20).
- I) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target

population, Hill Country will train staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

- J) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of Veterans referred for Veteran Mental Health services. In addition, Hill Country will do follow up surveys with individuals who receive Veteran Peer Services to determine satisfaction with services and to help ensure stabilization of symptoms.

Unique community need identification number the project addresses:

CAN-006 Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers

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

Hill Country MHDD Centers currently has one two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the service to add a concentrated Veteran Peer Coordinators to serve the eleven counties served by Hill Country within RHP6 in order to recruit and train veteran peer service providers and provide identified mental health services as needed.

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

OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:

Behavioral health issues impact veterans mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those

functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

**Relationship to other Projects:**

Provision of Veteran Mental Health Services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 13 (133340307.2.1 Co-occurring Psychiatric and Substance Use Disorder, 133340307.2.2 Trauma Informed Care, and 133340307.2.4 Whole Health Peer Support) by providing specialized services addressing mental conditions through Veteran Mental Health Services for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 13: Kimble, Mason, Menard, Schleicher, and Sutton The other four local mental health authorities (Center for Life Resources, MHMR Services for the Concho Valley, Permian Basin Community Centers and West Texas Centers) provides mental health services to the remaining counties within Regional Healthcare Partnership 13 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research The valuation is supported by cost-utility analysis which measures

program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). - The valuation on this project is based on - 20 consumers over the life of the project(number anticipated beginning service by year, DY3 4; DY4 6 DY5 10).

<b>133340307.2.3</b>	<b>2.13</b>	<b>2.13.1 A-E</b>	Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services	
<i>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</i>			<i>133340307</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<i>133340307.3.3</i>	<i>3.IT-10.2</i>	<i>Activities of Daily Living</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b>				
<b>Milestone 1</b> P-2: Design community-based specialized intervention for target population (Veteran Mental Health) <u>Metric 1</u> P-2.1: Baseline: No intervention has been designed  Goal: Submission of project plan  Data Source: Project documentation  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$23,692	<b>Milestone 2</b> [I-X]: Number of targeted individuals beginning wrap around service during demonstration year  <u>Metric 1</u> [I-X.1] Number of targeted individuals beginning service during demonstration year (Veteran Mental Health)  <b>Baseline/Goal:</b> Baseline - 0 individuals; Goal - 4 individuals beginning services during DY3. We anticipate a slow start given where we are in DY2, but will grow over time.  <b>Data Source:</b> Hill Country MHDD records/EHR  <b>Milestone 2 Estimated</b>	<b>Milestone 3</b> P-4: Evaluate and continuously improve interventions <u>Metric 1</u> P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records  Milestone 4 Estimated Incentive Payment: \$ 13,128.50	<b>Milestone 5</b> P-4: Evaluate and continuously improve interventions <u>Metric 1</u> P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records  Milestone 4 Estimated Incentive Payment: \$ 13,755  <b>Milestone 6</b> [I-X]: Number of	

	<b>Incentive Payment: \$25,450</b>	<p><b>Milestone 4 [I-X]:</b> Number of targeted individuals beginning service during demonstration year</p> <p><b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning service during demonstration year (Veteran Mental Health)</p> <p><b>Baseline/Goal:</b> Baseline - 4 during DY3; Goal – 6 total individuals beginning services in DY4.</p> <p><b>Data Source:</b> Hill Country MHDD records/EHR</p> <p><b>Milestone 4 Estimated Incentive Payment: \$13,128.50</b></p>	<p>targeted individuals beginning service during demonstration year</p> <p><b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning service during demonstration year (Veteran Mental Health)</p> <p><b>Baseline/Goal:</b> Baseline - 4 during DY3; Goal – 10 individuals beginning services in DY5.total of 20</p> <p><b>Data Source:</b> Hill Country MHDD records/EHR</p> <p><b>Milestone 8 Estimated Incentive Payment: \$13,755</b></p>
Year 2 Estimated Milestone Bundle Amount: \$23,692	Year 3 Estimated Milestone Bundle Amount: \$25,450	Year 4 Estimated Milestone Bundle Amount: \$26,257	Year 5 Estimated Milestone Bundle Amount: \$27,510
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5): \$102,909</i>			

### Summary Information

Performing Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Pass 2 Project

Project Unique ID #: 133340307.2.4

- Provider: Hill Country Community MHMR Center (dba Hill Country MHDD Centers) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP13 (Kimble, Mason, Menard, Schleicher, and Sutton). Hill Country serves a 5,847 square mile area of RHP13 with a population of approximately 19,125 in 2012.
- Intervention(s): This project will implement Whole Health Peer Support services within the 5 counties served by Hill Country in RHP13 in order to meet the overall health needs of individuals who have behavioral health issues. The project will identify and train behavioral health peers on whole health risk assessments and working with peers to address overall health issues in order to treat symptoms prior to the need for utilization of emergency departments or inpatient hospitalization.
- Need for the project: Individuals with severe and persistent mental illness die 25 years earlier than the general population. Identifying and addressing overall health symptoms, such as hypertension, diabetes, obesity, tobacco use and physical inactivity, of individuals with severe and persistent mental illness helps address this issue while reducing emergency department utilization and potentially preventable admissions to hospitals..
- Medicaid and Uninsured Target population: The target population is individuals within Kimble, Mason, Menard, Schleicher and Sutton counties who have severe and persistent mental illness and other health risk factors. Based on the population served in Hill Country's behavioral health program in RHP13, approximately 39% of our behavioral health patients within RHP6 have Medicaid and approximately 79% have income below \$15,000 per year.
- Category 1 or 2 expected patient benefits: The project aims to establish Whole Health Peer Support within the 5 counties served by Hill Country in RHP13. Whole Health Peer Support will provide whole health risk assessments to individuals with severe and persistent mental illness in an effort to identify physical health issues early and begin treatment to avoid emergency department utilization and potentially preventable hospital admissions. The project seeks to provide services to a minimum of 50 individuals from the 5 counties served by Hill Country in RHP13 by the end of DY5 (10 in DY3; 15 in DY4 and 25 in DY5).
- Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Whole Health Peer Support showing

improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization..

## **Pass 2**

### **Identifying Project and Provider Information**

**Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

**TPI: 133340307**

**Title: Project Option 2.18.1 Recruit, train and support consumers of mental health services to provide peer support services Whole Health Peer Support**

**Unique RHP ID#: 133340307.2.4**

### **Project Description:**

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature. By expanding peer services as an integral portion of the seven mental health clinics operated by Hill Country MHDD Centers and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments.

Hill Country's is planning to utilize consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide behavioral health services. Through Via Hope, a state wide organization established under the State's Mental Health Transformation grant, consumers are being trained to serve as whole health peer support specialists. Upon completion of training, peers are working with consumers to set achievable goals to prevent chronic diseases such as diabetes or to address when they exist. While Hill Country has begun the process of incorporating peer support services, there have been challenges with maintaining peer support specialists and fully incorporating peer services throughout the treatment process. The advancement to Whole Health Peer Support is needed along with increased emphasis on peer services in order to help individuals advance in their recovery.

In implementing this project, Hill Country will continue to train and educate clinicians on the importance of peer services, recruit and train peer specialists in the provision of Whole Health Peer Support, and utilize peer services to identify health risks and provide appropriate education and referrals regarding the health risks identified. Peer services will be tracked in Hill Country's information technology system (Anasazi) by location and consumer in order to monitor services delivered and outcomes of the services. In addition, Hill Country will conduct consumer satisfaction surveys for individuals receiving peer support services.

Improvement in NQF#0575—Comprehensive Diabetes Care: HbA1c control (<8%) was selected as an improvement measure due to more than 14% of the potentially preventable admissions for individuals with diabetes with short-term or long-term complications also having a secondary mental health diagnosis.

**Challenges:**

The challenges Hill Country has faced in establishing a robust peer support program have been in relation to retaining individuals in the positions for extended periods of time. Hill Country plans to address this challenge by shifting the focus of peer support to a whole health model that becomes more fully integrated into the regular practice of the mental health clinics. In addition, Hill Country intends to increase the percentage of full time equivalent for peer support specialists in order to increase retention.

**Goals:**

By the end of five years, Hill Country's goal is to have peer support specialists at the Kimble County Mental Health Clinic with a minimum full time equivalency of 1.0 and to have 20% of the consumers who participate in whole health peer support experiencing improvement in standardized health measures. Currently, Hill Country does not have any full-time equivalency for peer support services at the Kimble County Mental Health Clinic.

**Relationship to the Regional Goals:**

The goal of this project is to establish Whole Health Peer Support services based on each individual's needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way.

**Starting Point/Baseline:**

Hill Country MHDD Centers does not currently have any dedicated Whole Health Peer Support staff at the Kimble County Mental Health Clinic.

**Rationale:**

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature. By establishing peer services as an integral portion of the Kimble County Mental Health Clinic operated by Hill Country MHDD Centers within RHP13 and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments. Through this project Hill Country will acquire and maintain Whole Health Peer Support Specialists equivalent to a minimum of 1.0 full time equivalency at the Kimble County Mental Health Clinic operated by Hill Country within RHP13.

**Project Components:**

Through the Whole Health Peer Support, Hill Country MHDD Centers proposes to meet all required project components.

- A) *Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.* Hill Country MHDD Centers is currently participating in the Person Centered Recovery Initiative through Via Hope. The initiative is designed to promote mental health system transformation by 1) helping organizations develop culture and practices that support and expect recovery, and 2) promoting consumer voice in the transformation process and the future, transformed mental health system. On October 24<sup>th</sup>, 2012, the clinical leadership of Hill Country completed a one day training on integrating peer support and incorporating the patient in developing and implementing their treatment plan.
- B) *Conduct readiness assessments of organization that will integrate peer specialists into their network.* Hill Country will review readiness at the Kimble County Mental Health Clinic within RHP13 and address any potential barriers to full integration of Whole Health Peer Support.
- C) *Identify peer specialists interested in this type of work.* Hill Country will recruit peer specialists who have interest, first and foremost, in helping other on their journey of recovery and who also wish to receive training in providing whole health peer services and are interested in employment with Hill Country MHDD to provide whole health peer services.
- D) *Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity)).* Hill Country MHDD Centers will make arrangements for interested peer specialists to attend Whole Health Peer Support trainings and certifications available through the state of Texas Via Hope program. If training space becomes restrictive, Hill Country will find or develop similar training to bring peer specialists on board until such time as the certification training is available.
- E) *Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.* Hill Country MHDD Centers will have trained peer specialists utilize the health risk assessment tool to determine potential or current health risks, will track the completion of health risk assessments in the information technology system, and will address potential health risks with the patient.
- F) *Identify patients with serious mental illness who have health risk factors that can be modified.* Patients identified through the health risk assessment tool will receive education and information regarding potential health risks and, if appropriate, referred to primary care and preventive resources.
- G) *Implement whole health peer support.* Hill Country will track the occurrence of health risk assessments by location and patient in order to determine the project is fully implemented.
- H) *Connect patient to primary care and preventive services.* If risk factors or medical conditions are identified that require more than basic education, individuals will be referred to the appropriate primary care and preventive services.
- I) *Track patient outcomes Review the intervention(s) impact on participants and identify "lessons learned," opportunities to scale all or part of the interventions(s) to a broader*

*patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* Hill Country will utilize the Daily Living Activities assessment to determine progression of individuals receiving Whole Health Peer Support services. In addition, Hill Country will do follow up surveys with individuals who receive Whole Health Peer Support services to determine satisfaction with services and to help ensure stabilization of symptoms

Unique community need identification number the project addresses:

CAN-006 Mental health issues related to access, shortage of mental health professionals, lack of insurance and transportation, need for coordination between providers

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

Hill Country MHDD Centers currently does not have any Peer Specialists who serve the Kimble County Mental Health Clinic.

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

OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:

Whole Health Peer Support services impact an individual's mental and physical health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living (DLA-20) will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

**Relationship to other Projects:**

Provision of Whole Health Peer Support services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 13 (133340307.2.1 Co-occurring Psychiatric and Substance Use Disorder, 133340307.2.2 Trauma Informed Care, and 133340307.2.3 Veteran Mental Health Services) by providing specialized services addressing mental and physical conditions through Whole Health Peer Support for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 13: Kimble, Mason, Menard, Schleicher, and Sutton. The other four local mental health authorities (Center for Life Resources, MHMR Services for the Concho Valley, Permian Basin Community Centers and West Texas Centers) provides mental health services to the remaining counties within Regional Healthcare Partnership 13 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

**Plan for Learning Collaborative:**

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on the average of benefit-cost studies from Sari et al. (2008) and Kuyken et al. (2008) with an average benefit cost ratio of \$23.36 for every dollar invested. The project anticipates serving 50 individuals (10 in DY3; 15 in DY4 and 25 in DY5).

<b>133340307.2.4</b>	<b>2.18</b>	<b>2.18.1 A – I</b>	Project Option 2.18.1 Recruit, train and support consumers of mental health services to provide peer support services Whole Health Peer Support	
<i>Hill Country Community MHMR Center (dba Hill Country MHDD Centers)</i>			<i>133340307</i>	
<b>Related Category 3 Outcome Measure(s):</b>	<i>133340307.3.4</i>	<i>3.IT-10.2</i>	<i>Activities of Daily Living</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p><b>Milestone 1</b> P-3: Identify and train peer specialists to conduct whole health classes  <u>Metric 1</u> P-3.1: Number of peers trained in whole health planning  Goal: 4 peers trained in whole health planning during DY2  Data Source: Training records</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$31,084</p>	<p><b>Milestone 2</b> P-6: Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors  <u>Metric 1</u> P-6.2: Number and quality of person centered wellness plans  Goal: Person centered wellness plans have been developed with 4 individuals  Data Source: Hill Country MHDD records/EHR</p> <p>Milestone 2 Estimated Incentive Payment: \$26,992</p>	<p><b>Milestone 3</b> P-4: Evaluate and continuously improve peer support services  <u>Metric 1</u> P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement  Data Source: Hill Country MHDD records</p> <p>Milestone 4 Estimated Incentive Payment: \$ 12,076.50</p>	<p><b>Milestone 5</b> P-4: Evaluate and continuously improve interventions  <u>Metric 1</u> P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement  Data Source: Hill Country MHDD records</p> <p>Milestone 4 Estimated Incentive Payment: \$ 10,652</p>	

		<p><b>Milestone 4 [I-X]:</b> Number of individuals beginning service during demonstration year</p> <p><b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning services during demonstration year (Whole Health Peer Support)</p> <p><b>Baseline/Goal:</b> Baseline - 10 individuals beginning service in DY3; Goal – 15 new individuals beginning services during DY4 (for 25 total);</p> <p><b>Data Source:</b> Hill Country MHDD records/HER</p> <p><b>Milestone 4 Estimated Incentive Payment: \$12,076.50</b></p>	<p><b>Milestone 6 [I-X]:</b> Number of individuals beginning service during demonstration year</p> <p><b>Metric 1 [I-X.1]:</b> Number of targeted individuals beginning services during demonstration year (Whole Health Peer Support)</p> <p><b>Baseline/Goal:</b> Baseline - 10 individuals beginning service in DY3; Goal – 25 new individuals beginning services during DY5 (for 50 total);</p> <p><b>Data Source:</b> Hill Country MHDD records/HER</p> <p><b>Milestone 6 Estimated Incentive Payment: \$10,652</b></p>
Year 2 Estimated Milestone Bundle Amount: \$31,084	Year 3 Estimated Milestone Bundle Amount: \$26,991	Year 4 Estimated Milestone Bundle Amount: \$24,152	Year 5 Estimated Milestone Bundle Amount: \$21,304
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over Years 2-5): \$103,531			

## **Project Summary**

**Performing Provider: Kimble Hospital**

**Pass 1 Project: Innovation and Redesign**

**Project Unique ID #: Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2**

**Provider:** Kimble Hospital is a 15 Bed Critical Access Hospital with a level 4 designated Emergency Department. The Hospital also operates a Rural Health clinic that is staffed by 2 full time Physicians and 2 full time mid-level providers. Kimble Hospital is located in Junction Texas off the 1-10 Interstate. Kimble Hospital is the sole Health Care Facility for Kimble County with encompasses 1,250 square miles and has a population of approximately 4,627 people. The nearest Health Care Facility available to our community and county is located 56 miles southeast of Junction.

**Intervention(s):** This project seeks to provide outreach programs and education specific to heart disease and diabetes, as well as further immunization screenings, in an effort to prevent hospitalizations and complications related to those diseases. Implementing these preventive measures will reduce risk factors, encourage regular monitoring and promote patient compliance with treatment plans.

**Need for the project:** Currently the need is greater in our community than the supply of preventive services. Kimble Hospital has chosen this project option relating to the community needs survey CN-1 and CN-4 that indicates we have a population that is under served when it comes to disease prevention, such as TB, pertussis, Flu, Pneumonia, Diabetes and Heart Failure.

**Medicaid and Uninsured Target population:** Kimble Hospital's target population is all patients, however with 41% of Medicaid, uninsured and under-insured residing in Kimble County. With a total population 4627 as of 2009 that gives us a target population of Medicaid, uninsured and under-insured population of approximately 1,897.

**Category 1 or 2 expected patient benefits:** Kimble Hospital, through our evidence-based disease prevention programs expect to provide for the community immunization screenings and vaccinations, and better access to care, encouraging patients to be engaged in and take shared responsibility with staff and providers for managing chronic conditions and improving chronic disease outcomes. Kimble Hospital anticipates serving the community by implementing processes and quality improvements to improve patient outcomes.

**Category 3 outcomes:** The goal is to catch CHF early in a patients' diagnosis, so that other preventative and primary care services can better ensure healthy living in the community and reduce potentially preventable hospitalizations related to heart failure.

**Category 2: Innovation and Redesign**

Project Option 2.7.6 Implement Other Evidence-based Disease Prevention Programs

Unique Project ID: Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2

Performing Provider Name/TPI: Kimble Hospital/206083201

**Project Description:** Kimble Hospital currently screens upon discharge for immunizations, but there remains a community priority and need for further immunization screenings, health fairs, Congestive Heart Failure and diabetes education. We will implement evidence based protocols to screen people in our community for immunizations, Diabetes and heart disease. We will then provide immunizations and refer to specialty and primary care services when needed. By providing diabetes education outreach we will further prevent hospitalizations and complications related to progressive diabetes. The national culture for healthcare is focused on preventive services, which are more cost effective treatments and prevent more expensive acute and emergent care services. This is in line with our RHP 13 regional goals which include the Triple Aim: Right Care, Right Time, and Right Setting. This will also provide better health outcomes to persons who receive these services. By DY 5, we anticipate hosting health fairs and increasing screenings and administering immunizations, including Pneumococcal, Flu, Pertussis, TB, and any emergent disease such as Swine Flu, increasing screenings for heart disease and providing diabetes education. The Community Needs Assessment for RHP 13 Congestive Heart failure and Diabetes Short-term complications can be a focus for our entire region by providing education to reduce risk factors, encouraging regular monitoring and encouraging patient compliance with treatment plans.

Our target population of Medicaid, uninsured and under-insured in Kimble County and our primary service area is currently 41%. We will target this population and create a registry or tracking system to prove the Category 3 outcomes.

The challenges Kimble Hospital faces are as follows:

1. Full-time employees such as a registered nurse, Ultrasound Technician and additional time from a Dietician to facilitate the Disease Prevention Programs.
2. Additional staff for overseeing and implementing 1115 waiver
3. Identifying patients in rural areas that want and need education and services.
4. Patient participation and investment in offered programs

- **Starting Point/Baseline:** According to the RHP 13 Community needs assessment, Kimble County, which is served by Kimble Hospital and our RHC, has 1,108 people per Physician. By implementing an Evidence-based Disease Prevention Program in our local community and expanding Health fairs and Mini Clinics in outlying communities we can educate more people that don't have the means to access health care. Currently Kimble Hospital serves the communities of Junction, Menard, London and Roosevelt. Our County stretches over to other communities including Harper, Uvalde and Rocksprings. By offering outreach programs we can extend services to those in the rural areas that are unable to access healthcare due to resources and transportation. Kimble Hospital currently has 2 full time physicians and 2 full time Physician Assistants, as well as 7 full time RN's. All current providers can be utilized to educate and provide services to those in our area. Starting in 2013 we will include immunizations, Diabetes Education and Heart Failure during our 2 annual Health fairs and 5 mini clinics.
- **Rationale:** Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. It can help manage and improve the health status of Diabetic patients as well as Heart Failure patients. By providing immunizations and information at Health Clinics we can concentrate on the causes of chronic disease, and our community can move from a focus on sickness and disease to one based on wellness and prevention. We will work on the National Prevention Council strategy for Disease Prevention of expanding quality preventive services in clinical and community settings, helping people make healthy choices, and eliminating health disparities. To achieve these aims, our strategies will include, tobacco-free living, drug- and excessive alcohol-use prevention, healthy eating, active living, and targeted education of Immunizations, Diabetes and Heart Failure Education. Currently we vaccinate an estimated 300 people per year and turn away approximately 5%. The need is greater in our community than the supply of preventive services.

Kimble Hospital has chosen this Project option relating to the community needs survey CN-1, and CN-4 that indicates we have a population that is under served when it comes to disease prevention, such as TB, pertussis, Flu, Pneumonia, Diabetes and Heart Failure. Kimble Hospital currently has in place clinical guidelines for immunization and Congestive Heart failure. We currently have some programs in place for Diabetic education, but this is an area of improvement that can be targeted for our population. By further establishing and implementing Clinical practice guidelines we can improve our services to these populations. We plan to adopt a clinical care model for these programs as well. By establishing an evidence-based disease and disability prevention program for the targeted populations we can reduce their risk of disease, injury and disability.

Kimble Hospital currently uses and will continue to use the PDSA (Plan, Do Study, Act) model for ongoing evaluation of the selected projects. We will evaluate our current programs and outreach programs to determine how to improve targeting a larger population in the areas we serve. Currently we don't have all diagnostic equipment needed to perform current screenings for LVSF in patients with CHF. This will become a focus for this project funds.

- **Related Category 3 Outcome Measure(s):**  
 Kimble Hospital has selected OD-2- Potentially Preventable Admissions. IT-2.1 Congestive Heart Failure Admission rate. If we can catch CHF early in a patient’s diagnosis, then other preventative and primary care services can better ensure healthy living in the community and reduce potentially preventable hospitalizations related to heart failure.
  - Congestive Heart Failure costs for hospitalization in our county from 2005 -2010 was \$438,811 which is \$120 per adult population in the county. By increasing education and out of hospital care, we hope to reduce this cost on our community.
  - Various studies show that increasing access to care and education reduce hospital admissions.
  - Focusing on the Cat 3 outcomes will allow access to care and education. As the largest provider in the county, we expect to impact all low income, uninsured and Medicaid populations.
- **Relationship to other Projects:** Concho County Hospital in Eden has chosen IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure). So they will be a collaborator in the education of Diabetes in our region. They are approximately 52.7 miles from Kimble Hospital. Other RHP 13 members will participate in collaborative efforts to support this project and share best practices, new ideas, and solutions across the RHP.
- **Relationship to Other Performing Providers’ Projects in the RHP:** N/A
- **Plan for Learning Collaborative:** N/A
- **Project Valuation:**  
 Immunizations for children and the elderly prevent hospitalizations. DSHS has estimated hospital charges in Kimble County related to Bacterial Pneumonia to be \$928,875 and \$438,811 related to CHF from 2005 - 2010. In 2011, we had 55 admissions related to CHF and Pneumonia. We would anticipate Medicaid and uninsured savings related to potentially preventable hospitalizations. We plan to set our improvement targets in Category 3 for PPA once the baseline is established. Through this program we expect to expand our vaccination program to 5% annually and screen an additional 2% of patients for CHF we also are planning to improve and expand our program for Diabetes Education.  
 Project Investment: Purchase of Vaccines, equipment for CHF diagnosis, additional provider hours for Diabetes and CHF education, HCAHPS, Education materials.

Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2	<b>2.7.6</b>	<b>2.7.6</b>	<b>2.7 IMPLEMENT OTHER EVIDENCE-BASED DISEASE PREVENTION PROGRAMS</b>	
<i>Kimble Hospital</i>			<i>206083201</i>	
<b>OD-2</b>	OLD 206083201.3.1 NEW: 206083201.3.2	<b>IT-2.1</b>	<b>OD-2- Potentially Preventable Admissions</b>	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<b>Milestone 1</b> <b>P-1</b> Development of innovative evidence-based project for targeted population (Specifically Immunizations, diabetic and CHF populations) <u>Metric 1</u> P-1.1 Document innovational strategy and plan to increase awareness of immunizations available/recommendations, Diabetic resources/education and CHF testing/education.  Baseline/Goal: Determine current population needs  Data Source: Core measure reports, admission data, community needs assessment	<b>Milestone 2</b> <b>P-2</b> Implement evidence-based innovational project for targeted population (specifically Immunization, Diabetic and Congestive Heart Failure populations)  <u>Metric 1:</u> P-2.1: Document implementation strategy and testing outcomes.  Baseline/Goal: Develop programs and increase participation/outreach by 10%  Data Source: Documentation of completion of all items described by the	<b>Milestone 4</b> <b>P-4</b> Execution of evaluation process for project innovation <u>Metric 1:</u> Document evaluative process, tools and analytics.  Goal: Continue to fine tune program and increase participation and outreach through Quality Improvement and PDSA model.  Data Source: Documentation of implementation by year 4 by Kimble Hospital  Milestone 4 Estimated Incentive Payment: \$ 100,000  <b>Milestone 5</b>	<b>Milestone 6</b> <b>P-6</b> 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-6.1 Number of new ideas, practices, tools, or solutions tested by each provider.  Goal: Evidence of participation	

Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2	<b>2.7.6</b>	<b>2.7.6</b>	<b>2.7 IMPLEMENT OTHER EVIDENCE-BASED DISEASE PREVENTION PROGRAMS</b>	
<i>Kimble Hospital</i>			206083201	
<b>OD-2</b>	OLD 206083201.3.1 NEW: 206083201.3.2	<b>IT-2.1</b>	<b>OD-2- Potentially Preventable Admissions</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$179,062	RHP plan for this measure. Hospital Core Measure improvement, numbers served in community  Milestone 2 Estimated Incentive Payment: \$ 110,000  <b>Milestone 3</b> P-3 Execution of learning and diffusion strategy for testing, spread and sustainability.  <u>Metric 1</u> : P-3.1 Document learning and diffusion strategy for testing, spread and Sustainability  Baseline/Goal: Communicate with Providers and community	I-5. Milestone: Identify 2% of patient population with Diabetes and CHF receiving Innovative intervention consistent with evidence-based model.  I-5.1. Metric: Identification of patients receiving services for CHF and Diabetic Education. a. Numerator: Number of individuals of target population reached by the innovative project. b. Denominator: Number of individuals in the target population  Goal: We expect to improve incrementally 0.5% year over year.	and improved outcomes  Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Summarized at quarterly intervals through Quality Improvement and PDSA model  Milestone 6 Estimated Incentive Payment: \$ 161,843	

Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2	<b>2.7.6</b>	<b>2.7.6</b>	<b>2.7 IMPLEMENT OTHER EVIDENCE-BASED DISEASE PREVENTION PROGRAMS</b>	
<i>Kimble Hospital</i>			206083201	
<b>OD-2</b>	OLD 206083201.3.1 NEW: 206083201.3.2	<b>IT-2.1</b>	<b>OD-2- Potentially Preventable Admissions</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
	members the projects and goals. Begin education in Health Fairs and community outreach programs  Data Source: Evidence of education by patient number, educations program policy and procedures.  Milestone 3 Estimated Incentive Payment: \$ 87,347	Data Source: Documentation of target population reached, as designated in the project plan through Quality Improvement and PDSA model  Milestone 5 Estimated Incentive Payment: \$ 95,915		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$179,062	Year 3 Estimated Milestone Bundle Amount: \$195,347	Year 4 Estimated Milestone Bundle Amount: \$195,915	Year 5 Estimated Milestone Bundle Amount: \$161,843	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$732,167</b>				

### Summary Information^^

Performing Provider: MHMR Services for the Concho Valley

Pass 3B Project

Project Unique ID #: New ID - 109483102.2.2; Old ID – 109483102.2.1

Provider: MHMR Services for the Concho Valley (MHMRCV) is a small sized rural community mental health and IDD center located in San Angelo, TX. MHMRCV serves people with IDD and specific mental illnesses who have Medicaid entitlement or are indigent via a contract with the Texas Department of Aging and Disability Services (DADS) and the Department of State Health Services (DSHS). The people served by the Center must have proof of residence in Coke, Concho, Crockett, Irion, Reagan, Sterling or Tom Green Counties. The approximate total population of this seven county catchment area is 128,000. MHMRCV is contracted by DSHS to serve 413 unduplicated Medicaid/indigent adults and 65 Medicaid/indigent children with specific mental illnesses each six months during the fiscal year. The Center served 505 Medicaid/indigent adults and 236 children with mental illness (as defined by DSHS contract) from August 2012 – January 2013.

Intervention(s): This project will integrate primary and behavioral health care by co-locating a primary care clinic within the current MHMRCV adult mental health outpatient clinic setting. This venture is intended to offer the opportunity to provide basic physical healthcare for adult individuals who have severe and persistent mental illnesses (SPMI) so that these patients do not instead seek primary health care services in the emergency department.

Need for the project: In the MHMRCV catchment area there is currently not an integrated service setting available for adults with SPMI to also seek primary care services. In state fiscal year 2010, MHMRCV conducted an informal local study of its patient population to determine where the individuals served sought their primary care treatment. Of the 438 people surveyed, 18% of the respondents indicated that the local emergency room was their primary care provider. From these results we can deduct that there is an opportunity to provide primary care in the proposed integrated setting to at least 78 patients.

Medicaid and Uninsured Target population: The target population is any admitted MHMRCV adult patient with SPMI and a need for primary health care intervention. According to the Community Needs Assessment data, 11.8% of the RHP 13 population was enrolled in Medicaid as of April 2012 and 28.4% of the population was uninsured. Reports run from the MHMRCV electronic health record indicate that our current admitted adult mental health population payer mix is 62% indigent and 38% Medicaid entitlement.

Category 3B expected patient benefits: The project seeks to provide primary care treatment to 78 unduplicated adult individuals with SPMI by the end of DY 4 and 25 additional new/unduplicated adults with SPMI by the end of DY 5. The combined DY 4 and DY 5 patient impact is 103 adult SPMI patients receiving mental health and primary care intervention.

Category 3 outcomes: IT-10.1 Our goal is to demonstrate improvement in quality of life scores, as

measured by an evidence based and validated assessment tool, for the target population. Baseline rates will be determined by DY 3 and subsequent quality of life score improvement goals set for achievement in DY 4 and DY 5. Per CMS and HHSC, Category 3 methodology for targets will be redefined.

### **“Integrate Primary and Behavioral Health Care” - Pass 3B**

- **Identifying Project and Provider Information:** “Integrate Primary and Behavioral Health Care”; New ID – 109483102.2.2; Old ID - 109483102.2.1; MHMR Services for the Concho Valley/109483102.
- **Project Description:** MHMR Services for the Concho Valley (MHMRCV) aims to integrate primary and behavioral health care by co-locating a primary care clinic within the current adult mental health outpatient clinic setting. This venture is intended to offer the opportunity to provide basic physical healthcare for adult individuals who have severe and persistent mental illnesses (SPMI). This DSRIP project is designed to serve individuals who specifically live in Coke, Concho, Crockett, Irion, Reagan, Sterling or Tom Green counties. The precise plan of only serving residents of the seven counties previously listed is to ensure that there is not a duplication of services via DSRIP projects of other local mental health authorities in Regional Healthcare Partnership (RHP) 13.

There are three primary goals of this integration project. First is the creation of a medical home for MHMRCV patients with SPMI that is easily accessible, comfortable and convenient. The secondary goal of this project is to reduce the use of local emergency departments for routine primary health care by our MHMRCV patients. The third goal that we hope to achieve is the development of a level four integration model – “close collaboration in a partly integrated system.”

This integration DSRIP project poses four anticipated challenges. The first challenge is locating an appropriate service location large enough to accommodate both the current MHMRCV adult mental health staff and the additional primary care medical staff that will be needed to achieve a level four integration model. There will also be office modification considerations that will need to be taken into account when locating a physical plant for this project. Behavioral health exam offices do not require the same equipment as a medical exam room. As a part of milestone one during the waiver demonstration year two, MHMRCV will identify existing clinics or other community based settings where integration could be supported (core component a). The second challenge is recruiting one or more part-time family practice nurse practitioners to provide primary care in the behavioral health outpatient clinic. As a part of milestone three during DY 3 MHMRCV intends to work closely with Shannon Hospital, a fellow RHP 13 performing provider, to recruit one or more part-time primary care providers. Once the primary care provider(s) is located, MHMRCV will then contract with Shannon for the provider(s) to deliver primary care to the adult SPMI

population within the MHMRCV outpatient clinic and will provide integration process training prior to service implementation (core component d, e, g). The third challenge is information sharing between integrated providers. This integration project will require frequent and open verbal communication amongst providers in addition to technology based information sharing between separate electronic health systems. Data reporting, communication and collection tools will be developed to aid in this project during the demonstration year two as a part of milestone two (core components b,c,f). The final challenge is community education regarding the availability of new services within the MHMRCV behavioral health outpatient clinic. Historically MHMRCV has been known by reputation in the community for providing mental health services only to individuals with SPMI. With this plan to offer primary care services, MHMRCV will also need a plan for public awareness of this change. This public relations issue will be addressed during the project planning phase.

During DY three it is anticipated that the service location will be available and ready for implementation (core component h). At this time service delivery will begin and data collection related to outcomes will be aggregated for analysis and improvement as part of the quality improvement initiative associated with this project (core component i).

At the end of the five year waiver, as a performing provider, MHMRCV hopes that a successful and seamless primary and behavioral health care integration model has been developed that is easily recognized and respected in the community. The outcome of achieving this endeavor would be reduced emergency department costs in RHP 13.

From a patient perspective, the project seeks to provide primary care treatment to 78 unduplicated adult individuals with SPMI by the end of DY 4 and 25 additional new/unduplicated adults with SPMI by the end of DY 5. The combined DY 4 and DY 5 patient impact is 103 adult SPMI patients receiving mental health and primary care intervention. It is MHMRCV's desire that at the end of the demonstration waiver the people we serve have easy access to primary health care and a resulting promotion in their overall good health.

The RHP 13 goals are transformation of the healthcare system and further advances toward the Triple Aim: right care, right setting, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

- Starting Point/Baseline:** In state fiscal year 2010, MHMRCV conducted an informal local study of its patient population to determine where the individuals served sought their primary care treatment. Of the 438 people surveyed, 18% of the respondents indicated that the local emergency room was their primary care provider. From these results we can deduct that there is an opportunity to provide primary care in the proposed integrated setting to at least 78 patients. In April 2012 MHMRCV began a contract with Dr. Lindy Bankes to provide part-time medical director services at our center. Dr. Bankes currently practices outpatient psychiatry at Shannon Clinic (which is an outpatient clinic affiliated with Shannon Hospital – a fellow RHP 13 performing provider). As a result of this existing contractual relationship, MHMRCV leadership has begun to explore and discuss opportunities to work with Shannon Hospital to recruit a primary care nurse practitioner to provide primary care services on a part time basis in the MHMRCV outpatient clinic. There currently is not a coordinated primary and behavioral health care integration effort in existence in the MHMRCV catchment area (Coke, Concho, Crockett, Irion, Reagan, Sterling and Tom Green counties). The Center served 505 unduplicated Medicaid/indigent adults with SPMI (as defined by DSHS contract) from August 2012 – January 2013
- Rationale:** According to the RHP 13 Community Needs Assessment (CNA) document, one of the six opportunities that exist for region 13 is expansion of primary care in communities. Project option 2.15.1 was selected to address this community opportunity, and more specifically, to address community needs assessment identification numbers CNA-006 and CNA-007 (as defined in the CNA document). There is compelling information available to support our rationale for selecting this DSRIP integration project. For instance, reports show that adults 18 and older who have SPMI have increased rates of high blood pressure, asthma, diabetes, heart disease and stroke (SAMHSA Newswise 04/12/12). These ailments are some of those we hope to target with our integration project. In addition, according to an article released by the Substance Abuse and Mental Health Services Administration (SAMHSA), “adults with mental illness are also more likely to be treated in emergency rooms and to be hospitalized.” By creating a medical home for people with SPMI, we hope to provide physical health interventions in a timely manner that subsequently prevent the need for more costly primary care provided in an emergency department. To further support the need for primary health care integration into the behavioral health outpatient setting, the Journal of Health Psychology revealed that people who anticipated greater stigma from healthcare workers, in turn, access healthcare less and experienced a decreased quality of life (Journal of Health Psychology, “The Impact of Stigma in Healthcare...” 07/28/11). As trained mental health professionals, the staffs at MHMRCV strive to provide quality mental health care in an environment free from stigma. Offering primary care services to the adult SPMI population within the current behavioral healthcare location that they are comfortable with and accustomed to may promote greater access to improved physical health as well.
- Required QI:** MHMRCV will conduct quality improvement for this DSRIP project by using the rapid cycle improvement method. Specifically, process milestone P-7 “evaluate and continuously improve integration of primary and behavioral health services” was selected

for inclusion in DY 4 and DY 5. MHMRCV will utilize its standing Utilization Management Committee as a forum for documented discussion of monthly project reports and recommendations for improvement (core component j). The Center's Utilization Management Committee reports to the Center's Quality Assurance Committee. Reports will include real time data from the Center's electronic health record data system to guide improvements and/or changes in implementation as needed to ensure the project's success and achievement of milestones and metrics.

- **Related Category 3 Outcome Measure(s):** The process milestones selected to support project option 2.15.1 are P-1, project planning and P-2, establish baseline rates. The improvement target is Quality of Life/Functional Status, OD-10. The specific standalone measure is IT-10.1, Quality of Life. This outcome is a priority for the RHP because it supports the CNA description that mental and physical health is closely connected. More specifically, untreated mental health issues lead to increased emergency room utilization and complications in treating medical conditions which are worsened by the presence of mental health issues. By providing physical and mental health care in one treatment setting MHMRCV is promoting a less costly forum for healthcare intervention and also a remedy to a transportation hardship that so many of our patients with SPMI face. Lack of transportation is a common hardship cited by low income patients as a reason they delay or forgo health care interventions. A medical home will promote incentive to seek treatment since care can be delivered in one setting.
  
- **Relationship to other Projects:** MHMRCV is the local mental health authority that provides services within the following counties of RHP 13: Coke, Concho, Crockett, Irion, Reagan, Sterling and Tom Green. The other four local mental health authorities (Center for Life Resources, Hill Country MHDD Centers, Permian Basin Community Centers and West Texas Centers) provide mental health services to the remaining counties within RHP13 and service areas do not overlap. This MHMRCV DSRIP project entitled "Integrate Primary and Behavioral Health Care" is related to the following other projects within RHP 13 in that each focus on expansion of the capacity of primary care to better accommodate the needs of the RHP population and community. Though the performing providers for the projects listed below are not local mental health authorities, these projects are similar in their aim to expand or enhance primary care via a medical home model.
  - Project #022793601.1.1
  - Project #137226005.1.1
  - Project #121806703.1.1
  - Project #130616905.1.1
  - Project #136144610.1.1
  - Project #130089906.1.1
  - Project #136144610.2.1
  - Project #179272301.2.1

- **Project Valuation:** MHMR Services for the Concho Valley considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations. This project seeks to provide primary care treatment to 78 unduplicated adult individuals with SPMI by the end of DY 4 and 25 additional new/unduplicated adults with SPMI by the end of DY 5. The combined DY 4 and DY 5 patient impact is 103 adult SPMI patients receiving mental health and primary care intervention.

<p><b>New</b> <b>ID109483102.2.2</b> <b>Old</b> <b>ID109483102.2.1</b></p>	<p><b>2.15.1</b></p>	<p><b>2.15.1</b> <i>A,B,C,D,E,F,G,H,I,J</i></p>	<p><b>INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE</b></p>	
<p><i>MHMR Services for the Concho Valley</i></p>			<p>109483102</p>	
<p><b>Related Category 3 Outcome Measure(s): OD-10</b></p>	<p><i>New</i> <i>ID:109483102.3.4</i> <i>Old ID:</i> <i>109483102.3.3</i></p>	<p><i>IT-10.1</i></p>	<p><i>Quality of Life/Functional Status – Quality of Life</i></p>	
<p><b>Year 2 (10/1/2012 – 9/30/2013)      Year 3 (10/1/2013 – 9/30/2014)      Year 4 (10/1/2014 – 9/30/2015)      Year 5 (10/1/2015 – 9/30/2016)</b></p>				
<p><b><u>Milestone 1</u></b> P-2: Identify existing clinics or other community-based settings where integration could be supported.</p> <p><b><u>Metric 1</u></b> P-2.1: Discussions/interviews with community healthcare providers (physical &amp; behavioral), city and county govts., charities, faith-based organizations and other community based helping organizations.</p> <p><b><u>Goal:</u></b> Decide on and secure one physical plant with ample square footage in</p>	<p><b><u>Milestone 3</u></b> P-5: Develop integrated sites reflected in the # of locations &amp; providers participating in the integration project.</p> <p><b><u>Metric 1</u></b> P-5.2: Number of primary care providers newly located in behavioral health settings.</p> <p><b><u>Goal:</u></b> 1 primary care provider.</p> <p><b><u>Data Source:</u></b> Project Data.</p> <p>Milestone 3 Estimated Incentive Payment : \$231,181</p>	<p><b><u>Milestone 5</u></b> P-7: Evaluate and continuously improve integration of primary and behavioral health services.</p> <p><b><u>Metric 1</u></b> P-7.1: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles.</p> <p><b><u>Goal:</u></b> Bimonthly quality improvement meetings.</p> <p><b><u>Data Source:</u></b> Project reports include examples of how real-time data is used for rapid-cycle improvement to</p>	<p><b><u>Milestone 7</u></b> P-7: Evaluate and continuously improve integration of primary and behavioral health services.</p> <p><b><u>Metric 1</u></b> P-7.1: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles.</p> <p><b><u>Goal:</u></b> Bimonthly quality improvement meetings.</p> <p><b><u>Data Source:</u></b> Project reports include examples of how real-time data is used for rapid-cycle improvement to</p>	

<b>New</b> <b>ID109483102.2.2</b> <b>Old</b> <b>ID109483102.2.1</b>	<b>2.15.1</b>	<b>2.15.1</b> <i>A,B,C,D,E,F,G,H,I,J</i>	<b>INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3</b> <b>Outcome</b> <b>Measure(s): OD-10</b>	<i>New</i> ID:109483102.3.4 <i>Old ID:</i> 109483102.3.3	<i>IT-10.1</i>	<i>Quality of Life/Functional Status – Quality of Life</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>which to co-locate and deliver primary and behavioral healthcare services. <u>Data Source:</u> Information from persons interviewed.</p> <p>Milestone 1 Estimated Incentive Payment: \$209,099</p> <p><b><u>Milestone 2</u></b> 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 BH clients to physical health providers and vice versa.</p> <p><b><u>Metric 1</u></b></p>	<p><b><u>Milestone 4</u></b> P-6: Develop integrated behavioral health &amp; primary care services within co-located sites.</p> <p><b><u>Metric 1</u></b> P-6.1: Number of providers achieving Level 4 interaction (close collaboration in a partially integrated system).</p> <p><u>Goal:</u> 3 providers</p> <p><u>Data Source:</u> Project Data</p> <p>Milestone 4 Estimated Incentive Payment : \$231,182</p>	<p>guide continuous quality improvement.</p> <p>Milestone 5 Estimated Incentive Payment : \$247,993</p> <p><b><u>Milestone 6</u></b> I-8: Integrated services.</p> <p><b><u>Metric 1</u></b> I-8.1: Number of individuals receiving both physical and behavioral health care at the established locations.</p> <p><u>Goal:</u> 78 unduplicated individuals with SPMI</p> <p><u>Data Source:</u> Project data; claims and encounter data;</p>	<p>guide continuous quality improvement.</p> <p>Milestone 7 Estimated Incentive Payment : \$240,367</p> <p><b><u>Milestone 8</u></b> I-8: Integrated services.</p> <p><b><u>Metric 1</u></b> I-8.1: Number of individuals receiving both physical and behavioral health care at the established locations.</p> <p><u>Goal:</u> 25 unduplicated individuals with SPMI</p> <p><u>Data Source:</u> Project data; claims and encounter data;</p>	

<b>New ID109483102.2.2 Old ID109483102.2.1</b>	<b>2.15.1</b>	<b>2.15.1 A,B,C,D,E,F,G,H,I,J</b>	<b>INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-10</b>	<b>New ID:109483102.3.4 Old ID: 109483102.3.3</b>	<b>IT-10.1</b>	<b>Quality of Life/Functional Status – Quality of Life</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>P-3.1: Number and types of referrals that are made between providers at the location.</p> <p><u>Goal</u>: Development of a procedure for information sharing and a procedure for referrals of BH clients to PCP.</p> <p><u>Data Source</u>: Surveys of providers to determine the degree and quality of information sharing; Review of referral data &amp; survey results.</p> <p>Milestone 2 Estimated Incentive Payment: \$209,099</p>		<p>medical records.</p> <p>Milestone 6 Estimated Incentive Payment : \$247,994</p>	<p>medical records.</p> <p>Milestone 8 Estimated Incentive Payment : \$240,367</p>	

<b>New ID109483102.2.2 Old ID109483102.2.1</b>	<b>2.15.1</b>	<b>2.15.1 A,B,C,D,E,F,G,H,I,J</b>	<b>INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE</b>	
<i>MHMR Services for the Concho Valley</i>			109483102	
<b>Related Category 3 Outcome Measure(s): OD-10</b>	<b>New ID:109483102.3.4 Old ID: 109483102.3.3</b>	<b>IT-10.1</b>	<b>Quality of Life/Functional Status – Quality of Life</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Milestone Bundle Amount:: \$418,198	Year 3 Estimated Milestone Bundle Amount: \$462,363	Year 4 Estimated Milestone Bundle Amount: \$495,987	Year 5 Estimated Milestone Bundle Amount: \$480,734	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$1,857,282</b>				

### *Summary Information*

*Performing Provider: North Runnels County Hospital*

*Pass 3b Category 2 Project*

*Project Unique ID #: New: 020989201.2.2/ Old 020989201.2.1*

☐ Provider: North Runnels County Hospital is a 25–bed Critical Access Hospital in Winters, TX serving the surrounding North Runnels County a population of approximately 2562.

☐ Intervention(s): This project will implement an imaging system CT-Scan to provide local and faster service to the residents of North Runnels County Hospital. This will also alleviate patient transport for those who are in need of a CT-Scan and this will also alleviate patient cost.

☐ Need for the project: We are in need of a CT-Scan because we do not provide these services. Patients who need a CT-Scan have been transported or sent to another facility. This has been an inconvenience to the Patient and also to the physician. Our patients have to travel or be transported via ambulance to another facility for a CT-Scan. This is an increase of cost to the patient because of ER and transport charges incurred at NRCH and charges incurred from another facility. By adding a CT-Scan this will allow faster results and will alleviate cost. Our overall goal is to improve quality and efficiency of care.

☐ Medicaid and Uninsured Target population: The target population is for our patients that need a CT-scan imaging services that are ordered by our physicians for office visit and/or ED care. There are around 50% of our patients that are either Medicaid eligible, Uninsured or indigent, we do expect that the patient will benefit by North Runnels County Hospital implementing a CT-Scan.

☐ Category 1 or 2 expected patient benefits: The project seeks to provide faster and better service to the residents of Winters Texas and the surrounding areas. The project seeks to provide CT-Scan services to the residents of North Runnels residents and the surrounding areas. At this time when the patient is seen in the ED or Clinic the patient will have to go to another facility for a CT-Scan. This has been a problem due to the impact of cost to the patient and decreased response time for immediate care. This will benefit the patient and will improve the overall health to the patient, including the Medicaid and/or indigent patients. DY2 and DY3 TBD; build space and purchase CT-Scan also train and hire staff. We also understand that this will be a challenge educating the patient that we provide CT-Scan services so our goal is for on DY2 TBD, DY3 TBD, DY4 100 and DY5 150.

☐ Category 3 outcomes: IT 5:1 Improve Cost savings, our goal for DY4 and DY5 is to have at least 100 visits and for visits to increase in the following years the number visits is not yet determined.

## **E. Category 2: Program Innovation and Redesign**

- **Identifying Project and Provider Information:**
  - 2.5 Redesign for Cost Containment
  - CT-Scan Imaging System
  - New ID 020989201.2.2 / Old ID 020989201.2.1
  - 020989201
- **Project Description:** As a provider within a Health Care Shortage Area, North Runnels County Hospital plans to expand and improve access to the residents of Runnels County and the surrounding areas by adding a CT-Scan. At this time when a patient is in need of a CT-Scan the overall cost is higher for an episode of care without the CT scan locally, be that primary or emergent care needs. We know that local PCP doctors who order Scans and send patients around 100 miles or more round trip for the scan increase the cost of care. Medicaid for example would pay MTP costs. However, if North Runnels County Hospital offered CT Scans locally, it would reduce the cost of care and provide faster results. When in the ED it would stop/reduce the burden on EMS for potential emergent transfers from rural hospitals to urban hospitals for CT scans that result in minor treatments that could have been done in our hospital if there had been the needed imaging equipment.

Example: A patient treated in the ED with complications needing an abdomen CT-Scan, will have to be transported by ambulance to another facility. Not only has the patient now incurred charges from North Runnels County Hospital, for an ED charge of or around \$650 and an Ambulance cost of around \$1,000 to \$1,200, the patient will also incur new charges if transported to another facility that is around 100 miles round trip to the nearest ED. The additional charges could cost up to \$1000 with other pending charges incurred at that facility. An abdomen CT-Scan can cost up to \$2,000. After all is said and done, the patient would have accrued over double the charges and more.

This is a significant cost to the patient who have to travel and don't have transportation. Also the patient's that receive Medicaid, Medicaid will have to pay MTP cost and other cost that was incurred to the patient.

Project Selected: 2.5 Redesign for Cost Containment

2.4.4 Other Project Option: Cost saving by adding a CT-Scan- Imaging System

Our goal is to improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government. This project includes a specific focus on improving the North Runnels population health inside and outside of the walls of the hospital. Therefore, this will provide the opportunity to examine important measures that will develop the capability to test methodologies for measuring cost containment. This will be used to determine outcomes subsequently applied to other projects or efforts so that the ability to measure the efficiency of these initiatives is in

place, so integrated care models that use data-based cost and quality measures can be developed for the future.

As a provider within a Health Provider shortage area North Runnels County Hospital faces the following challenges for implementation:

**Challenges**

- Funding for a CT-Scan
- Full-time employee with the proper credentials to operate CT-Scan equipment effectively and efficiently.
- Patient awareness that North Runnels County Hospital will provide CT-Scan's.
- Remodel of facility Space for a CT-Scan Department.
- CT-Scan Maintenance and software updates.

Within the five years this project will help the patient by allowing them to stay in our facility with their providing doctor and to decrease the cost that the patient will incur if transported to another facility. Enhance service availability for faster and prompt access to a CT-Scan for Runnels County residents and surrounding areas. This will allow faster results at North Runnels County Hospital and will eliminate patient transport to other facilities for a CT-Scan when it can be done at our facility. Our overall goal is to improve cost, quality, and efficiency and to be more effective in how we provide care.

- It will increase specialty care staff FTE's by 1.
  - Increase patient visits.
  - Expand Cost effectiveness by alleviating, other incurring patient charges and transport services to other facilities.
  - It will improve patient satisfaction.
- **Starting Point/Baseline:** North Runnels County Hospital currently does not serve any patients because we do not have a CT-Scan. Therefore, this service is not provided and there has been no need for trained staff. There have been 0 encounters. All patients needing a CT-Scan had to either drive to another city or be transported at the patient's Medicaid, Uninsured and indigent expense. With this information, our baseline starting point is zero for the first year. DY2 TBD, DY3 100 patients and hire 1 staff and train, DY4 100 patients, train and marketing and DY5 150 and marketing
  - **Rationale:** As a provider within a Health Provider Shortage Area, North Runnels County Hospital has selected this innovated project to better serve the residents of Runnels County and the surrounding areas. As such, the patients of North Runnels that now use our facility, have to travel or be transported via ambulance service to other facilities for a CT-Scan. This increases the cost to the patient because of ER and Transport charges incurred at North Runnels and also charges incurred at another facility.

Health care spending for a given population might be roughly defined as a function of five basic factors:

Population needs or morbidity,

- Access to services,
- Propensity to seek services,
- Volume, nature, or intensity of services supplied or ordered, and
- Unit cost or price of services.

For the purpose of this project area, “cost containment” will be defined as any set of policies or measures intended to affect any one or more of these factors.

Milestone 1: Metric 1 To be achieved towards the improvement of cost containment utilizing this innovative project option is broken down below; Metric:

Total cost per member of the population per month;

- Total cost for episode of care
- This will encompass the North Runnels patients.
- EHR documentation will be used to track monthly data

Milestone 2: Will be used to track the cost per episode for the Metric hospital and ER utilization rates for cost of care measurement; for the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures will be developed to track CT-Scan usage. Metrics: Total number of patients

- Total number of hospital and ER utilization
- Monthly patients usage
- EHR software will be used to track regional data
- Our goal is to increase CT-Scan visits per month

Milestone 3 IX: Improved Clinical outcomes of target population for Patient Satisfaction by improving healthcare cost to the patient. Metric: Target Population reached

- North Runnels County Hospital as the service provider will use software to track and regulate regional data monthly according to CT-Scan patient visits and services.
- Improved cost to patient and Medicaid

Rationale: This will increase patient satisfaction by allowing patients to stay close to home to receive specialty care CT-scan locally. Currently, patients have to travel over 100 miles or more round trip when they can receive the same service here. This will be a cost savings to the patient and Medicaid. Innovations in medical care have led to improvements in quality and quantity of life. By adding imaging equipment this will improve the response time of care to the patient who is in need of urgent care

North Runnels County Hospital realizes as health care costs rise – regulators, policymakers and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as

well as society. North Runnels County Hospital hopes that in developing these cost-of-care measures, it will help those who get, give and pay for care. This will help them to understand how different providers use resources and compare them to national benchmarks.

#### Required CQI Core measure

By adding a CT-Scan our patients will see improved quality of care and significant cost saving. This will be achieved by establishing rapid cycle improvement by implementing teamwork, collaboration and improved quality of care. Our areas of focus are the patient, planning, and decision making, train staff and educate the patient that we will provide CT services. We will identify project impacts, “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

- Establish a rapid cycle improvement
  - Leadership and team work
  - Meet regularly to plan and collect data for decision making.
  - Develop strategies for producing improvement
  - Create and establish Policy & Procedure
  - Enhance Service Availability
  - Establish a safety-net plan

**Unique community need identification numbers the project addresses:** CNA.009  
Access to specialty care. CNA-008 Measuring Patient Satisfaction

- **Related Category 3 Outcome Measure(s):** OD-5 Cost of Care is selected to accommodate the Category 2 project for 2.5 to Redesign for Cost Containment.
- **Relationship to other Projects:** In relation to North Runnels County Hospital Category 3 project New ID 020989201.3.3/Old ID 020989201.3.1
- **Relationship to Other Performing Providers’ Projects in the RHP: N/A**
- **Plan for Learning Collaborative: N/A**
- **Project Valuation:**
- North Runnel County Hospital has selected Cost benefits analysis to determine the positive factors in implementing a CT-Scan Imaging System. This will decrease the cost to the patient by increasing the opportunity to diagnose and treat patient at an earlier stage without having to transport. As a result this improves the value in emergency care to diagnose locally and treat immediately. We have done an experiential analysis demonstrating why there is a need of an imaging system in our community. If our

doctors order a CT-Scan, the patient then has to travel to another facility to receive this service. This then accumulates more cost to the patient. Again, if the patient is seen in the ED and a CT-Scan is needed, the patient will need to be transported to another facility. We have discovered that this has been a problem due to the overall impact cost to the patient and decreased response time for immediate care. This outcome will help improve the overall health for all patients and including the low-income population. North Runnels County Hospital project scope is to reduce health care costs for the patient's in our community. North Runnels County Hospital will develop cost-of-care measures by achieving high value to benefit the community. This will help those who get, give and pay for care. Value is our overall goal of health care delivery, with value defined as the health outcomes achieved per dollar spent. This goal is what matters for our patients served in our community.

North Runnels County Hospital is one of two current healthcare providers within Runnels County. Our hospital covers the northern district population to include Winters TX of 2562. Our goal is to be the preferred provider for our residents in this northern district. With the ability to provide quicker and better service, to be more efficient, effective and lower cost to the patient we can meet any new challenges that may arise.

**Community Needs:** By providing a CT-Scan at North Runnels County Hospital it will better serve the residents in the community. By not having a CT-Scan on site has been a problem for the patient when seen in the ED or Clinic the patient has to go to another facility for a CT-Scan. This has been a problem due to the impact of cost to the patient and decreased response time for immediate care. This will benefit the patient and will improve the overall health to the patient, including the Medicaid and/or indigent patient DY2 and DY3 TBD; build space and purchase CT-Scan also train and hire staff. We also understand that this will be a challenge educating the patient that we provide CT-Scan services so our goal is for on DY2 build space and CT-Scan purchase DY3 100 patients and hire 1 staff and train, DY4 100 patients, train and marketing and DY5 150 patients and marketing.

This project will provide easier and faster access to advanced diagnostic and specialty care locally. Therefore, allowing the needs of those that have no transportation for out of town travel to be easily accessed. With the CT-Scan available, it will provide lower costs for those with no health insurance. North Runnels County Hospital understands that as health care costs rise that we will strive to find better ways to stay increasingly interested in developing accurate ways to measure outcomes. To be achieved towards the improvement of cost containment. This will be done by tracking the total cost per member of the population per month and to track the cost per episode for the hospital and ED utilization rates for cost of care measurement; for the services involved in the diagnosis, management and treatment of specific clinical conditions. North Runnels County Hospital's ultimate challenge is to try to reduce health care costs for the patients in our community.

New 020989201.2.2 Old 020989201.2.1	<b>2.5.4</b>	<b>I-11</b>	2.5 Redesign for Cost Containment- Imaging System	
North Runnels County Hospital			020989201	
OD-5	IT-5.1 Improved cost savings	New 020989201.3.3 Old 020989201.3.1	Cost of Care	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1</b> I-11. Milestone: Improvements in cost containment using innovative project option. <u>Metric 1</u> I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: TBD Data Source: Documentation</p> <p><u>Metric 2</u> I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Baseline/Goal: TBD Data Source: Documentation Incentive Payment: 94,798</p> <p>Milestone I-X: Improved Clinical outcomes of target population: Patient Satisfaction adding a CT-Scan to improve patient cost. Baseline/goal- TBD Data/Source- Documentation Incentive Payment: 94,797</p>	<p><b>Milestone 1</b> I-11. Milestone: Improvements in cost containment using innovative project option. <u>Metric 1</u> I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: 100 patients Data Source: Documentation</p> <p><u>Metric 2</u> I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Baseline/Goal: TBD Data Source: Documentation Incentive Payment: \$73,256</p> <p>Milestone I-X: Improved Clinical outcomes of target population: Patient Satisfaction adding a CT-Scan to improve patient cost. Baseline/goal- TBD Data/Source- Documentation Incentive Payment: \$73,255</p>	<p><b>Milestone 1</b> I-11. Milestone: Improvements in cost containment using innovative project option. <u>Metric 1</u> I-11.1. Metric: Total cost per member of the population per month Baseline/Goal: 100 patients Data Source: Documentation</p> <p><u>Metric 2</u> I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Baseline/Goal: TBD Data Source: Documentation Incentive Payment: \$74,013</p> <p>I-X: Improved Clinical outcomes of target population: Patient Satisfaction adding a CT-Scan to improve patient cost. Baseline/goal- TBD Data/Source- Documentation Incentive Payment: 74,012</p>	<p><b>Milestone 1</b> I-11. Milestone: Improvements in cost containment using innovative project option. <u>Metric 1</u> I-11.1. Metric: Total cost per member of the population per month Baseline/Goal 150 patients Data Source: Documentation</p> <p><u>Metric 2</u> I-11.2. Metric: Hospital and ED utilization rates per episode cost of care Baseline/Goal: TBD Data Source: Documentation Incentive Payment: \$63,412</p> <p>I-X: Improved Clinical outcomes of target population: Patient Satisfaction adding a CT-Scan to improve patient cost. Baseline/goal- TBD Data/Source- Documentation Incentive Payment:\$63,412</p>	

New 020989201.2.2 Old 020989201.2.1	<b>2.5.4</b>	<b>I-11</b>	2.5 Redesign for Cost Containment- Imaging System	
North Runnels County Hospital			020989201	
OD-5	IT-5.1 Improved cost savings	New 020989201.3.3 Old 020989201.3.1	Cost of Care	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
Milestone 1 Estimated Incentive Payment : \$189,595	PX-Milestone: Community or population marketing, hire staff and training, Baseline/Goal: Hire 1 staff and training Data Source: Documentation Incentive Payment: \$73,255  Milestone 2 Estimated Incentive Payment: \$ 219,766	PX-Milestone: Community or population marketing Baseline/Goal: continue training, Market Data Source: Documentation- advertise, flyers and posters Incentive Payment: \$74,012  Milestone 3 Estimated Incentive Payment: \$222,037	PX-Milestone: Community or population marketing Baseline/Goal: continue training, Market Data Source: Documentation- advertise, flyers and posters Incentive Payment: \$63,412  Milestone 4 Estimated Incentive Payment: \$190,236	
Year 2 Estimated Milestone Bundle Amount:: \$189,595	Year 3 Estimated Milestone Bundle Amount: \$219,766	Year 4 Estimated Milestone Bundle Amount: \$222,037	Year 5 Estimated Milestone Bundle <b>Amount:</b> \$190,236	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over DY's 2-5): \$821,634				

## Summary Information

Performing Provider: Pecos County Memorial Hospital

Pass 3b Project (Pass 1)

Project Unique ID #: New ID:130616905.2.3 3b

Old ID: (130616905.2.1)

- Provider: Pecos County Memorial Hospital is a 27-bed hospital in Fort Stockton, Texas serving a 4,764 square mile area and a population of approximately 8,300.
- Intervention(s): This project will expand the chronic care management model by establishing a cardiopulmonary rehabilitation program to provide cardiac and pulmonary rehab for cardiac patients who have been referred to rehab by their physician.
- Need for the project: Currently, there are no cardiopulmonary rehab facilities or programs in Fort Stockton. Therefore, when a Pecos County resident is referred to rehab by their specialist, only 20% follow up with this service since they normally have to drive to Odessa, Texas.
- Medicaid and Uninsured Target population: The target population is Pecos County patients that need specialty care. Approximately 50% of Pecos County patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the visits.
- Category 1 or 2 expected patient benefits: The project seeks to establish a cardiopulmonary program with 2 FTE's. This program will include monitored exercise routines as well as psychosocial and nutritional education. We expect to begin seeing patients in DY2 and plan to have at least 5 patients for this year with an increase in PCMH Cardiopulmonary patients in DY3, DY4, and DY5 to 10, 15, and 20 patients respectively.
- Category 3 outcomes:
  - IT-3.6 Our goal is to reduce the 30-day readmission rates for CAD by our patients as well as to reduce ED visits by our patients enrolled in our cardiac rehab program.
  - IT-3.2 Our goal is to reduce the 30-day readmission rates for CHF by our patients as well as to reduce ED visits by our patients enrolled in our cardiac rehab program.
  - IT-3.3 Our goal is to reduce the 30-day readmission rates for COPD by our patients as well as to reduce ED visits by our patients enrolled in our cardiac rehab program.

## **Category 2: Program Innovation and Redesign**

- **Identifying Project and Provider Information:**

- **Project Option 2.2** Expand Chronic Care Management Models

- **Unique Project ID:** New ID: 130616905.2.3 3b (Old ID: 1306169052.1)

- **Performing Provider Name/TPI:** Pecos County Memorial Hospital/130616905

- **Project Description:**

As stated in the Community Needs Assessment for Region 13, “as the Baby Boomers move into the Medicare age, greater needs will exist for access to care, especially relating to chronic health needs”. Since cardiovascular disease remains the number one cause of death in Texas and the financial burden of this disease is in the billions of dollars in hospitalization charges every year, it is absolutely critical that health care providers address this issue. In addition to this, the cardiologists in Odessa, Texas, have informed us that only 20% of the cardiac patients they see from Pecos County return to Odessa for cardiopulmonary rehabilitation. Fort Stockton, Texas, is located 95 miles Southwest of Odessa, the closest tertiary facility. Our goal is to open a cardiopulmonary rehab center connected to our wellness center. This would provide a source for local access point for cardiac patients to receive cardiopulmonary rehab which we assume they are foregoing due to the one way drive of 95 miles for services. We expect to increase the percentage of patients who receive cardiopulmonary rehab services following a cardiac event. Therefore, in conjunction with Community Needs Assessment number 009 for RHP 13, access to specialty care, we will develop and implement chronic disease management interventions that are geared toward improving effective management of chronic cardiac conditions. These management initiatives will include developing care teams that will assist patients with their health-care needs. Critical to this scenario is patient involvement through patient education, group visits, self-management support, improved communication between patient/provider, and patient access to community resources.

### **5-Year Expected Outcome for Provider and Patients:**

By DY 5, we expect to have a chronic care management service specifically for cardiopulmonary patients. The provider expects to improve cardiac episode outcomes within the system as well as community outreach programs. Expected outcomes will relate to the project goals described above.

- **Starting Point/Baseline:**

- CHF patients who discharge to home do not have a local option for cardiopulmonary rehabilitative services.

- **Rationale:**

- PCMH has identified project option:

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

Required core project components:

- a) Design and implement care teams that are tailored to the patient's healthcare needs, including non-physician health professionals.
- b) Ensure that patients can access their care teams in person or by phone or email.
- c) Increase patient engagement, such as through education, etc.
- d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their conditions.
- e) Conduct quality improvement for project using methods such as rapid cycle improvement.

As supported in 2.2, almost half of all Americans live with a chronic condition. That number is expected to increase by more than 1 percent per year by 2030. As a result, healthcare must come up with innovative and nonrestrictive ways to help combat these staggering odds. PCMH will strive to do this by becoming proactive as opposed to being reactive when it comes to chronic cardiac related illnesses and conditions. We will do so by utilizing the Chronic Care Model for Improving Chronic Illness Care. In doing so, we can address Community Needs Assessment 009 for Region 13 which is access to specialty care.

#### **Quality Improvement Component:**

PCMH will apply best practices as we work towards continuous quality improvement throughout the program years. We also plan on forming learning collaboratives with providers in Odessa and Midland since many people in our community see specialists from these cities. This way, we can communicate with other providers and share best practices, breakthrough ideas, challenges and solutions.

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

PCMH has selected OD-3 Potentially Preventable Readmissions:

The number of patients identified as needing screening tests, preventative tests, or other clinical services

Programs to assist patients to better self-manage their chronic conditions

Region's goals for overcoming barriers to accessing care as well as improving the quality of care delivered

- **Relationship to other Projects:**

PCMH projects interrelate with each other as shown in 1.1 and 2.2, expanding primary care capacity by establishing more clinics and by redesigning the outpatient delivery system to coordinate care for patients with chronic diseases. This will allow us to expand clinic space and hours (1.1 P-1) and implement a community/school-based clinics program (1.1 P-2) and expand the hours of a primary care clinic, including evening and/or weekend hours (1.1 P-4) which will result in increased primary care clinic volume of visits and evidence of improved access for patients seeking services (1.2.1). This, in turn, will help patients receive care for chronic conditions (2.2 P-9) as well as develop

and implement programs to assist patients to better self-manage their chronic conditions (2.2 P-11). This will result in an improvement of the percentage of patients with self-management goals (I18.1) as well as improvement in access to care of patients receiving chronic care management services (I21.1).

- **Project Valuation:**

By providing access to specialty care through redesigning the outpatient delivery system to coordinate care for patients with chronic diseases, we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings. We will provide the other 80% of Pecos County cardiac patients who do not follow up with cardiopulmonary rehabilitation. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. The project seeks to establish a cardiopulmonary program with 2 FTE's. This program will include monitored exercise routines as well as psychosocial and nutritional education. We expect to begin seeing patients in DY2 and plan to have at least 5 patients for this year with an increase in PCMH Cardiopulmonary patients in DY3, DY4, and DY5 to 10, 15, and 20 patients respectively. We propose a valuation of \$ \$198,671 per measure which is supported by the community need for access to quality specialty care, the aging population served, the cost factors and barriers to find providers for frontier counties and local funding which will support this initiative.

<b>NEW 130616905.2.3</b> <b>OLD 130616905.2.1</b>	<b>2.2.1</b>	<b>2.2.1.A,B,C,D,E</b>	<b>2.2 EXPAND CHRONIC CARE MANAGEMENT MODELS</b>	
<i>Pecos County Memorial Hospital</i>			<i>130616905</i>	
<b>OD-3</b>	<i>New 130616905.3.8</i> <i>New 130616905.3.9</i> <i>New</i> <i>130616905.3.10</i> <i>Old 130616905.3.2</i> <i>Old 130616905.3.3</i> <i>Old 130616905.3.4</i>	<i>IT.2.2.</i>	<i>IT-3.2 CHF 30 day readmission rate, IT-3.6 CAD 30 day readmission rate, IT-3.9 COPD 30 day readmission rate</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>		<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Milestone 1</b> P-1. Milestone: Expand the Chronic Care Model to primary care clinics. P-1.1 Metric: Increase number of primary care clinics using the Chronic Care Model. Baseline/Goal: Establish cardiopulmonary program.  Data Source: Documentation of practice management.  Milestone 1 Estimated Incentive Payment (maximum amount): \$199,237  Add more milestones and metrics as applicable	<b>Milestone 3:</b> P-9. Milestone: Develop program to identify and manage chronic care patients needing further clinical intervention. P-9.1 Metric: Increase the number of patients identified as needing screening test, preventative tests or other clinical services. Baseline/Goal: Increase number of referrals of patients to 10  Data Source: HER, patient registry  Milestone 3 Estimated	<b>Milestone 5:</b> P-6.Milestone: implement redesign of rehabilitation delivery model that is tailored to care setting. P6.1.Metric: Redesigned rehabilitation delivery model. Goal: Documentation of program elements. Data Source: Program materials.  Milestone 5 Estimated Incentive Payment: \$217,989  <b>Milestone 6:</b> P-11.Milestone: Develop and implement program to assist patient to better self-manage	<b>Milestone 7:</b> I-20 Milestone: Redesign Rehabilitation Delivery Model I-20.1 Metric 1: Maintain or improve (case-mix adjusted) 3-month Functional Independence Measure (FIM) Follow-up scores Goal: increase patient volume to 20  Data Source: Documentation of target population reached, as designated in the project plan;  Milestone 7 Estimated Incentive Payment: \$360,155	

<b>NEW 130616905.2.3</b> <b>OLD 130616905.2.1</b>	<b>2.2.1</b>	<b>2.2.1.A,B,C,D,E</b>	<b>2.2 EXPAND CHRONIC CARE MANAGEMENT MODELS</b>	
<i>Pecos County Memorial Hospital</i>			<i>130616905</i>	
<b>OD-3</b>	<i>New 130616905.3.8</i> <i>New 130616905.3.9</i> <i>New</i> <i>130616905.3.10</i> <i>Old 130616905.3.2</i> <i>Old 130616905.3.3</i> <i>Old 130616905.3.4</i>	<i>IT.2.2.</i>	<i>IT-3.2 CHF 30 day readmission rate, IT-3.6 CAD 30 day readmission rate, IT-3.9 COPD 30 day readmission rate</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<b>Milestone 2</b> P-2. Milestone: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care. P-2.1 Metric: Increase percent of staff trained. Baseline/Goal: Hire and train staff to begin cardiopulmonary rehabilitation department. Data Source: HR training program materials.  Milestone 2 Estimated Incentive Payment (maximum	Incentive Payment (maximum amount): \$217,357  Add more milestones and metrics_as applicable  <b>Milestone 4:</b> I-18 Milestone: Improvement of percentage of patients with self-management goals. I18.1 Metric: Patients with self-management goals. Baseline/Goal: Increase number of patients using program tools by 5% from Year 2 Data Source: Registry	their chronic conditions. P-11.1Metric: Increase the number of patients enrolled in a self-management program. Goal: Documentation of program elements; increase number of patients to 15 Data Source: HER, patient registry, class enrollment and attendance records.  Milestone 6 Estimated Incentive Payment: \$217,989		

<b>NEW 130616905.2.3</b> <b>OLD 130616905.2.1</b>	<b>2.2.1</b>	<b>2.2.1.A,B,C,D,E</b>	<b>2.2 EXPAND CHRONIC CARE MANAGEMENT MODELS</b>	
<i>Pecos County Memorial Hospital</i>			<i>130616905</i>	
<b>OD-3</b>	<i>New 130616905.3.8</i> <i>New 130616905.3.9</i> <i>New</i> <i>130616905.3.10</i> <i>Old 130616905.3.2</i> <i>Old 130616905.3.3</i> <i>Old 130616905.3.4</i>	<i>IT.2.2.</i>	<i>IT-3.2 CHF 30 day readmission rate, IT-3.6 CAD 30 day readmission rate, IT-3.9 COPD 30 day readmission rate</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
amount): \$199,237	Milestone 4 Estimated Incentive Payment: \$217,357			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$398,474	Year 3 Estimated Milestone Bundle Amount: \$434,714	Year 4 Estimated Milestone Bundle Amount: \$435,978	Year 5 Estimated Milestone Bundle Amount: \$360,155	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over DYs 2-5): \$1,629,321</i>				

## Summary Information

*Performing Provider: Pecos County Memorial Hospital*

*Pass3 Project*

*Project Unique ID #: 130616905.2.2*

- Provider: Pecos County Memorial Hospital is a 27-bed hospital in Fort Stockton, Texas serving a 4,764 square mile area and a population of approximately 8,300. There are approximately 1,462 students enrolled in the Fort Stockton ISD/Buena Vista ISD.
- Intervention(s): This project will implement a Coordinated Approach to Child Health (CATCH) program to the students in Pecos County at risk in the rising epidemic of childhood obesity.
- Need for the project: In Texas, one in three children over the age of 5 is considered obese, according to the CDC. Obesity can result in long-term health issues such as diabetes, heart disease, and high blood pressure.
- Medicaid and Uninsured Target population: The target population for this program is students residing within Pecos County. This project will potentially serve up to 4 schools and approximately 1,340 students. The program will likely impact the students' families as well. Approximately 50% of the population in these school districts are either Medicaid eligible or indigent, so we expect that half of the population targeted will benefit from this program.
- Category 1 or 2 expected patient benefits: The overall goals of this program are to provide students, teachers, and parents with the equipment, training, and resources necessary for students to develop lifelong healthy habits. Baselines will be determined in DY3.
- Category 3 outcomes: IT-10.1 Our goal is to demonstrate improvement in quality of life (QOL) scores in DY4 and DY5 as measured by evidence based and validated assessment tools for the target population.

### Pass 3

#### Category 2: Innovation and Redesign

#### Project Option: 2.6 Implement Evidence-based Health Promotion Programs

- **Project Title:** CATCH® in Motion
- **Unique Project ID Number:** 130616905.2.2
- **Performing Provider Name/TPI:** Pecos County Memorial Hospital/130616905

#### Project Description:

Obesity is a rising epidemic across the United States. According to the CDC, almost one in five children over the age of 5 is obese. Compared to the national average, one in three children is obese in Texas. Obesity can result in long-term health concerns considering most children that are obese grow up to be obese adults with serious health issues. Some of these health issues include high blood pressure, heart disease, diabetes and some cancers<sup>26</sup>. By focusing on interventions at an early age, children can be reached before becoming overweight or obese. For children that are already overweight or obese, these interventions could prevent them from becoming overweight or obese adults. These interventions can have a greater impact during childhood which would lead to a healthier and more productive future.

Pecos County Memorial Hospital will contract with Shannon Medical Center to perform the services under this proposed project. Pecos County Memorial Hospital is considered one of the piloted programs to determine best practices and lessons learned under this proposed project for Region 13. This project will be considered for regional expansion if potential funds become available under the 1115 waiver.

#### Project Goals:

Childhood obesity can be effectively treated and reduced by learning healthier habits and daily routines. Children spend the majority of their day at school making school an ideal place for interventions targeting healthy behaviors to occur. Coordinated Approach to Child Health (CATCH®) is a Texas Education Agency (TEA) recognized, evidence-based program designed to promote physical activity and healthy habits. By integrating healthier habits as a child into everyday life, individuals are more likely to establish positive behavior changes that last a lifetime.

Demonstration Year 2 will consist of planning processes to determine the needs in the schools and/or community-based organizations located in Pecos County, so the program can be tailored to specifically meet the needs of the community. During this process, Shannon will speak with school administrators, school teachers and staff, community leaders, pediatricians, dieticians, and experts in childhood obesity on assessment tools and curriculum to determine the most adequate resources to use for implementation. CATCH® curriculum is available for Pre-Kindergarten, elementary, and middle school children, so the assessment will determine which age group has the greatest need and will benefit most from this intervention.

Based on the National Heart, Lung, and Blood Institute's research in the Child and Adolescent Trial for Cardiovascular Health, the CATCH® in Motion program was designed to assist elementary schools in coordinating complimentary school health efforts between physical

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<sup>26</sup> [www.dshs.state.tx.us](http://www.dshs.state.tx.us)

education teachers, classroom teachers, food and nutrition services staff, school counselors, and school nurses. The CATCH® in Motion program will potentially serve 7 schools and approximately 1,600 students in Pecos County. In school, it is reported that obesity increases absenteeism, lowers academic performance, and takes an emotional toll on children. By collaborating with children, families, schools, hospitals, and communities there is great potential to improve health outcomes and quality of life for children in Region 13.

**Relationship to Regional Goals:**

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting healthcare resources in the healthcare system. With defined target populations, such as children, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

**Challenges:**

A challenge with this proposed project is engaging the secondary population consisting of parents, teachers, and staff. Parent involvement and support, as well as buy in from the teachers and staff has the potential to be a challenge since parents and teachers have a major influence on children’s health to make healthier, and more active decisions. Another challenge could be to show measurable improvement in behavior change over a short period of time (the 5 year waiver period).

**5 Year Expected Outcomes:**

Because health habits are established at an early age, it is essential to help students develop lifelong healthy habits. The overall goals of this program are to: 1) provide students, teachers, and parents with the equipment, training, and resources necessary for students to develop lifelong healthy habits, 2) for children to participate in at least 150 minutes amount of moderate to vigorous physical activity per week (MVPA), 3) develop healthy eating habits, and 4) maintain sustainability of the program after the waiver period.

**Starting Point/Baseline:**

Baselines will be determined in Demonstration Year 3

**Project Components:**

2.6.4 Other project option: Implement other evidence-based project to implement the project options above

**Unique Community Need Identification Number**

Pecos County Memorial Hospital will address CN-003, one in three Texas children is overweight or obese, to meet the goals set by Texas Health and Human Services Commission to

ensure the innovation of the healthcare delivery system will improve the cost effectiveness of care.

**Rationale:**

Childhood obesity is a preventable condition where prevention is significantly cheaper than the healthcare costs associated with children becoming obese adults. Individuals who are obese throughout childhood have a higher likelihood of remaining obese throughout adulthood which means these individuals suffer the consequences of obesity over many years of their lives. Research suggests that when children become obese adults their medical costs are 42% higher than for normal-weight adults.<sup>27</sup> According to Abigail Arons in Childhood Obesity in Texas: The Costs, The Policies, and a Framework for the Future, “upstream” interventions are more feasible approaches to reducing childhood obesity. “Upstream” interventions focus on the root cause of obesity compared to a “downstream” intervention such as medical treatment because it treats obesity after it has occurred. By focusing on the factors that cause obesity, upstream strategies implement effective use of resources to prevent and reverse obesity in the broader population of children<sup>28</sup>.

According to CATCH<sup>®</sup> research and development, a cost-effectiveness study reports the program cost-effectiveness ratio was \$889.68 and net benefit was \$68,125 (comparison of the present value of averted future costs with the cost of the CATCH<sup>®</sup> intervention). An independent review article in Health Affairs reports, the most cost-effective way to prevent obesity in youth is the Coordinated Approach to Child Health (CATCH<sup>®</sup>), a comprehensive intervention to promote healthy eating and physical activity in elementary schools, which costs \$900 per quality-adjusted life year (QALY) saved.<sup>29</sup>

During childhood, research suggests the most expensive obesity-related costs are due to hospitalization. In addition, the cost of hospitalizing children that are obese is higher than the cost of hospitalizing a normal-weight child. For example, children hospitalized with a secondary diagnosis of obesity have 29% higher costs for asthma and 26% higher costs for pneumonia than children with the same primary diagnosis but without a secondary diagnosis of obesity.<sup>30</sup>

**Required Quality Improvement (QI) Component:**

In forming a learning collaborative with Shannon Medical Center, PCMH can apply best practices in continuous quality improvement with this project; especially, since Shannon already has a CATCH<sup>®</sup> program in place. This project will allow both providers in assisting our communities with achieving and sustaining success in battling childhood obesity.

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

This proposed project represents a new initiative of implementing CATCH<sup>®</sup> in Motion to Pecos County. This program will address the rising epidemic of childhood obesity to educate

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<sup>27</sup> (Arons, 2011)

<sup>28</sup> (Arons, 2011)

<sup>29</sup> [www.catchinfo.org](http://www.catchinfo.org)

<sup>30</sup> (Arons, 2011)

children, parents, and the community of the importance of developing healthy habits at an early age. Considering obesity is preventable, this initiative can positively impact daily lifestyles and eliminate lifelong consequences for children and their families.

### **Related Category 3 Outcome Measure(s)**

OD-10 Quality of Life; IT-10.1 Quality of Life (standalone measure)

### **Rationale for Selecting Outcome measure:**

Considering this project will be implemented in the schools, Quality of Life will be assessed using a validated assessment tool that will be determined throughout the project planning in demonstration year 2. The importance of quality of life in children is essential to daily life as children grow older. By working with children, there is the opportunity to develop lifestyle and behavior changes that will impact the quality of their lifetime.

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

This proposed project of CATCH® in Motion is Regional project within Region 13. Heart of Texas Memorial Hospital and Pecos County Memorial Hospital are the initial Performing Providers through a subcontract with Shannon Medical Center to assess, plan, and implement this evidence-based health promotion program. Pecos County Memorial Hospital will serve the students in Pecos County only. There are approximately 1,341 students attending the public schools targeted for this program in Pecos County. This project will be considered for expansion if potential funds become available under the 1115 waiver to additional Performing Providers in Region 13.

### **Plan for Learning Collaborative**

Because individuals, institutions, needs, and resources differ from community to community, no two approaches are expected to look exactly alike. Each new setting will bring together a unique group of people to determine the specific needs facing young people in their schools and build on the many resources that are already in place to support positive youth development and healthy behaviors.<sup>31</sup> A learning collaborative will take place between Pecos County Memorial Hospital and the school districts located in Pecos County to determine the greatest needs and resources for program implementation. In addition, learning collaboratives will take place across Region 13 to determine best practices and lessons learned to reduce childhood obesity and related health complications.

### **Project Valuation:**

Abigail Arons reviewed the following data in 2011 of hospital costs in Texas. According to her review, by 2005 obesity-related hospital costs for children were approximately \$237.6 million per year. One study estimates that the cohort of obese children in the U.S. who were twelve years old in 2005 would incur \$6.24 billion dollars over their lifetime, in direct medical

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<sup>31</sup> [www.tea.state.tx.us](http://www.tea.state.tx.us)

expenditures alone.<sup>32</sup> This data suggests that a reduction in obesity among children has huge cost-saving potential for individuals facing obesity, as well as hospitals.

The valuation methodology for this proposed project was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. After considering the collaboration efforts of Heart of Texas and Shannon, the valuation methodology, and the needs of the community, the project value was determined based on the available pass 2 allocation.

By reviewing this data and taking the valuation methodology into account, Pecos County Memorial Hospital and Shannon determined the valuation for this proposed project. The valuation of this proposed project includes many factors including the significance of cost-savings for the hospital, training teachers, administration, and staff, possible incentives for program implementation, and the resources needed for implementation. Planning and an assessment will take place to determine the needs of Pecos County. At this time, the assessment tool will be determined and the corresponding evaluation team from The University of Texas Health Science Center will assist in training for future implementation. CATCH® curriculum training will take place for all of the involved staff members that will be incorporating the intervention. The option of stipends for Campus Champions will be determined to incentivize the CATCH® in Motion representatives in the schools.

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<sup>32</sup> (Arons, 2011)

130616905.2.2	2.6.4 Other	CATCH® in Motion	
Pecos County Memorial Hospital			130616905
OD-10	130616905.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<p><b>Milestone 1</b> P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community</p> <p><u>Metric 1</u> P-2.1: Documentation of innovational strategy and plan</p> <p><u>Goal</u>: Determine the target population and needs of the community</p> <p><u>Data Source</u>: Performing Providers evidence of innovational plan</p> <p>Milestone 1 Estimated Incentive Payment: \$659,216</p>	<p><b>Milestone 2</b> I-8: Increase access to health promotion programs and activities using innovative project option</p> <p><u>Metric 1</u> I-8.1: Increase percentage of target population reached by the innovative project</p> <p><u>Numerator</u>: Number of individuals of target population reached by the innovative project</p> <p><u>Denominator</u>: number of individuals in the target population</p> <p><u>Baseline/Goal</u>: Demonstration Year 2; Determine target population based on greatest need; approximately 39 in Head Start, 119 in grades 4<sup>th</sup> &amp; 5<sup>th</sup>, and 285 in grades pre-k</p>	<p><b>Milestone 3</b> P-5: Execution of evaluation process for project innovation</p> <p><u>Metric 1</u> P-5.1 Document evaluative process, tools, and analytics</p> <p><u>Goal</u>: Implement assessment tool to survey children in target population</p> <p><u>Data Source</u>: Performing Provider contract or other documentation of implementation TBD by Performing Provider</p> <p>Milestone 3 Estimated Incentive Payment: \$390,563</p> <p><b>Milestone 4</b> I-8: Increase access to health promotion programs and activities using innovative project option</p> <p><u>Metric 1</u> I-8.1: Increase percentage of target</p>	<p><b>Milestone 5</b> 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 agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</p> <p><u>Metric 1</u> P-8.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p><u>Goal</u>: Participate in 2 face-to-face meetings per year to</p>

130616905.2.2	2.6.4 Other		CATCH® in Motion	
Pecos County Memorial Hospital			130616905	
OD-10	130616905.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
	through 3 <sup>rd</sup> . <u>Data Source:</u> Documentation of target population reached, as designated in the project plan  Milestone 2 Estimated Incentive Payment: \$769,777	population reached by the innovative project <u>Numerator:</u> Number of individuals of target population reached by the innovative project <u>Denominator:</u> Number of individuals in the target population <u>Goal:</u> 5% increase over baseline <u>Data Source:</u> Documentation of target population reached, as designated in the project plan  Milestone 4 Estimated Incentive Payment: \$390,564	discuss best practices <u>Data Source:</u> Documentation of semiannual meetings including meeting agendas, slides from the presentations, and/or meeting notes  Milestone 5 Estimated Incentive Payment: \$334,955  <b>Milestone 6 I-8:</b> Increase access to health promotion programs and activities using innovative project option <u>Metric 1 I-8.1:</u> Increase percentage of target population reached by the innovative project <u>Numerator:</u> Number of individuals of target population reached by the innovative project <u>Denominator:</u> Number of	

130616905.2.2	2.6.4 Other	CATCH® in Motion	
Pecos County Memorial Hospital			130616905
OD-10	130616905.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
			individuals in the target population <u>Goal:</u> 10% increase over baseline <u>Data Source:</u> Documentation of target population reached, as designated in the project plan  Milestone 6 Estimated Incentive Payment: \$334,956
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$659,216	Year 3 Estimated Milestone Bundle Amount: \$769,777	Year 4 Estimated Milestone Bundle Amount: \$781,127	Year 5 Estimated Milestone Bundle Amount: \$669,911
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$2,880,031			

*Schleicher County Hospital Summary Information:*

- Provider: Schleicher County Medical Center Hospital is a 14-bed Critical Access Hospital (CAH) located in Eldorado serving the 1,311 square mile area of Schleicher County with a population of approximately 3,461.
- Intervention(s): The PCMH project in Schleicher County will be based on emphasizing the central importance of primary health care and the promotion of more patient-centered care based on:
  - Convenience
  - Continuity
  - Coordination
  - Comprehensive Care
  - Culture
- Need for the project: Primary and preventative care can be provided in a far less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care.
- Target population: Schleicher has a high number of dual eligible Medicare and Medicaid patients and an ever-growing number of aging persons. County data also reveals that Schleicher has a higher Hispanic population percentage as compared to the state as a whole. The United States Department of Health and Human Services cites cultural barriers and a lack of access to preventive care as characteristics shaping Hispanic health. These hurdles have led to higher rates of uninsured, obese and diabetics within the county.
- Category 1 or 2 expected patient benefits: The PCMH brings care and treatment to a level of proactive response in promoting higher standards of community health through preventative care. Creation of the PCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider
- Category 3 outcomes: IT-9.2 The goal in PCMH development is a multi-year transformational effort as an innovative way to deliver care. By providing the right care at the right time and in the right setting, over time, patients in Schleicher County will hopefully see their overall health improve, and cut costly ED visits 10% by DY5.

**Identifying Project and Provider Information:**

Patient Centered Medical Home Implementation, 2.1.4 - readiness preparations and the establishment of a medical home to more appropriately deliver primary health care to the residents of Schleicher County.

Pass3B

NEW: 179272301.2.2

OLD: 179272301.2.1

Schleicher County Medical Center TPI: 179272301

**Project Description:**

Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

The proposed Patient-Centered Medical Home (PCMH) clinic model for Schleicher County will be based on emphasizing the central importance of primary health care. As a 'home base,' patients of all ages will have direct access to a personal health care provider. A primary care provider's direct and trusted rapport with patients, paired with a depth and breadth of clinical training across body systems, uniquely position them to assess an individual's health needs and to tailor an individualized care plan. This relationship is intended to promote provider directed medical practice and ultimately enhance access to care, assure quality and safety and promote comprehensive care coordination.

Emergency Department (ED) utilization has continued to rise across the nation and especially in rural areas. Schleicher has experienced the same increase. High ED utilization is a considerable concern as it correlates to the increasing cost of health care. Frequent and inappropriate use of hospital EDs is extremely costly. Primary and preventative care through the PCMH can be provided in a far less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care. Schleicher Hospital views the decreasing of unnecessary emergency room visits through the implementation of the PCMH as an innovative approach to community education and access to information, reduce healthcare costs and tackle health disparities in the county.

The following are primary goals of expanding and enhancing clinical care delivery to the underserved and undereducated Schleicher County population will be provided through:

**Convenience** - The PCMH is an accessible point of entry into the health care system each time new care is needed.

- Simplified appointment scheduling
- Reduced wait times
- Expanded hours
- Acceptable opportunities for patients to communicate with personal physician and office staff

**Continuity** - Each patient has an ongoing relationship with a personal provider.

- Each patient has an identifiable primary care clinician for ongoing care
- Patient is able to make appointments with that particular clinician
- Discussion about PCMH role and expectations with the patient
- Discussion between personal physician and patient on the roles and expectations for the medical home
- Person-focused (not just disease specific) care over time.
- Registry of patients into the PCMH database
- Complete medical records are retrievable and accessible

**Coordination** – Care plan arrangement alternatives across all domains of the health care system.

- Synchronize care patients receive from other providers (e.g. specialists, hospitals, home health agencies)
- Referral tracking and follow up

**Comprehensive Care** – A medical home for all stages of life from preventive services to end-of-life care.

- Planned visits
- Patient registry enabling searches for particular conditions and characteristics
- Range of services offered
- Physician directed practice with a team that taking collective responsibility for ongoing patient care

**Culture** – Implementation and staff education on systems creating an environment focused on quality and safety

- Decision making guided by evidence-based medicine and decision-support tools
- Quality improvement efforts
- Patients participate in decision-making
- Patient feedback is sought to ensure expectations are met

Under this model, patients not only develop a direct relationship with their primary care provider, but also are backed by a clinical care team who service the individualized needs of each patient. This team might include physicians, midlevel providers, pharmacists, nurses, medical assistants, volunteer patient advocates, educators, and personal care coordinators. As

a small rural practice, the ultimate goal will be building an integrated team through networking and linking patients to providers and services in surrounding communities. A PCMH will essentially act as the hub of a comprehensive care network accountable for meeting the large majority of each patient's physical needs.

**Starting Point/Baseline Data (if applicable)**

As a PCMH does not currently exist in Schleicher County, implementation of a medical home is an ambitious undertaking that will require the reengineering and redesign of the existing primary clinic operated by the hospital. This practice-altering evolution will include new scheduling and access arrangements, new coordination planning, group visits, new ways to improve quality care, development of team-based care, multiple uses of healthcare information systems and training to assist providers educate their patients about the need for PCMH and the healthcare transformation process.

**Rationale:**

Schleicher County Medical Center currently operates a Rural Health Clinic with a yearly encounter rate of approximately 3,700 per year. Within this patient pool, Schleicher County has a high number of dual eligible Medicare and Medicaid patients and an ever-growing number of aging persons. County statistics reveal that 13.5% of the population is above the age of 65. This is clearly above the 10.5% state average. (U.S. Census Bureau, 2011). The United States Department of Health and Human Services cites cultural barriers and a lack of access to preventive care as characteristics shaping Hispanic health. These hurdles have led to higher rates of uninsured, obese and diabetics within the county.

The primary 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. By providing the right care at the right time and in the right setting, over time, patients will hopefully see their health improve, rely less on costly ED visits and incur fewer avoidable hospital stays.

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

OD-9 Right Care Right Setting: IT-9.2 ED appropriate utilization – Reduce overall visits by 5% over established DY2 baseline by end of DY5

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. Although major evaluations of the PCMH are only now getting off the ground, there is an ever-growing body of data supported by research organizations spanning privately insured patients, Medicaid, SCHIP and Medicare beneficiaries, and the uninsured. The findings of these studies are starting to emerge in peer-reviewed journals and other publications demonstrating that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care.

Across diverse settings and patient populations, evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield an excellent return on investment in:

- Quality of care - patient experiences and satisfaction, care coordination, and access are demonstrably better.
- Strengthened primary care - within a relatively short time, reductions in emergency department visits and inpatient hospitalizations are realized producing savings in total costs. These savings at a minimum offset the new investments in primary care. In many cases initial investments appear to produce a reduction in total costs per patient.

**Relationship to other Projects:**

In category 4, PPCs and ED utilization should be impacted with the creation of a medical home.

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

N/A

**Plan for Learning Collaborative:**

RHP 13 plans to meet quarterly to discuss waiver operations and timelines during each year of the waiver. Leadership within the region has also discussed the possibility of having a yearly summit at varying locations to discuss regional issues and opportunities. These learning collaborative would focus on 4 to 5 regional needs and would allow for substantial interaction. Plans will be crafted during DY2.

**Project Valuation**

The PCMH brings care and treatment to a level of proactive response in promoting higher standards of community health through preventative care. Without the proper continuum of care, the Schleicher population often arrives at the ER for treatment. The creation of the PCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider.

Schleicher County Medical Center used a basic valuation tool to measure the efficacy of potential project. The tool was centered on the following questions:

- Does the project meet the waiver goals?
- Does the project address a pressing community need?
- Which population is being served?
- What is the project investment (Resources needed)?

After consulting and visiting with local stakeholders, the PCMH Project was deemed to be a top priority in strengthening the health delivery system of Schleicher County.

Pass3B NEW: 179272301.2.2 OLD: 179272301.2.1	<b>2.1</b>	<b>2.1.3</b>	Schleicher County Medical Home Feasibility and Implementation		
<i>Schleicher County Medical Center</i>			179272301		
<b>Related Category 3 Outcome Measure(s):</b>	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1	<i>IT-9.2</i>	<i>Right care, right setting</i>		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)		
<b>Milestone 1:</b> P-6. Establish criteria for medical home assignment <b>Metric 1:</b> P-6.1. Medical home assignment criteria a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of primary care clinics <b>Baseline/Goal:</b> 0 PCMH in Schleicher County at December 2011. Goal is Establishment of a referral program and process to Medical Advocacy Services	<b>Milestone 3:</b> P-1. Milestone: Implement the medical home model in primary care clinics P-1.1. Metric: Increase number of primary care clinics using medical home model a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of primary care clinics  Baseline/Goal: 0 PCMH in Schleicher County at December 2011. Goal to increase number of primary care clinics using the	<b>Milestone 5</b> P-11: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. <b>Metric 1</b> P-11.1]: Goal: Contact 60% of patients for select specific preventive services to remind them to come in for service. Data Source: Registry  Milestone 4 Estimated Incentive Payment: \$46,236	<b>Milestone 5</b> I-17 <b>Metric 1</b> I-17.1: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes  Goal: Increase patients that are identifying their usual source of care to being managed by a medical home by 50% Data Source: Patient survey		

Pass3B NEW: 179272301.2.2 OLD: 179272301.2.1	<b>2.1</b>	<b>2.1.3</b>	Schleicher County Medical Home Feasibility and Implementation	
<i>Schleicher County Medical Center</i>			179272301	
<b>Related Category 3 Outcome Measure(s):</b>	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1	<i>IT-9.2</i>	<i>Right care, right setting</i>	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
for Healthcare and Medicaid eligibility assistance program. <b>Data Source:</b> Submission of medical home assignment criteria, such as patients with specified chronic conditions; patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high users of health care services; and patients with particular socio-economic, linguistic, and physical needs.	PCMH model.  Data Source: Submission of data supporting the implementation of a patient centered medical home in the clinic space. Referral program data base.  Milestone 3 Estimated Incentive Payment: \$23,049  <b>Milestone 4:</b> P-11: Identify current utilization rates of preventive services and implement a system to		Milestone 5 Estimated Incentive Payment: \$38,195	

Pass3B NEW: 179272301.2.2 OLD: 179272301.2.1	<b>2.1</b>	<b>2.1.3</b>	Schleicher County Medical Home Feasibility and Implementation	
<i>Schleicher County Medical Center</i>			179272301	
<b>Related Category 3 Outcome Measure(s):</b>	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1	<i>IT-9.2</i>	<i>Right care, right setting</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Evidence of referral program process.  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$21,131  <b>Milestone 2:</b> P-6. Put in place policies and systems to enhance patient access to the medical home . Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between	improve rates among targeted population <u>Metric 1</u> P-11.1 Baseline/Goal: Baseline of no current determination of utilization rates among targeted population with a goal of determining utilization rates of preventive services and improving them by 5%. Data Source: Patient registry or electronic medical records.  Milestone 4 Estimated			

Pass3B NEW: 179272301.2.2 OLD: 179272301.2.1	<b>2.1</b>	<b>2.1.3</b>	Schleicher County Medical Home Feasibility and Implementation	
<i>Schleicher County Medical Center</i>			179272301	
<b>Related Category 3 Outcome Measure(s):</b>	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1	<i>IT-9.2</i>	<i>Right care, right setting</i>	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
patients, their personal physician, and practice staff. <b>Metric 1:</b> P-6.1 Increase number of primary care clinics using medical home model a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of primary care clinics <b>Baseline/Goal:</b> 0 PCMH in Schleicher County at December 2011. Goal is to implement PCMH Model in the existing clinic.	Incentive Payment: \$23,048			

Pass3B NEW: 179272301.2.2 OLD: 179272301.2.1	<b>2.1</b>	<b>2.1.3</b>	Schleicher County Medical Home Feasibility and Implementation	
<i>Schleicher County Medical Center</i>			<i>179272301</i>	
<b>Related Category 3 Outcome Measure(s):</b>	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1	<i>IT-9.2</i>	<i>Right care, right setting</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>Data Source:</b> Submission of medical home assignment criteria, such as patients with specified chronic conditions; 17 patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high utilizers of health care services; 18 and patients with particular socio-economic, linguistic, and physical needs; 19 Performing Provider policies and procedures or other similar				

Pass3B NEW: 179272301.2.2 OLD: 179272301.2.1	<b>2.1</b>	<b>2.1.3</b>	Schleicher County Medical Home Feasibility and Implementation	
<i>Schleicher County Medical Center</i>			<i>179272301</i>	
<b>Related Category 3 Outcome Measure(s):</b>	Pass3B NEW: 179272301.3.2 OLD: 179272301.3.1	<i>IT-9.2</i>	<i>Right care, right setting</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
documents  Milestone 2 Estimated Incentive Payment: \$21,131				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$42,262	Year 3 Estimated Milestone Bundle Amount: \$46,097	Year 4 Estimated Milestone Bundle Amount: \$46,236	Year 5 Estimated Milestone Bundle Amount: \$38,195	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$172,790</b>				

**Add additional projects using same format above**

## **Summary Information**

**Performing Provider: Shannon Medical Center**

**Pass 1 Project: Patient Experience**

**Project Unique ID #: 137226005.2.1**

Provider: Shannon West Texas Memorial Hospital, a non-profit health system established in the 1930's, is the only safety net hospital in Region 13, and provides the communities of West Central Texas with a variety of medical services. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust. Dedicated to the region's health and well-being, the medical center offers diverse clinical services, including a nationally-recognized cardiac care program, nationally-recognized ICU, the region's only Level III Trauma Facility and AirMed 1 air ambulance serving a 200-mile radius of San Angelo, and a dedicated Women's & Children's Hospital which is home to the Children's Miracle Network. Shannon Medical Center is a 409-bed safety net hospital located in Tom Green County. Shannon Clinic is a Physician Group made up of more than 250 Physicians. The estimated population for Shannon's service area as of 2011 including Tom Green County, is 288,304. (*U.S. Census Bureau, State & County Quickfacts*)

Intervention(s): The primary focus will be patient-centered care that will have a positive impact on patient education, patient experience, and patient communication with staff. Initially, work has been accomplished to develop and implement hourly rounding, management rounding, bedside reports, and communication boards.

Need for the project: Given the association between patient perceptions and better outcomes, research suggests that patient-centered care can be used to assess the degree to which patients will be more likely to experience better health outcomes.

Medicaid and Uninsured Target population: The target population for this project is all patients. Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid and uninsured patient encounters.

Category 1 or 2 expected patient benefits: With improved patient experience, our patients likely have better access to care and are better able to be engaged in and take shared responsibility with staff and providers for managing chronic conditions and improving chronic disease outcomes. HCAHPS will be reviewed monthly by hospital administrators and management so that all staff can be informed, engaged, and accountable for improving patient experience. Shannon anticipates serving all patients at Shannon Medical Center and Shannon Clinic by implementing processes and quality improvements to improve patient experience. Shannon expects to impact at least 300,000 patient encounters through clinic visits and 80,000 patient encounters through inpatient and outpatient volumes at the hospital. By incorporating

patient-centered care into the goals of this project, Shannon seeks to impact a total of 380,000 patient encounters.

Category 3 outcomes: IT-6.1 The goal is to increase patient satisfaction through doctor communication with the patients and focus on patient-centered care to improve the overall patient experience.

## **Category 2: Innovation and Redesign**

### **Project Option: 2.4 Redesign to Improve Patient Experience**

- Project Title: Patient Experience
- Unique Project ID Number: 137226005.2.1
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Project Description:**

Shannon Medical Center proposes under the 1115 Waiver to Redesign Patient Experience. At Shannon Medical Center, we strive to improve and enhance the patient experience to deliver a positive overall experience with each patient encounter. Currently, we use Hospital Care Quality Information from the Consumer Perspective (HCAHPS) survey to measure the hospital care provided from the patient's perspective. It is an important initiative to make all patients feel not only cared for, but cared about.

#### **Project Goals:**

In this project, Shannon will appoint an executive and create a committee that will carry out a plan to improve the patient experience. The primary focus will be patient-centered care that will have a positive impact on patient education, patient experience, and patient communication with staff. Initially, work has been accomplished to develop and implement hourly rounding, management rounding, bedside reports, and communication boards. Further pending actions that will be added will be follow up discharge phone calls, as well as, the addition of more structure to recently implemented processes. Shannon Medical Center will focus to implement standards set by Institute for Healthcare Improvement to develop the patient-centered care model.

#### **Relationship to Regional Goals:**

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, projects support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting healthcare resources in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

#### **Challenges:**

An anticipated challenge will be the loss of gained knowledge through employee turnover. In order to maintain system-wide improvements, continual training will take place during new employee orientation and employee updates.

A potential challenge, related to all projects, is the impact of the Cline Shale oil boom. The impact to our area is expected to significantly hit hospitals, though no one has been able to project the actual magnitude of the growth we will experience. For this reason, Shannon cannot

predict how this will impact patients, staff, and other factors that could influence this project but we anticipate this will be a challenge to some degree.

**5 Year Expected Outcomes:**

At the end of the waiver period, Shannon expects to improve over baseline in patient satisfaction for all patients related to doctor communication. Throughout the waiver period, Shannon seeks to improve patient satisfaction by incorporating patient-centered care to relate to the goals of this project.

**Starting Point/Baseline:**

This proposed project has a baseline from July 1, 2011 through June 30, 2012. The data concludes that 75% of patients scored care in a range of 9 or 10 in HCAHPS scores.

**Project Components:**

Shannon has identified the following project options and will address all of the required components:

- 2.4.1 Implement processes to measure and improve patient experience
  - a) Organizational integration and prioritization of patient experience
  - b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
  - c) Implementing processes to improve patient’s experience in getting through to the clinical practice;
  - d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

**Unique Community Need Identification Number:**

Shannon Medical Center will address CN-008, Measuring Patient Satisfaction, to meet the goals set by Texas Health and Human Services Commission to ensure the innovation of the healthcare delivery system will improve the quality of care.

**Rationale:**

The Institute for Healthcare Improvement suggests that hospitals create and continuously improve meaningful and productive partnerships with patients and families. Shannon will use the IHI framework to design their efforts to improve the patient and family experience focusing on leadership, hearts and minds, respectful partnerships, reliable care, and evidence-based care. Evidence based patient centered care demonstrates improved patient compliance with follow up chronic treatment needs. With improved patient experience, our patients likely have better access to care and are better able to be engaged in and take shared

responsibility with staff and providers for managing chronic conditions and improving chronic disease outcomes<sup>33</sup>. Data suggests that hospitals that consider the patient's voice as a priority and focuses on integrating patient input into the delivery system of care will change the patients overall experience of care. HCAHPS will be reviewed monthly by hospital administrators and management so that all staff can be informed, engaged, and accountable for improving patient experience.

**Required Quality Improvements:**

Shannon doctors will receive training focused on communicating with patients and families in demonstration year 2 and 4 to improve patient satisfaction. Input from the Community Health Needs Assessment conducted by Shannon Medical Center will provide community and patient feedback as well as, key stakeholder perspective that will be used to implement strategic, quality improvements. Additionally, HCAHPS results will drive organizational strategies.

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

Currently a steering committee and formal program to enhance the patient experience is not available. Structure and training in both areas will assure continuity of programs that evolve from this process change.

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

OD-6 Patient Satisfaction; IT-6.1 Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure).

**Rationale for Selecting Outcome measure:**

Evidence based patient centered care demonstrates improved patient compliance with follow up chronic treatment needs. As identified in the needs assessment, RHP 13 has high rates of chronic diseases, such as diabetes, obesity, and heart disease. Management of these diseases could be positively impacted by enhancing doctor communication.

**Relationship to other Projects:**

A desired goal of improving patient experience is to improve customer/patient satisfaction. The underlying theme of patient centered care is carried through all of Shannon Medical Center's proposed projects. In addition, this project is connected to each of Shannon's proposed projects because patient centered care plays an important role in improving clinical outcomes, quality, and compliance.

- 1.1 Expand Primary Care Capacity (137226005.1.1)
- 2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency (137226005.2.1)
- 2.10 Use of Palliative Care Programs (137226005.2.3)

Related Category 4 measures include:

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<sup>33</sup> (Balik, Conway, Zipperer, & Watson, 2011)

- Potentially Preventable Admissions
- Potentially Preventable Readmissions – 30 days
- Potentially Preventable Complications
- Patient Centered Healthcare
- Emergency Department

**Relationship to Other Performing Providers’ Projects in the RHP:**

There is a relationship between Shannon with many Performing Providers in Region 13. Shannon sees approximately 40% of all patient encounters within its service area. As the only safety net hospital in RHP 13, Shannon chose to not use their full Pass 1 allocation to allow these funds to move to Pass 3B for the Anchor to redistribute to support more robust projects for rural providers in RHP 13. This initiates regional transformation to best meet the needs of Region 13.

**Plan for Learning Collaborative:**

There is no direct learning collaborative for this project considering Shannon is the only Performing Provider in Region 13 that is proposing to Redesign to Improve Patient Experience. However, as the safety net hospital for Region 13, Shannon looks forward to potentially hosting an annual face-to-face meeting to provide the opportunity for members of Region 13 to collaborate by sharing experiences and challenges regarding DSRIP projects. In addition, Region 13 plans to maintain the RHP 13 website with up-to-date information from HHSC and CMS, as well as, DSRIP project information.

**Project Valuation:**

Shannon used a valuation methodology that was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. Each project was weighted and compared to all of Shannon’s proposed projects to determine the valuation for each project.

According to IHI, evidence shows improved patient experience and involving patients in decision-making leads to improved health outcomes and shorter stays in the hospital. Because Shannon is the only safety net hospital for Region 13, the extent of this project reaches the broader regional population and addresses the community needs to improve patient satisfaction throughout Region 13.

The scope of this project will consist of reaching the entire staff of Shannon Medical Center and Shannon Clinic, which is made up of approximately 2000 employees. This project will impact all patient encounters at Shannon Medical Center and Shannon Clinic. Shannon will use various forms of technology and postings for communication to educate staff on patient satisfaction. In addition, the quality improvements in demonstration year 2 and 4 will specifically target Physicians to focus on doctor communication. Shannon anticipates serving all patients at Shannon Medical Center and Shannon Clinic by implementing processes and quality improvements to improve patient experience. Shannon expects to impact at least 300,000 patient encounters through clinic visits and 80,000 patient encounters through inpatient and outpatient volumes at the hospital. By incorporating patient-centered care into the goals of this project, Shannon seeks to impact a total of 380,000 patient encounters.

137226005.2.1	2.4.1	2.4.1.a, 2.4.1.b, 2.4.1.c, 2.4.1.d	Patient Experience
Shannon Medical Center	137226005		
OD-6	137226005.3.2	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Milestone 1</b> P-1: Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance  <u>Metric 1</u> P-1.1 : Documentation of an executive assigned responsibility experience performance  <u>Goal:</u> Appoint an executive  <u>Data Source:</u> Executives schedule/calendar</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$322,926.00</p> <p><b>Milestone 2</b> P-3: Establish</p>	<p><b>Milestone 4</b> P-4: Integrate patient experience into employee training  <u>Metric 1</u> P-4.1: Percent of new employees who received patient experience training as part of their new employee orientation  <u>Numerator:</u> percent of new employees who received patient experience training as part of their new employee orientation  <u>Denominator:</u> total number of new employees  <u>Goal:</u> Provide patient experience orientations and updates for at least 250 new employees  <u>Data Source:</u> Human Resource records for Shannon Medical Center and Shannon Clinic</p>	<p><b>Milestone 5</b> P-12: Implement and sustain at least one organizational strategy per year aimed at improving patient, family, and/or employee experience. These strategies must involve patients/families as partners in organizational quality improvement, development, and/or governance.  <u>Metric 1</u> P-12.1: Number of experience improvement initiatives conducted  <u>Goal:</u> Implement 1 QI plan per year that impacts at least 380,000 patient encounters (300,000 Shannon Clinic encounters and 80,000 Shannon Medical Center patient encounters)  <u>Data Source:</u> Documentation of strategy(ies) implemented</p>	<p><b>Milestone 7</b> P-5: Integrate patient and/or employee experience into management performance measures  <u>Metric 1</u> P-5.1: Documentation of specific patient and/or employee experience objectives into management work plans and measures of performance, such as internal quality controls or performance dashboard.  <u>Numerator:</u> 0 if no documentation is provided, 1 if documentation is provided  <u>Goal:</u> Implement performance measures into quality management that impacts at least 380,000 patient encounters (300,000 Shannon Clinic encounters and 80,000 Shannon Medical Center patient encounters)  <u>Data Source:</u> Performance report,</p>

137226005.2.1	2.4.1	2.4.1.a, 2.4.1.b, 2.4.1.c, 2.4.1.d	Patient Experience	
Shannon Medical Center	137226005			
OD-6	137226005.3.2	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. <u>Metric 1</u> P-3.1: Documentation of committee proceedings and list of committee members <u>Goal:</u> Appoint steering committee members <u>Data Source:</u> Meeting minutes, agendas, participant lists, and/or list of steering committee members	Milestone 4 Estimated Incentive Payment: \$ 1,076,885.00	Milestone 5 Estimated Incentive Payment: \$ 529,979.00  <b>Milestone 6</b> I-18: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families <u>Metric 1</u> I-18.1: Number of organization-wide displays (can be physical or virtual) about the organization’s performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. <u>Goal:</u> Inform staff of progress	reporting policies and procedures or division/unit/department work plans, documentation of incentive in employee performance plan  Milestone 7 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 437,808.00  <b>Milestone 8</b> P-13: Perform a mid-course evaluation of the results of improvement projects / Make necessary adjustments and continue with implementation <u>Metric 1</u> P-13.1 : Submission of evaluation results <u>Numerator:</u> 0 if evaluation results are not submitted, 1 if evaluation results are submitted <u>Goal:</u> Evaluate improvement projects and integrate findings into management performance measures to impact up to 380,000	

137226005.2.1	2.4.1	2.4.1.a, 2.4.1.b, 2.4.1.c, 2.4.1.d	Patient Experience	
Shannon Medical Center	137226005			
OD-6	137226005.3.2	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>Milestone 2 Estimated Incentive Payment: \$ 322,926.00</p> <p><b>Milestone 3 P-12:</b> Implement and sustain at least one organizational strategy per year aimed at improving patient, family, and/or employee experience. These strategies must involve patients/families as partners in organizational quality improvement, development, and/or governance</p> <p><u>Metric 1 P-12.1:</u> Number of experience improvement initiatives conducted</p> <p><u>Goal:</u> Implement 1 QI plan</p>		<p>through monthly management and quarterly medical staff meetings that will impact at least 380,000 patient encounters (300,000 Shannon Clinic encounters and 80,000 Shannon Medical Center patient encounters)</p> <p><u>Data Source:</u> Display and internal communication at Shannon Medical Center and Shannon Clinic</p> <p>Milestone 6 Estimated Incentive Payment: \$ 529,978.00</p>	<p>patient encounters (300,000 Shannon Clinic encounters and 80,000 Shannon Medical Center patient encounters)</p> <p><u>Data Source:</u> Evaluation write-up</p> <p>Milestone 8 Estimated Incentive Payment (<i>maximum amount</i>): \$ 437,809.00</p>	

137226005.2.1	2.4.1	2.4.1.a, 2.4.1.b, 2.4.1.c, 2.4.1.d	Patient Experience	
Shannon Medical Center	137226005			
OD-6	137226005.3.2	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
per year that targets Physician training that impacts at least 380,000 patient encounters (300,000 Shannon Clinic encounters and 80,000 Shannon Medical Center patient encounters) <u>Data Source:</u> Documentation of strategy(ies) implemented  Milestone 3 Estimated Incentive Payment: \$ 322,926.00				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$ 968,778.00	Year 3 Estimated Milestone Bundle Amount: \$ 1,056,885.00	Year 4 Estimated Milestone Bundle Amount: \$ 1,059,957.00	Year 5 Estimated Milestone Bundle Amount: \$ 875,617.00	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$ 3,961,237</b>				

## Summary Information

**Performing Provider: Shannon Medical Center**

**Pass 1 Project: Lean**

**Project Unique ID #: 137226005.2.2**

Provider: Shannon West Texas Memorial Hospital, a non-profit health system established in the 1930's, is the only safety net hospital in Region 13, and provides the communities of West Central Texas with a variety of medical services. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust. Dedicated to the region's health and well-being, the medical center offers diverse clinical services, including a nationally-recognized cardiac care program, nationally-recognized ICU, the region's only Level III Trauma Facility and AirMed 1 air ambulance serving a 200-mile radius of San Angelo, and a dedicated Women's & Children's Hospital which is home to the Children's Miracle Network. Shannon Medical Center is a 409-bed safety net hospital located in Tom Green County. Shannon Clinic is a Physician Group made up of more than 250 Physicians. The estimated population for Shannon's service area as of 2011 including Tom Green County, is 288,304. (*U.S. Census Bureau, State & County Quickfacts*)

Intervention(s): The project goals will include: 1) identifying delays, waste, and the problems they create in timely delivery of care, 2) the quality and safety of care, 3) patient and caregiver satisfaction, and 4) financial impacts. The process will identify opportunities to improve the process through a regimen of facilitated collaborative activities and just-in-time training of staff in continuous problem solving.

Need for the project: With more than 2,000 Shannon employees, there are gaps in knowledge and performance, inefficiencies, and waste in care processes. These gaps translate to increased expense and declining patient satisfaction. Shannon must implement change in an efficient and effective manner in order to accomplish this goal and secure its future for those it serves. To accomplish this, Shannon plans to implement Lean training in Lean Healthcare Concepts.

Medicaid and Uninsured Target population: The target population for this project is all patients. Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid and uninsured patient encounters.

Category 1 or 2 expected patient benefits: Lean provides tools and services for quality compliance monitoring, active point-of-care communication, and successful behavior modification. Redundancy in the process of health care delivery results in delays for the staff and patients of needed supplies, medication, and equipment. Shannon plans to implement two rapid improvement projects at Shannon Medical Center and one rapid improvement project at Shannon Clinic. Though the rapid improvement projects have not been selected because Shannon is still in the assessment phase, the two projects implemented at the hospital are expected to each impact at least 10,000 patient encounters and the one project at the clinic could impact up to 100,000 patient encounters.

Category 3 outcomes: IT-6.1 Evidence-based patient-centered care demonstrates improved patient compliance with follow up chronic treatment needs. These diseases could be positively impacted by implementing Lean principles to improve patient satisfaction.

## **Category 2: Innovation and Redesign**

### **Project Option: 2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency**

- Project Title: Lean
- Unique Project ID Number: 137226005.2.2
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Project Description:**

Shannon Medical Center proposes under the 1115 Waiver to Apply Process Improvement Methodology to Improve Quality/Efficiency by implementing Lean. Shannon Medical Center will contract with a consultant group to implement Lean process improvement methodology. Initial training will be targeted to key leadership, management, and staff.

In 2011, the Institute of Medicine published *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, reporting that of the \$2.5 trillion dollars spent in healthcare in 2009, \$765 billion (30% of healthcare spending) was waste. Of that figure, \$330 billion in waste is due to excessive administrative cost and inefficiently delivered services. With more than 2,000 Shannon employees, there are gaps in knowledge and performance, inefficiencies, and waste in our care processes. In a downturned economy, the question facing Shannon as a locally owned medical center becomes, "How do we provide the highest quality care at the lowest cost?"<sup>34</sup> Shannon must implement change in an efficient and effective manner in order to accomplish this goal and secure its future for those it serves. To accomplish this, Shannon is planning to implement Lean, including training in Lean Healthcare Concepts.

#### **Project Goals:**

The project goals will include: 1) identifying delays, waste, and the problems they create in timely delivery of care, 2) the quality and safety of care, 3) patient and caregiver satisfaction, and 4) financial impacts. The process will identify opportunities to improve the process through a regimen of facilitated collaborative activities and just-in-time training of staff in continuous problem solving. The focus of Shannon's proposed project is to improve in quality, satisfaction, financial, and time based-improvements. Healthcare Performance Partners will identify Rapid Improvement activities for all Shannon Medical Center and Shannon Clinic staff. These activities will provide a rapid approach to improvement of a process or area, and serve as a method of utilizing Lean to achieve quick success and exposure. Initial efforts will consist of training at least 75 managers and directors.

#### **Relationship to Regional Goals:**

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, projects support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting

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<sup>34</sup> (Yong, Saunders, & Olsen, 2010)

healthcare resources in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

### **Challenges:**

The challenge of this project is finding time for leadership/management to train and implement programs. An additional challenge is working within the current culture of Shannon, and more importantly healthcare. Shannon leadership has to create a culture free of fear for staff who may believe they are replaceable. In such a large organization, it is often difficult to implement change without it creating an unforeseen ripple effect. Staff will need encouragement to welcome and accept change for the benefit of the organization and the patients it serves.

A potential challenge, related to all projects, is the impact of the Cline Shale oil boom. The impact to our area is expected to significantly hit hospitals, though no one has been able to project the actual magnitude of the growth we will experience. For this reason, Shannon cannot predict how this will impact patients, staff, and other factors that could influence this project but we anticipate this will be a challenge to some degree.

### **5 year Expected Outcomes:**

Healthcare Performance Partners, the Lean consulting firm, will complete a Kaizen assessment in demonstration year 2 to identify key areas to reduce cost, improve efficiency, and improve patient satisfaction. Shannon plans to complete 3 rapid improvement activities that may remove waste, improve patient satisfaction, improve the caregivers' workplace, reduce cost, and improve capacity over the 5 year period. By demonstration year 5, Shannon expects to impact at least 30,000 patient encounters of which 10% are Medicaid/uninsured through the three rapid improvement projects.

### **Starting Point/Baseline:**

Define operational procedures that will be addressed through Lean and determine number of staff to be trained in Demonstration Year 2.

### **Project Components:**

Shannon has identified the following project options

- 2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency
  - a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
  - b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.
  - c) Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and

- dissemination of performance on these measures ((i.e. weekly or monthly dashboard).
- 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
  - 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.

**Unique Community Need Identification Number:**

Shannon Medical Center will address CNA-008, Measuring Patient Satisfaction, and CNA-011, Addressing Cost/Waste through the Lean process, to meet the goals set by Texas Health and Human Services Commission to ensure the innovation of the healthcare delivery system will improve the quality of care.

**Rationale:**

Shannon, as the only private non-profit safety net hospital in Region 13, has been providing comprehensive, high quality acute inpatient, outpatient, diagnostic, and specialty medical care, health and wellness services, and community benefits responsive to the diverse cultural needs of a broad geographic area for over 75 years. Shannon Medical Center's service area covers 18 counties totaling 25,000 square miles, roughly the size of Maine. Though large in expanse, the total population is less than 1% of Texas' total state population. The region lacks many of the services offered in more populated areas such as easily accessible public transportation, resource centers, and public outreach programs. Shannon is seated in Tom Green County, the only county in the region not classified as a Health Professional Shortage Area. With a licensed 409 bed hospital and a group of 263 physicians, Shannon has vowed to provide exceptional healthcare to its family, friends and neighbors.

Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid and uninsured patient encounters.

The project will include training and coaching for key leaders, managers and frontline providers, as well as 3 Rapid Improvement activities. Tailored for healthcare organizations, anticipated improvements based on engagement goals may include: 1) removal of waste 2) improvement to the caregivers' workplace 3) improvement in customer/patient satisfaction 4) reduced cost 5) improved throughput and capacity. Shannon will integrate the following software systems to improve workflow and provide real-time performance feedback to allow for continuity of care, increased quality of care, and reduced costs. Shannon will utilize patient surveys and other means of communication to gather patient input related to issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

Proventix Systems, Inc. is an outcomes-driven technology to help healthcare providers deliver the highest quality of care. It helps protect patients, visitors, customers and workers by reducing the human and economic losses associated with illness. It provides tools and services for quality compliance monitoring, active point-of-care communication, and successful behavior modification. The Rothman Index provides a universal metric tool for patient assessment that pinpoints patients that are experiencing declining health states. Plus, Shannon has added a Midas+ Software System which helps in quality and case management [bed management] including improving patient safety and reducing length of stay.

**Required Quality Improvements:**

The milestones associated with Lean lend themselves to shared learning and opportunities to scale project findings to the broader hospital organization. The “Lean Committee” will report progress and lessons learned, as well as share these findings through employee trainings.

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

Currently there is not a formal structure or training for the skills needed to identify ways to enhance the delivery process. Redundancy in the process of health care delivery results in delays for the staff and patients of needed supplies, medication and equipment. Through restructuring processes using a Lean approach direct care can be enhanced.

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

OD-6, Patient Satisfaction: IT-6.1 Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)

**Rationale for Selecting Outcome measure:**

Evidence based patient centered care demonstrates improved patient compliance with follow up chronic treatment needs. As identified in the needs assessment, RHP 13 has high rates of chronic diseases, such as diabetes, obesity, and heart disease. These diseases could be positively impacted by implementing Lean principles to improve patient satisfaction. Once the rapid improvement activities are selected by Shannon and Healthcare Performance Partners, processes will be implemented to reduce cost, improve efficiency, and improve patient satisfaction. For instance, the discharge process is an example of an area Shannon hopes to improve using Lean principles. By potentially creating a more efficient, comprehensive discharge process, implementing Lean principles will result in more timely care to improve patient satisfaction.

**Relationship to other Projects:**

A desired goal of implementing Lean is to improve customer/patient satisfaction. The underlying theme of patient centered care is carried through all of Shannon Medical Center’s proposed projects.

- 2.4 Redesign to Improve Patient Experience (137226005.2.1)

- Potentially Preventable Admissions
- Potentially Preventable Readmissions – 30 days
- Patient Centered Healthcare
- Emergency Department

**Relationship to Other Performing Providers’ Projects in the RHP:**

There is a relationship between Shannon with many Performing Providers in Region 13. Shannon sees approximately 40% of all patient encounters within its service area. As the only safety net hospital in RHP 13, Shannon chose to not use their full Pass 1 allocation to allow these funds to move to Pass 3B for the Anchor to redistribute to support more robust projects for rural providers in RHP 13. This initiates regional transformation to best meet the needs of Region 13.

**Plan for Learning Collaborative:**

There is no direct learning collaborative for this project considering Shannon is the only Performing Provider in Region 13 that is proposing to Apply Process Improvement Methodology to Improve Quality/Efficiency. However, as the safety net hospital for Region 13, Shannon looks forward to potentially hosting an annual face-to-face meeting to provide the opportunity for members of Region 13 to collaborate by sharing experiences and challenges regarding DSRIP projects. In addition, Region 13 plans to maintain the RHP 13 website with up-to-date information from HHSC and CMS, as well as, DSRIP project information.

**Project Valuation:**

Shannon used a valuation methodology that was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. Each project was weighted and compared to all of Shannon’s proposed projects to determine the valuation for each project.

Because Shannon is the only safety net hospital for Region 13, the scope of each project reaches the broader regional population and addresses community needs related to RHP 13. By incorporating Lean methodologies at Shannon to improve in quality, satisfaction, financial, and time based-improvements, Shannon will have a greater impact on overall patient satisfaction for patients served throughout Region 13.

Shannon plans to implement two rapid improvement projects at Shannon Medical Center and one rapid improvement project at Shannon Clinic. Though the rapid improvement projects have not been selected because Shannon is still in the assessment phase, the two projects implemented at the hospital are expected to each impact at least 10,000 patient encounters and the one project at the clinic could impact up to 100,000 patient encounters. It is expected that at least 10% of the total encounters will be Medicaid/uninsured.

The project will incorporate the Hospital, as well as 200 Physicians from the Clinic Group. Given the training will be system wide, it will impact all of the population we serve. The scope of this project will consist of reaching the entire staff of Shannon Medical Center and Shannon Clinic, which is made up of approximately 2000 employees. Shannon will use various forms of technology and postings for communication to educate staff on patient satisfaction. The project will help us identify areas of waste; thus, result in “cost avoidance”.



137226005.2.2	2.8.1	2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F	Lean	
Shannon Medical Center			137226005	
OD-6	137226005.3.3	IT-6.1.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (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)	
<p><b>Milestone 1</b> P-5: Complete a Kaizen assessment</p> <p><b>Metric 1</b> P-5.1: Implement at least one patient care centered process improvement project in 3 practices</p> <p>Baseline/Goal: Identify 2 Shannon Medical Center practices that will each impact at least 10,000 hospital patient encounters; 1 Shannon Clinic practice that will impact up to 100,000 clinic patient encounters</p> <p>Data Source: Performing provider report from Shannon Medical Center and/or Shannon Clinic</p>	<p><b>Milestone 3</b> P-7: Implement a rapid improvement project using a proven methodology (i.e., Lean/Kaizen, Institute for Healthcare Improvement Rapid Cycle improvement method).</p> <p><b>Metric 1</b> P-7.1: Rapid improvement cycle</p> <p>Baseline/Goal: Develop and implement practices: 2 Shannon Medical Center practices that will each impact at least 10,000 hospital patient encounters; 1 Shannon Clinic practice that will impact up to 100,000 clinic patient encounters</p> <p>Data Source: Documentation of rapid improvement project</p>	<p><b>Milestone 6</b> P-8: Train providers/staff in process improvement</p> <p><b>Metric 1</b> P-8.2: Number of trainings held</p> <p>Baseline/Goal: 5 staff trainings and/or facilitation meetings</p> <p>Data Source: Agenda, curriculum or other training schedules/materials</p> <p>Milestone 6 Estimated Incentive Payment: \$ 492,123.00</p> <p><b>Milestone 7</b> I-15 Increase the number of process improvement champions</p> <p><b>Metric 1</b> I-15.1 Number of designated quality champions</p>	<p><b>Milestone 8</b> P-4: Define operational procedures needed to improve overall efficiencies in care management.</p> <p><b>Metric 1</b> P-4.1: Report on at least two new operational procedures needed to improve overall efficiencies in care management</p> <p>Goal: Report the 2 new operational procedures that impacts at least 380,000 patient encounters (300,000 Shannon Clinic encounters and 80,000 Shannon Medical Center patient encounters)</p> <p>Data Source: Performing Provider report from Shannon Medical Center and Shannon Clinic</p>	

137226005.2.2	2.8.1	2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F	Lean	
Shannon Medical Center			137226005	
OD-6	137226005.3.3	IT-6.1.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 449,790.00  <b>Milestone 2</b> P-8: Train providers/staff in process improvement <b>Metric 1</b> P-8.1: Number of providers/staff trained Baseline/Goal: 75 staff trained Numerator: number of providers/staff trained Denominator: total number of providers/staff Data Source: Training Documentation  Milestone 2 Estimated Incentive Payment: \$	such as idea sheets, attendance sheets, daily reports of progress made, final report out. Or documentation of materials produced by the improvement event such as new standard workflows.  Milestone 3 Estimated Incentive Payment: \$ 327,131.00  <b>Milestone 4</b> P-8: Train providers/staff in process improvement <b>Metric 1</b> P-8.2: Number of trainings held Baseline/Goal: 5 trainings and/or facilitation meetings Data Source: Agenda,	Baseline/Goal: Increase by 3 process improvement champions Data Source: HR or training materials  Milestone 7 Estimated Incentive Payment: \$ 492,123.00	Milestone 8 Estimated Incentive Payment: \$ 813,073.00	

137226005.2.2	2.8.1	2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F	Lean	
Shannon Medical Center			137226005	
OD-6	137226005.3.3	IT-6.1.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
449,790.00		<p>curriculum or other training schedules/materials</p> <p>Milestone 4 Estimated Incentive Payment: \$ 327,131.00</p> <p><b>Milestone 5</b> I-15: Increase the number of process improvement champions <u>Metric 1</u> I-15.1: Number of designated quality champions Baseline/Goal: Increase by 3</p> <p>Data Source: HR, or training curriculum or other program materials</p> <p>Milestone 5 Estimated Incentive Payment: \$ 327,131.00</p>		

137226005.2.2	2.8.1	2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F	Lean	
Shannon Medical Center			137226005	
OD-6	137226005.3.3	IT-6.1.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>		<b>Year 4 (10/1/2014 – 9/30/2015)</b>
<b>Year 5 (10/1/2015 – 9/30/2016)</b>				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$ 899,580.00	Year 3 Estimated Milestone Bundle Amount: \$ 981,393.00	Year 4 Estimated Milestone Bundle Amount: \$ 984,246.00	Year 5 Estimated Milestone Bundle Amount: \$ 813,073.00	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over DYs 2-5): \$ 3,678,292.00				

## **Summary Information**

**Performing Provider: Shannon Medical Center**

**Pass 1 Project: Palliative Care**

**Project Unique ID #: 137226005.2.3**

## **Summary Information**

**Performing Provider: Shannon Medical Center**

**Pass 1 Project: Palliative Care**

**Project Unique ID #: 137226005.2.3**

Provider: Shannon West Texas Memorial Hospital, a non-profit health system established in the 1930's, is the only safety net hospital in Region 13, and provides the communities of West Central Texas with a variety of medical services. Shannon Medical Center and Shannon Clinic report to the same Chief Executive Officer (CEO) and Board of Directors under the Trustees of Shannon West Texas Memorial Hospital, a testamentary trust. Dedicated to the region's health and well-being, the medical center offers diverse clinical services, including a nationally-recognized cardiac care program, nationally-recognized ICU, the region's only Level III Trauma Facility and AirMed 1 air ambulance serving a 200-mile radius of San Angelo, and a dedicated Women's & Children's Hospital which is home to the Children's Miracle Network. Shannon Medical Center is a 409-bed safety net hospital located in Tom Green County. Shannon Clinic is a Physician Group made up of more than 250 Physicians. The estimated population for Shannon's service area as of 2011 including Tom Green County, is 288,304. (*U.S. Census Bureau, State & County Quickfacts*)

Intervention(s): The goal of the palliative care program is to serve a broader patient population by expanding the type and volume of patients that are initially considered for palliative care services. The number of palliative care screens will be increased when front line nursing staff identifies palliative care triggers. By providing education for physicians and staff, Shannon Medical Center will have the opportunity to target patients that are seriously ill or have multiple chronic conditions that may benefit from being seen by professionals in the palliative care program.

Need for the project: Intensive Care Unit (ICU) treatment can be more burdensome than beneficial, as well as, inconsistent with the patient's goals and treatment preferences. Treatment in the ICU can be stressful on the patients and families, and wasteful of costly resources. By implementing an effective palliative care program, outcomes will lead to improved quality and reduction in costs of care for the sickest and most complex patients.

Medicaid and Uninsured Target population: The target population for this project is all patients. Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid and uninsured patient encounters. In fiscal year 12, 285 patients received a palliative consult of which 30 were Medicaid/uninsured.

Category 1 or 2 expected patient benefits: Shannon will increase the number of palliative care consults by 15% over baseline (42 patient consults) by demonstration year 5, as well as implement a survey regarding the quality of care, pain and symptom management, and degree of

patient/family centeredness in care. Shannon will be able to decrease the suffering of a broader population of patients through improved pain and symptom management, decrease futile and burdensome treatments and interventions, and provide more comfortable and informed alternatives to care at the end of life.

Category 3 outcomes: IT-13.4 Shannon would like to see a decrease in patients spending their end-of-life stages in the ICU to reduce burdens, stress, and unnecessary costs to improve the patient experience in the last days of life.

## **Category 2: Innovation and Redesign**

### **Project Option: 2.10 Use of Palliative Care Programs**

- Project Title: Palliative Care
- Unique Project ID Number: 137226005.2.3
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Project Description:**

Shannon Medical Center (137226005) proposes under the 1115 Waiver to expand Palliative Care (2.10) services to improve patient outcomes and quality of life. Palliative Care programs have been proven to relieve pain and distressing symptoms caused by a variety of disease states in the medically complex patient. When a patient is facing a serious illness, they need relief from symptoms, to better understand their condition and choices for care, to improve their ability to tolerate medical treatments, and need to be able to carry on with everyday life. This is what palliative care can do.

By initiating a palliative care consult at the time of diagnosis, the patients and families have the opportunity to establish clear goals, tailor treatment to those plans, and develop care plans that can reduce costly and preventable hospitalizations, readmissions, and emergency department visits. According to recent data, the average per-patient per-admission net cost saved by hospital palliative care consultation is \$2,659.<sup>35</sup> Of the \$491 billion spent by Medicare in 2009, 27% (132.5 billion) was spent on acute care (hospital) services and a small proportion, 10%, of the sickest Medicare beneficiaries accounted for about 57% of total program spending, which was more than \$44,220 per capita per year.<sup>36</sup> In addition, palliative care helps with difficult decision making, boosts patient and family satisfaction, and eases the transition to alternative care settings. Fundamentally, palliative care programs shift the course of care off the usual hospital pathway and substantially reduce costs by establishing clear treatment goals and legitimizing discontinuation of treatments or tests that do not meet established goals. Shannon plans to hold a symposium to engage local community resources and coordinating palliative care.

#### **Project Goals:**

The goal of the expanding palliative program is to serve a broader patient population by expanding the type and volume of patients that are initially considered for palliative care services. The number of palliative care screens will be increased when front line nursing staff identify palliative care triggers. Having palliative care staff in place does not guarantee palliative care for patients considering the inconsistency in Physicians and hospital awareness, training, and practice patterns for referrals. Therefore, educational programs will be offered to M.D.s, hospital staff, and clergy to increase awareness and benefits of the program and for a better understanding of the importance of symptom/disease management.

#### **Relationship to Regional Goals:**

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<sup>35</sup> (Meier, 2011)

<sup>36</sup> (Meier, 2011)

Region 13 seeks to transform healthcare in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, projects support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensure patients receive quality, patient centered care without exhausting healthcare resources in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

### **Challenges:**

The challenge is to recruit support of the program by physicians and other hospital staff that affect the number of palliative care orders written. Another challenge is educating staff to make referrals upon diagnosis for chronic illnesses, such as, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Earlier referrals will lead to improving quality of life and symptom management, as well as, starting to set goals, talking about wishes, and completing advance directives. Increasing awareness for the patient and family could create a challenge because there is an association of palliative care with hospice care. This leads to resistance for the patient and family to accept that a loved one is nearing end-of-life.

Educating patients, family, and staff will lead to a better understanding of the palliative care program at Shannon and will increase awareness of the importance of palliative care for patients. Earlier referrals will lead to a more positive understanding of palliative care and, in turn allow for better outcomes associated with decision-making throughout end-of-life.

A potential challenge, related to all projects, is the impact of the Cline Shale oil boom. The impact to our area is expected to significantly hit hospitals, though no one has been able to project the actual magnitude of the growth we will experience. For this reason, Shannon cannot predict how this will impact patients, staff, and other factors that could influence this project but we anticipate this will be a challenge to some degree.

### **5 Year Expected Outcomes:**

Over the five year waiver period, Shannon would like to an increase in volume of patients served by palliative care, as well as an increase in overall awareness and training of palliative care services. As the palliative care program expands, Shannon would like to see a decrease in unnecessary readmission rates by educating patients and families, controlling symptoms, encouraging patients to consider goals and wishes, and making appropriate referrals.

In fiscal year 12, 285 patients received a palliative consult of which 30 were Medicaid/uninsured. Shannon expects at least a 15% increase in palliative care consults by demonstration year 5. Increasing consults will be a direct result from increased staff, patient, and family awareness, employee training, and patient survey input to enhance services.

### **Starting Point/Baseline:**

Establish baseline rates in Demonstration Year 1

**Project Components:**

Shannon has identified the following project options and will address all of the required core components:

**2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs**

- a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
- b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility
- c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
- d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Unique Community Need Identification Number:**

Shannon Medical Center will address CNA-009, Access to Specialty Care, related to care to meet the goals set by Texas Health and Human Services Commission to ensure the innovation of the healthcare delivery system will improve the cost effectiveness of care.

**Rationale:**

The target population for this project is all patients. Shannon Medical Center treats approximately 50% of the Medicaid and uninsured population of Tom Green County. From July 2011 to June 2012, Shannon had approximately 450,000 patient encounters of which 100,000 were Medicaid and uninsured patient encounters.

Shannon Medical Center seeks to expand the palliative care program and provide an enhanced opportunity for patients and families to establish goals of care, offer support, and develop smooth transitions to appropriate levels of care. An important aspect of palliative care is communication which leads to better informed decision making, clarity of the care plan, and consistent follow through. Furthermore, these discussions lead to lower healthcare costs, less family burdens, and improved patient satisfactions.<sup>37</sup> A business case will be developed that will support cost savings through palliative care. In addition, patients and families will be better prepared to transition to a more appropriate level of care and manage pain and other symptoms more effectively, thus avoiding ED visits and acute hospitalizations. Patients and families will have a much better understanding of disease states and will be more receptive to alternative levels of care such as, Skilled Nursing Facility (SNF) placement and earlier hospice

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<sup>37</sup> (Meier, 2011)

care. A patient satisfaction survey will be developed to not only measure the success of the program but to identify challenges and obstacles for further program development. By implementing a palliative care program and providing education for physicians and staff, Shannon Medical Center will have the opportunity to target patients that are seriously ill or have multiple chronic conditions that may benefit from being seen by professionals in the palliative care program. The outcomes will lead to improved quality and reduction in costs of care for the sickest and most complex patients.<sup>38</sup>

**Required Quality Improvement:**

Considering the supportive evidence of the impact of palliative care, Shannon will potentially host annual Palliative Care Symposia for Regional providers to attend and learn innovative strategies to implement palliative care.

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

Shannon identified the need of providing improved care to the suffering and/or dying patient as they approached end of life. Organizational leaders attended a CAPC program in an effort to learn how to initiate and sustain a successful Palliative Care Program.

We believe that by enhancing the current palliative program, Shannon will be able to decrease the suffering of a broader population of patients through improved pain and symptom management, decrease futile and burdensome treatments and interventions, and provide more comfortable and informed alternatives to care at the end of life. The initiative will decrease readmissions, decrease costs, and assist the patient/family throughout the dying process particularly as patients with medically complex illnesses account for a growing proportion of admissions.

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

OD-13 Palliative Care: IT-13.4: Proportion admitted to the ICU in the last 30 days of Life (NQF 0213) (standalone measure)

**Rationale for Selecting Outcome measure:**

Intensive Care Unit (ICU) treatment can be more burdensome than beneficial, as well as, inconsistent with the patient's goals and treatment preferences. Treatment in the ICU can be stressful on the patients and families, and wasteful of costly resources. Overall, Shannon would like to see a decrease in patients spending their end-of-life stages in the ICU to reduce burdens, stress, and unnecessary costs to improve the patient experience in the last days of life.

**Relationship to other Projects:**

The underlying theme of Shannon's projects is patient centered care because it plays an important role in improving clinical outcomes, quality, and compliance. This project's focus on expanding palliative care by incorporating the patient and families to establish goals of care has

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<sup>38</sup> (Meier, 2011)

a direct relationship to 2.4 Redesign to Improve Patient Experience (137226005.2.1). Related Category 4 measures include:

- Potentially Preventable Admissions
- Potentially Preventable Readmissions – 30 days
- Potentially Preventable Complications
- Patient Centered Healthcare

**Relationship to Other Performing Providers’ Projects in the RHP:**

There is a relationship between Shannon with many Performing Providers in Region 13. Shannon has 10 transfer agreements including: Ballinger Memorial Hospital District, Coleman County Medical Center, Concho County Hospital, Heart of Texas Memorial Hospital, Kimble Hospital, North Runnels Hospital, Pecos County Memorial Hospital, Reagan Memorial Hospital, Schleicher County Medical Center, and Sutton County Hospital District dba Lillian M. Hudspeth Memorial Hospital. Because many of the rural hospitals in Region 13 received inadequate allocation, Shannon has transferred approximately \$7,500,000 to rural hospitals to support transformation in their community with a more robust project.

Shannon is the only Performing Provider in Region 13 proposing to implement/expand the Use of Palliative Care Programs. Therefore, there is no direct relationship to other Performing Providers in the Region. Shannon does plan to implement a learning collaborative with other Provider’s in the Region to share best practices for palliative care.

**Plan for Learning Collaborative:**

Shannon is the only Performing Provider in Region 13 proposing to implement/expand the Use of Palliative Care Programs. Considering the supportive evidence of the impact of palliative care, Shannon will potentially host annual Palliative Care Symposia for Regional providers to attend and learn innovative strategies to implement palliative care.

In addition, as the safety net hospital for Region 13, Shannon looks forward to potentially hosting an annual face-to-face meeting to provide the opportunity for members of Region 13 to collaborate by sharing experiences and challenges regarding DSRIP projects. Region 13 plans to maintain the RHP 13 website with up-to-date information from HHSC and CMS, as well as, DSRIP project information.

**Project Valuation:**

Shannon used a valuation methodology that was based on a ranking scale of 1 to 5 for the following attributes: achieves regional waiver goals, addresses community needs, the project scope, and the project investment. Each project was weighted and compared to all of Shannon’s proposed projects to determine the valuation for each project. After considering the collaboration efforts of Shannon, the valuation methodology, and the needs of the community, the project value was determined from the remaining pass 1 allocation.

Because Shannon is the safety net hospital for Region 13, the scope of each project reaches the broader regional population and addresses community needs related to RHP 13. As indicated in the Rationale for this project, the implementation of palliative care lowers healthcare costs, decreases family burdens, and improves patient experience.

By increasing education about palliative care to patients and staff, Shannon projects there will be an increase in consults made to the palliative care program. The palliative care staff intends to consult at least 42 additional patients by demonstration year 5. Increasing consults will be a direct result from increased staff, patient, and family awareness, employee training, and patient survey input to enhance services.

The investment will require the additional training for an Advanced Practice Nurse and a supervising Hospitalist/Palliative Care Physician, as well as, additional training and resources for clinicians and staff. In addition, the scope of the project includes hosting an annual Palliative Care Symposium to provide resources and training for Region 13 to better serve the patient's needs during end-of-life. By expanding our current palliative care program, Shannon will develop a specialized care program that focuses on pain symptoms and stress due to illness. Shannon plans to serve all patients in Region 13 with the palliative care program by recognizing the regional need to better serve patients upon diagnosis with a chronic condition as well as, at the end-of-life. In addition, valuable healthcare resources may be used more efficiently to better meet the needs of patients, families, and the community.

137226005.2.3	2.10.1	2.10.1.a, 2.10.1.b, 2.10.1.c, 2.10.1.d	Palliative Care	
Shannon Medical Center			137226005	
OD-13	137226005.3.4	IT-13.4	Palliative Care: Proportion admitted to the ICU in the last 30 days of life (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)	
<p><b>Milestone 1 P-5:</b> Implement/expand a palliative care program <u>Metric 1</u> P-5.1: Implement comprehensive palliative care program <u>Baseline/Goal:</u> Expand existing Palliative Care Program to improve the quality of care at Shannon Medical Center and Shannon Clinic <u>Data Source:</u> Palliative care program</p> <p>Milestone 1 Estimated Incentive Payment: \$ 1,176,374.00</p>	<p><b>Milestone 2 P-3:</b> Implement palliative care education and training programs for providers (physicians, RNs, PAs, NPs, etc.) that incorporates management of non-cancer patients. <u>Metric 1</u> P-3.1: Palliative care training and education for other providers <u>Documentation:</u> Provider training and education curriculum <u>Goal:</u> 2 training programs for providers <u>Data Source:</u> Sign-in sheets, agenda, training materials</p> <p>Milestone 2 Estimated Incentive Payment: \$ 641,680.00</p> <p><b>Milestone 3 P-6:</b> Increase the</p>	<p><b>Milestone 4 P-6:</b> Increase the number of palliative care consults <u>Metric 1</u> P-6.1: Palliative care consults meet targets established by the program Numerator: number of palliative care consults Denominator: target number of palliative care consults <u>Baseline/Goal:</u> Increase the number of consults by 10% over baseline (28 patient consults) <u>Data Source:</u> EHR, palliative care database</p> <p>Milestone 4 Estimated Incentive Payment: \$ 1,287,091.00</p>	<p><b>Milestone 5 I-12:</b> Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time <u>Metric 1</u> I-12.1 Survey developed and implemented; scores increased over time <u>Goal:</u> Develop a survey to increase patient and family satisfaction over time <u>Data Source:</u> Patient/family experience survey</p> <p>Milestone 5 Estimated Incentive Payment: \$ 531,624.00</p> <p><b>Milestone 6 P-6:</b> Increase the</p>	

137226005.2.3	2.10.1	2.10.1.a, 2.10.1.b, 2.10.1.c, 2.10.1.d	Palliative Care		
Shannon Medical Center			137226005		
OD-13	137226005.3.4	IT-13.4	Palliative Care: Proportion admitted to the ICU in the last 30 days of life (standalone measure)		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>		<b>Year 4 (10/1/2014 – 9/30/2015)</b>	
<b>Year 5 (10/1/2015 – 9/30/2016)</b>					
	number of palliative care consults <u>Metric 1</u> P-6.1: Palliative care consults meet targets established by the program Numerator: number of palliative care consults Denominator: target number of palliative care consults <u>Baseline/Goal:</u> Increase the number of consults by 5% over baseline (14 patient consults) <u>Data Source:</u> EHR, palliative care database  Milestone 3 Estimated Incentive Payment: \$ 641,681.00		number of palliative care consults <u>Metric 1</u> P-6.1: Palliative care consults meet targets established by the program Numerator: number of palliative care consults Denominator: target number of palliative care consults <u>Baseline/Goal:</u> Increase the number of consults by 15% over baseline (42 patient consults) <u>Data Source:</u> EHR, palliative care database  Milestone 6 Estimated Incentive Payment: \$ 531,625.00		
Year 2 Estimated Milestone Bundle Amount: \$ 1,176,374.00	Year 3 Estimated Milestone Bundle Amount: \$ 1,283,361.00	Year 4 Estimated Milestone Bundle Amount: \$ 1,287,091.00	Year 5 Estimated Milestone Bundle Amount: \$ 1,063,249.00		

137226005.2.3	2.10.1	2.10.1.a, 2.10.1.b, 2.10.1.c, 2.10.1.d	Palliative Care	
Shannon Medical Center			137226005	
OD-13	137226005.3.4	IT-13.4	Palliative Care: Proportion admitted to the ICU in the last 30 days of life (standalone measure)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>		<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>		<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>
				<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 4,810,075.00</b>				

## *Summary Information*

*Performing Provider: Sutton County Hospital District dba  
Lillian M. Hudspeth Memorial Hospital*

*Pass Community Paramedic Project*

*Project Unique ID #: PASS 3B 121781205.2.2*

- Provider: Lillian M. Hudspeth Memorial Hospital is a 12-bed hospital Critical Access Hospital serving a 1400 square mile area with a population of 4200.
- Intervention(s): This project will provide in-home services to patients to reduce re-admissions, unnecessary emergency department admissions and increase compliance with disease management.
- Need for the project: This is a new project in which there are only a hand full of such programs in the United States.
- Medicaid and Uninsured Target population: The target population is all patient serviced by the District. It will look at patients who are frequent emergency department visitors and patients who have non-compliance issues.
- Category 1 or 2 expected patient benefits: Reduce readmission and unnecessary emergency department visits.
- Category 3 outcomes: 2.9 - Establish/Expand a Patient Care Navigation Program OD-2 Potential Preventable Admissions

## **Category 2: Program Innovation and Redesign**

Program Innovation and Redesign projects emphasize the piloting, testing, and replicating of innovative care models. Performing Providers participating in Category 2 projects may include hospitals, community mental health centers, local health departments, physician practices affiliated with academic science health centers and physician practices not affiliated with academic health science centers, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

### **Narrative for each Category 2 Project shall include:**

- The narrative for each Category 2 Project is limited to 6 pages.
- **Identifying Project and Provider Information:** Community Paramedic Program, 121781205.2.2, Lillian M. Hudspeth Memorial Hospital, 121781205.
- **Project Description:**

The Sutton County Hospital District dba Lillian M. Hudspeth Memorial Hospital currently operates a full-time Paramedic Level Emergency Medical Service. As defined in the targeted population the program will address the critical shortage of health care professionals and services in rural and remote areas, the Sutton County Hospital District proposes to develop a Community Paramedic Program based on the Nova Scotia Community Paramedic Model. The Community Paramedic Program will focus on all patient's populations including Medicare, Medicaid and indigent populations. We expect visits to range between 20/month at the beginning of the program and growing to 40/month by FY2 years end. By year 5 of the waiver we expect to serve 60-80/month. Patients having face to face interaction with a medical provider will allow for more direct care management. Patients will be evaluated by established protocols. Cost avoidance is achieved by the prevention of unnecessary visits to the ED or preventable admissions to either the hospital or long term care.

EMS personnel are community based personnel and historically provide only 911 emergency care. The Community Paramedics will not replace existing health care services, but will fill the gaps revealed by examining each community. These personnel are well trained and have a skill set that align with most basic nursing provided by home care nurses. The Community Paramedic is community based. The personnel already possess the skills and know how to assess resources and make decisions. Community based personnel will also have a familiarity with the patient which will enhance satisfaction of the patient. The Community Paramedic is part of an integrated health care system.

Patients are referred by primary care physician's hospital personnel and other county entities. Services provided will be as follows:

**Discharge Follow-up:** After discharge from hospital care, the resident would receive follow-up visits at their home. This visit would include an assessment of proper medication, primary safety check of the home, and address any concerns the patient may have after their recent hospitalization. Discharge follow-up is a proven yet rarely utilized method to reduce repeat occurrences of injury and illness to an already high risk population. Results are not only a reduction in future injuries and re-admissions but increases levels of patient satisfaction.

**Medication Reconciliation:** EMS personnel would be able to obtain a required medications list and place this on a standardized form to ensure no critical omissions are present. While the

importance of medication reconciliation is universally recognized, the optimal method for reconciling medications has not widely been achieved. EMS personnel with the use of a standardized form, will ensure that the required medications list is established and easily scanned into the provider's electronic health record. The medication list is a requirement of meaningful use.

**Injury Prevention:** An initial safety check would be performed on the home. Focus would be trip hazards, smoke/carbon monoxide detectors, and other potential risks. Hazards reports will be made available to the patient, family and other county resources to assist with elimination of such hazards. Fall prevention will remain a high priority. It is proven that falls make up a large percentage of Medicare expenditures.

**Regular Blood Sugar Checks:** Residents will be maintained on a "drop by" list dependent on their healthcare needs. These weekly "drop by" will provide patient blood sugar and blood pressure evaluations. These measurements will be maintained on standardized forms and results will be discussed with the patient and primary care provider. Coordination of diabetic educators and dieticians could be expedited through the host agency resulting in complications and hospitalizations.

**Wound Care:** Basic home health services would also include bandage changes and wound monitoring. These services will be supervised by a staff physician. Wound monitoring and care would eliminate the difficulty or cost for patients to find transportation and reduce complications from very expensive hospitalization due to difficult wounds.

**Lab Specimens:** EMS personnel would perform phlebotomy services based on physician order and eliminated the need for patient transportation thus better managing the patients care.

**Flu Shots:** EMS personnel will provide annual flu shots to home bound patients.

**ED Overutilization:** EMS personnel will assist with frequent ED visit patients to assist with appropriate utilization and navigation to appropriate services.

**General Welfare Checks:** Welfare checks are drop in assessments of elderly or disabled populations that could be shut ins that do not have a family support system or family live a distance and cannot regularly check on the patient.

All Community Paramedic services will be monitored through a multidiscipline quality assurance program. The QA program will include physicians, physical therapist, dieticians, educators and other hospital personnel. This multidiscipline effort will ensure that the patient receives high quality care and prevention services.

The Community Paramedic program will dramatically alter the traditional work of the paramedic. Traditionally the paramedic would respond quickly to emergency calls. The medics will now spend time with the patient in their home before a 911 call is necessary. This time with the patient should reduce cost by elimination of hazards and better health management through aggressive monitoring.

The Community Paramedic program will relate to regional goals CNA-004, Potentially Preventable Hospitalizations and CNA-007 Inappropriate utilization of Emergency Room. In addition to these regional goals, the overall cost of healthcare should be impacted by navigation of these patients to a more appropriate FY02 will establish baselines. FY03-FY05 we hope to reduce cost by 5%, 10% and 15% respectively.

## **Service Delivery Model is Appropriate and Responsive to Identified Needs**

SCHD's service delivery model is a family practice model, which maximizes responsiveness to identified needs by allowing providers to direct EMS personnel to follow patients from all lifecycles in the home environment. This model is essential in an extremely rural service area where it is not financially viable to have multiple disciplines of providers such as internal medicine for adults, pediatrics for children and OB/GYN for women's health.

The proposed Community Paramedic Program delivery sites will be directed by a Critical Access Hospital and hospital based rural health clinic that has been providing comprehensive primary care and supplemental health care services to the medically underserved since 1951. This extensive experience with both the target population and service area has provided the organization with the knowledge and expertise to develop an effective service delivery model which is designed specifically to address identified community health care needs, thus making the model both appropriate and responsive. Specific components of the service delivery model which illustrate appropriateness and responsiveness include:

- Providing required primary, preventive and supplemental health care discharge services to patients of all ages, regardless of their ability to pay for services.
  - Providing these services to qualified uninsured patients to ensure access and improve health status and health outcomes.
  - Conducting periodic community health needs assessments to identify any new and/or changing needs, followed by development of appropriate programs and services to address identified needs.
  - Offering comprehensive prevention services to ensure the target population and general community are aware of available services and how to access them.
  - Providing home services during hours of operation which improve access for the target population.
  - Collaborating with community health and social service entities to provide the full continuum of care and improve health outcomes and status.
- 
- **Starting Point/Baseline:** The evidence consists of pre and post-implementation comparisons with ED visits and admissions, along with estimates of the cost savings generated.
  - **Rationale:** The proposed service area for Sutton Hospital District (SCHD) includes Sutton County, located in west central Texas. Sutton County is a designated Medically Underserved Area (MUA) (ID# 03427) as well as a designated Health Professional Shortage Area (HPSA) (ID #14899948OV) for primary care and (ID#748435) for mental health. The reduction of unnecessary ED visits and reduction of hospital and LTC admissions will be addressed in this project. The multipoint home visits will intervene before a patient becomes ill enough to go to the hospital as well as monitoring non-compliance which will greatly reduce ED and hospital admissions. The system is overviewed by a multidisciplinary quality care team that includes the medical staff of both the Hospital and Clinic as well as the QA/QI team of the hospital. The reviews of the program are performed ongoing with direct contact with the medical providers and in the formal setting of the monthly QA/QI team management.

### **Cultural/Ethnic Factors**

As indicated above, the service area is comprised of 49.4% Hispanic residents; however, this percentage is expected to be significantly higher (estimated at 65% and rapidly increasing) as SCHD's

proposed service area is only 90 miles from the Mexican border, and many Hispanic residents are undocumented and generally seek to avoid any self-reporting of their status. With this population come language barriers and a general lack of information regarding the importance of regular preventive care and the health benefits related to a healthy lifestyle. Diabetes and obesity are highly prevalent among the Hispanic population. Among the service area population, 48.3% of Sutton County residents, and 46.7% of Edwards County residents ages five years and older speak a language other than English at home, compared to only 31.2% for all of Texas (U.S. Census QuickFacts, 2000).

**Geographic/Transportation Barriers**

Sutton County is extremely rural, with only 2.8 and 1.0 persons per square mile, respectively. The county is relatively large in land area, 1,454 square miles. The number of persons per square mile for the entire service area is 1.72. The extreme rural nature of the proposed service area precludes any public transportation from being available, and travel distances for even common activities are extensive.

**d. Unique Health Care Needs**

The table below demonstrates additional unique health care needs and health disparities among service area residents and the target population, with comparisons to Texas. (Note: Bolded data illustrate a disparity in one or both service area counties when compared to Texas.)

<b>Health Indicator</b>	<b>Sutton County</b>	Texas
Low birth weight rate <sup>1</sup>	<b>8.8</b>	7.4
Births to mothers aged 10 to 17 <sup>1</sup>	<b>9.0</b>	5.7
Lack of prenatal care in first trimester <sup>1</sup>	<b>23.3</b>	21.2
Infant mortality <sup>1</sup>	<b>8.0</b>	5.7
Percent of children <17 years in poverty <sup>1</sup>	<b>21.9%</b>	20.2%
Percent of children <18 who are uninsured <sup>2</sup>	<b>26.2%</b>	19.5%
Death rate (all causes) <sup>1</sup>	<b>524.2</b>	495.9
Heart disease death rate <sup>1</sup>	<b>141.7</b>	131.1
Cardiovascular death rate <sup>1</sup>	<b>176.8</b>	171.4
Lung cancer death rate <sup>1</sup>	<b>36.8</b>	34.8
Suicide death rate <sup>1</sup>	<b>11.0</b>	9.6
Work-related injury death rate <sup>1</sup>	<b>7.1</b>	3.1
Syphilis incidence rate (per 100,000 pop.) <sup>2</sup>	1.3	6.6
Gonorrhea incidence rate (per 100,000 pop.) <sup>2</sup>	<b>119.7</b>	115.7
Chlamydia incidence rate (per 100,000 pop.) <sup>2</sup>	<b>475.3</b>	417.4
Female breast cancer death rate <sup>1</sup>	14.4	17.3
Chronic lower respiratory disease death rate <sup>2</sup>	<b>56.8</b>	42.5
Diabetes death rate <sup>2</sup>	20.7	25.5
Unintentional injury death rate <sup>2</sup>	<b>51.8</b>	42.2
Current smoker <sup>3</sup>	<b>24.5%</b>	22.4%
Binge drinker (5+ drinks in one occasion in past 30 days) <sup>3</sup>	<b>18.1%</b>	15.1%
Overweight and obese <sup>3</sup>	57.2%	61.3%
Ever told had high blood pressure <sup>3</sup>	<b>26.5%</b>	25.6%
Ever told had diabetes <sup>3</sup>	<b>7.5%</b>	7.1%
Women 40+ who had mammogram in past two	<b>67.2%</b>	69.4%

years <sup>3</sup>		
Ever had blood cholesterol checked <sup>3</sup>	<b>67.7%</b>	73.8%

Sources:

- <sup>1</sup> Texas Department of State Health Services, Public Health Region Reports (Region 9 for Sutton County and Region 8 for Edwards County), 2000; all death rates is per 100,000 population.
- <sup>2</sup> Texas Department of State Health Services, Texas Health Currents Database, Public Health Regions, 2007.
- <sup>3</sup> Texas Department of State Health Services, Texas Behavioral Risk Factor Surveillance System, Public Health Regions, 2001.

This is a new project for the District. There are only a few such projects in the United States. Enhancing the role of the paramedic to home visits will not only expand our role as primary care providers it will all for face to face interaction with the patient. By contacting the patient that has shown poor compliance, abuse of the emergency department or at risk for falls will be addressed on a regular basis. This face to face interaction will directly tie to CNA-004 and CNA-007.

- **Related Category 3 Outcome Measure(s):** OD-2 Potentially Preventable Admissions, IT-2.13 Other Admissions Rate. This outcome measures looks at reduction of ED utilization, Acute Care preventable (Hospital) admissions and LTC admissions. This stand alone measure will be benchmarked in the first year. Patients abusing the emergency department will be measured against historic visits of the previous year. These patients are those that are in most cases non-compliant with diabetes, heart disease and respiratory disease. Monitoring of blood sugar and blood pressure and their corresponding ED visits will be benchmarked with previous year experience. Fall prevention will be measured by ED/Clinic visits for similar events. Referrals of these types of patients will focus on prevention of recurrence and avoidance of both hospital and nursing home admissions. Related cost savings estimates will be monitored and measured.
- **Relationship to other Projects:** NA.
- **Relationship to Other Performing Providers' Projects in the RHP:** NA
- **Plan for Learning Collaborative:** NA
- **Project Valuation:** Community Paramedic referred patients will be evaluated based on a specific order. Referred patients will include all payers to include Medicare, Medicaid and Indigent patients. Visits will vary depending on condition or specific patient need. The scope will be all patients living in Sutton County. The number of patients from this 4000+ population will be benchmarked in the first year. It is expected that visits will range from 20/month at the beginning to program and growing to 40/month by FY2 year end. Patients having face to face with a medical provider will allow for more direct care management. Patients will be evaluated by established protocols. Cost avoidance is achieved by the prevention of unnecessary visits to the ED or preventable admissions to either the hospital or nursing home. One ED visit avoidance can cut cost by an average of \$3500. Keeping a patient out of acute care or LTC can save the taxpayers \$100's of thousands of dollars. Savings will be measured based on County Medicare dollars spent for location of service as provided by CMS. The program supports CNA-004 and CNA-007. Estimated savings based on estimated referrals will be FY2 \$250000, FY3 \$350000 FY 4 \$500000 and FY 5 \$650000.

**Milestones/Metric Table for each Category 2 Project shall include:**

- **Identifying Project and Provider Information:** Community Paramedic Program, 121781205.2.2, 2.9 Established/Expand a Patient Care Navigation Program 2.92, Lillian M. Hudspeth Memorial Hospital, 121781205 Category 3 OD-5 Potential Preventable Admissions, IT-2.13 Other Admission Rate.
- **Milestone bundles:** See chart
- **RHP Planning Protocol Reference:** See Chart
- **Incentive Payment Amount:** See Chart

121781205.2.2	<b>2.9.2</b>		<b>COMMUNITY PARAMEDIC PROGRAM</b>	
Lillian M. Hudspeth Memorial Hospital			121781205	
<b>Related Category 3 Outcome Measure(s): OD-2</b>	IT-2.13		Potential Preventable Admissions – Other Admission Rate	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>Milestone 1</b> P-3 ED visits and other data to be determined in first year. <b>Metric 1</b> P-3.1.1]: Baseline/Goal: The evidence consists of pre and post-implementation comparisons with ED visits and admissions, along with estimates of the cost savings generated. Data Source: EHR Estimated savings \$250000 Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$303912	<b>Milestone 2</b> [P-4]: Patients Engaged <b>Metric 1</b> [P-4.1]: Baseline/Goal : Patient Contacts Data Source: EHR Estimated savings \$350000 Numerator: # of patients engaged. Denominator# Patients referred to program  Milestone 2 Estimated Incentive Payment: \$ 176113.50	<b>Milestone 3</b> [P-5]: Encounter Services <b>Metric 1</b> [P-5.1]: Goal: Engaged patients and navigation patient to appropriate care resource. All services will be reported. Data Source: EHR Estimated savings \$500000 Milestone 3 Estimated Incentive Payment: \$ 177952.50	<b>Milestone 4</b> [P-6]: <b>Metric 1</b> [P-6.1]: Goal: Meet weekly with providers to ensure loop closure. Data Source: EHR Estimated savings \$650000  Milestone 4 Estimated Incentive Payment: \$304939	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$ 303912	Year 3 Estimated Milestone Bundle Amount: \$352227	Year 4 Estimated Milestone Bundle Amount: \$ 355915	Year 5 Estimated Milestone Bundle Amount: \$304939	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over DYs 2-5): \$ 1,316,993				

## Category 3 Projects

**Patient Satisfaction –RHP Project 130089906.3.1  
Ballinger Memorial Hospital District/130089906**

**Pass 3B**

**Patient Satisfaction –  
RHP Project Old ID 130089906.3.1 New ID 130089906.3.4  
Ballinger Memorial Hospital District/130089906**

- **Outcome Measure Description:** Ballinger Memorial Hospital District (BMHD) will survey patient in the rural health clinic, Ballinger Hospital Clinic (BHC), to determine patient satisfaction. The target of this project is to improve patient satisfaction by 3% at the end of the project (DY5). BMHD currently uses HCAHPS in the inpatient hospital setting. This project would expand patient surveys to BHC.
- **Rationale:** The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.
- **Outcome Measure Valuation:** CNA-008 Measuring Patient Satisfaction is addressed with the accomplishment of this project. This project is directly related to the category 1 project 130089906.1.1. IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) The measures for the project include the following questions:
  1. Are getting timely care, appointments, and information
    - a. The convenience of the location of the clinic
    - b. The hours when the clinic is open
    - c. Getting through to the clinic by phone
    - d. The personal matter (courtesy, respect, sensitivity, friendliness) of the telephone and scheduling staff
    - e. The length of time you waited between making the appointment for your visit and the day of your visit
    - f. The length of time you spent waiting to see the provider
    - g. The availability of medical information or advice by phone

Patient surveys will provide the data for determining percent improvement in targeted patient satisfaction domain (numerator) and number of patients who were administered the survey (denominator). DY2 will be an implementation year and a process measure will be used to gauge successful implementation of surveys. DY2 will serve as the baseline with

goals to be determined after implementation with approval of CMS and HHSC. Each of the above questions will be measured independently with goals and metrics provided for each accordingly.

Old ID 130089906.3.1 New ID 130089906.3.4	IT-6.1		Patient Satisfaction	
Ballinger Memorial Hospital District			130089906	
Related Category 1 or 2 Projects::	Old ID 130089906.1.1 New ID 130089906.1.2			
Starting Point/Baseline:				
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p><b>Process Milestone 1</b> P-7 Other activities not described above (Develop BHC surveys and implement process to establish baseline)</p> <p>Data Source: Documentation of surveys</p> <p>Process Milestone 1 Estimated Incentive Payment: \$21,066</p>	<p><b>Outcome Improvement Target 1</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 1 Estimated Incentive Payment: \$3,488</p> <p><b>Outcome Improvement Target 2</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 2 Estimated Incentive Payment: \$3,488</p> <p><b>Outcome Improvement Target 3</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 3</p>	<p><b>Outcome Improvement Target 1</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 1 Estimated Incentive Payment: \$5,598</p> <p><b>Outcome Improvement Target 2</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 2 Estimated Incentive Payment: \$5,598</p> <p><b>Outcome Improvement Target 3</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 3</p>	<p><b>Outcome Improvement Target 1</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 1 Estimated Incentive Payment: \$13,415</p> <p><b>Outcome Improvement Target 2</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 2 Estimated Incentive Payment: \$13,414</p> <p><b>Outcome Improvement Target 3</b> IT-6.1: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 3</p>	

Old ID 130089906.3.1 New ID 130089906.3.4	<i>IT-6.1</i>	<i>Patient Satisfaction</i>	
<i>Ballinger Memorial Hospital District</i>			130089906
<b>Related Category 1 or 2 Projects::</b>	<b>Old ID 130089906.1.1 New ID 130089906.1.2</b>		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	<p>Estimated Incentive Payment: \$3,488</p> <p><b>Outcome Improvement Target 4</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 4 Estimated Incentive Payment: \$3,488</p> <p><b>Outcome Improvement Target 5</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 5 Estimated Incentive Payment: \$3,489</p> <p><b>Outcome Improvement Target 6</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p>	<p>Estimated Incentive Payment: \$5,598</p> <p><b>Outcome Improvement Target 4</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 4 Estimated Incentive Payment: \$5,598</p> <p><b>Outcome Improvement Target 5</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 5 Estimated Incentive Payment: \$5,597</p> <p><b>Outcome Improvement Target 6</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p>	<p>Estimated Incentive Payment: \$13,414</p> <p><b>Outcome Improvement Target 4</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 4 Estimated Incentive Payment: \$13,414</p> <p><b>Outcome Improvement Target 5</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p> <p>Outcome Improvement 5 Estimated Incentive Payment: \$13,414</p> <p><b>Outcome Improvement Target 6</b> <i>IT-6.1</i>: TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b></p>

Old ID 130089906.3.1 New ID 130089906.3.4	IT-6.1	Patient Satisfaction	
Ballinger Memorial Hospital District			130089906
Related Category 1 or 2 Projects::	Old ID 130089906.1.1 New ID 130089906.1.2		
Starting Point/Baseline:			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	Outcome Improvement 6 Estimated Incentive Payment: \$3,489 <b>Outcome Improvement Target 7 IT-6.1:</b> TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b> Outcome Improvement 7 Estimated Incentive Payment: \$3,488	Outcome Improvement 6 Estimated Incentive Payment: \$5,597 <b>Outcome Improvement Target 7 IT-6.1:</b> TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b> Outcome Improvement 7 Estimated Incentive Payment: \$5,597	Outcome Improvement 6 Estimated Incentive Payment: \$13,414 <b>Outcome Improvement Target 7 IT-6.1:</b> TBD with approval of CMS and HHSC Data Source: <b>Patient survey</b> Outcome Improvement 7 Estimated Incentive Payment: \$13,414
Year 2 Estimated Outcome Amount:): \$21,066	Year 3 Estimated Outcome Amount: \$24,418	Year 4 Estimated Outcome Amount: \$39,183	Year 5 Estimated Outcome Amount: \$93,899
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$178,566</b>			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

**Pass 2**  
**Diabetes care: HbA1c poor control –RHP Project 130089906.3.2**  
**Ballinger Memorial Hospital District/130089906**  
**Diabetes care: HbA1c poor control –**  
**RHP Project Old ID 130089906.3.2 New ID 130089906.3.5**  
**Ballinger Memorial Hospital District/130089906**

**Outcome Measure Description:** Ballinger Memorial Hospital District (BMHD) will implement a diabetes management program in the Ballinger Hospital Clinic (BHC), to improve the healthcare of patients with this chronic disease. The target of this project is to improve the health of patients by monitoring, controlling, and educating patients with diabetes. Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 will be the measure for this project. The baseline and goals of this project will be determined after the implementation of the project with the approval of HHSC and CMS.

**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:** CNA-001 Adult Diabetes Rate is addressed through the success of this project. As RHP 13's community needs assessment states, the adult diabetes rate for the region is a need that requires addressing. This project would fulfill this need.

Old ID 130089906.3.2 New ID130089906.3.5	<i>IT-1.10</i>	<i>Primary Care and Chronic Disease Management</i>	
<i>Ballinger Memorial Hospital District</i>			130089906
<b>Related Category 1 or 2 Projects::</b>	130089906.2.2		
<b>Starting Point/Baseline:</b>	<i>TBD based on approval of HHSC and CMS</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 <i>IT-1.10</i>:</b> Develop diabetes management program plan and enroll patients into program.  Data Source: Documentation of diabetes management plan and protocol and enrollment of patients to establish baseline of HbA1c.  Process Milestone 1 Estimated Incentive Payment: \$4,132	<b>Outcome Improvement Target 1 <i>IT1.10</i>:</b> TBD with approval of CMS and HHSC Data Source: <b>EMR</b>  Outcome Improvement 1 Estimated Incentive Payment: \$4,789	<b>Outcome Improvement Target 2 <i>IT1.10</i>:</b> TBD with approval of CMS and HHSC Data Source: <b>EMR</b>  Outcome Improvement 2 Estimated Incentive Payment: \$7,685	<b>Outcome Improvement Target 3 <i>IT1.10</i>:</b> TBD with approval of CMS and HHSC Data Source: <b>EMR</b>  Outcome Improvement 3 Estimated Incentive Payment: \$18,377
Year 2 Estimated Outcome Amount:): \$4,132	Year 3 Estimated Outcome Amount: \$4,789	Year 4 Estimated Outcome Amount: \$7,685	Year 5 Estimated Outcome Amount: \$18,377
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): \$34,983			

**Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects**

**Pass 2**  
**Diabetes care: BP Control (<140/80mm Hg) –RHP Project 130089906.3.3**  
**Ballinger Memorial Hospital District/130089906**

**Pass 3B**  
**Diabetes care: BP Control (<140/80mm Hg) –**  
**RHP Project Old ID 130089906.3.3 New ID 130089906.3.6**  
**Ballinger Memorial Hospital District/130089906**

**Outcome Measure Description:** Ballinger Memorial Hospital District (BMHD) will implement a diabetes management program in the Ballinger Hospital Clinic (BHC), to improve the healthcare of patients with this chronic disease. The target of this project is to improve the health of patients by monitoring, controlling, and educating patients with diabetes. Diabetes care: BP control (<140/80mm Hg) - NQF 0061 will be the measure for this project. The baseline and goals of this project will be determined after the implementation of the project with the approval of HHSC and CMS.

**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:** CNA-001 Adult Diabetes Rate is addressed through the success of this project. As RHP 13's community needs assessment states, the adult diabetes rate for the region is a need that requires addressing. This project would fulfill this need.

Old ID 130089906.3.3 New ID 130089906.3.6	<i>IT-1.11</i>	<i>Primary Care and Chronic Disease Management</i>	
<i>Ballinger Memorial Hospital District</i>			130089906
<b>Related Category 1 or 2 Projects::</b>	130089906.2.2		
<b>Starting Point/Baseline:</b>	<i>TBD based on approval of HHSC and CMS</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 <i>IT-1.11</i>:</b> Develop diabetes management program plan and enroll patients into program.  Data Source: Documentation of diabetes management plan and protocol and enrollment of patients to establish baseline of blood pressure.  Process Milestone 1 Estimated Incentive Payment: \$4,132	<b>Outcome Improvement Target 1 <i>IT1.11</i>:</b> <i>Diabetes care: BP control (&lt;140/80mm Hg)</i> <b>Improvement Target:</b> TBD with approval of CMS and HHSC Data Source: <b>EMR</b>  Outcome Improvement 1 Estimated Incentive Payment: \$4,789	<b>Outcome Improvement Target2 <i>IT1.11</i>:</b> TBD with approval of CMS and HHSC Data Source: <b>EMR</b>  Outcome Improvement 2 Estimated Incentive Payment: \$7,685	<b>Outcome Improvement Target 3 <i>IT1.11</i>:</b> TBD with approval of CMS and HHSC Data Source: <b>EMR</b>  Outcome Improvement 3 Estimated Incentive Payment: \$18,378
Year 2 Estimated Outcome Amount:): \$4,132	Year 3 Estimated Outcome Amount: \$4,789	Year 4 Estimated Outcome Amount: \$7,685	Year 5 Estimated Outcome Amount: \$18,378
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$34,984</i>			

**Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects**

**Category 3 DSRIP Project Narrative**  
**Center for Life Resources – 133339505.3.1**

**Outcome Domain:** OD-9 Right Care, Right Setting

**Title of Outcome Measure (Improvement Target):** IT-9.2 ED appropriate Utilization (Standalone measure). Reduce Emergency Department visits for target conditions. Target conditions being Behavioral Health/Substance Abuse.

**Unique RHP Outcome Identification Number:** 133339505.3.1

**Title of Category 1 or 2 Project:** 133339505.1.1 - Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services

**Performing Provider Name:** Center for Life Resources

**Performing Provider TPI #:** 133339505

**Outcome Measure Description:**

OD -9 – Right Care, Right Setting

IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse.

**Process Milestones:**

- **DY 2:**
  - P-1 Project planning -engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 Establish baseline rates
  
- **DY 3:**
  - P-3 Develop and test data systems
  - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Outcome Improvement Target for each year:**

- **DY 4:**
  - IT-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse – Reduction to Baseline to be determined
  
- **DY 5:**
  - IT-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse Reduction to Baseline to be determined

**Rationale:**

We chose to use project planning and establishing baselines in DY2 in order to form a solid foundation to measure the change we hope to introduce. In DY3 we will test our conclusions from DY2 and make adjustments in order to better plan, do, study and act. In DY4 and DY5 we will implement what we have learned in the previous years. We expect to see the resultant information become useful for other rural/frontier areas facing similar issues.

**Outcome Improvement Targets:**

Our goal with the right care, right setting emphasis is to do just what is implied but also to reduce unnecessary emergency room visits. As our program begins to provide services to those who thought they would need to go to an emergency room for behavioral health/substance use treatment previously. Individuals will now have a choice to receive telemedicine services in their own community without having to drive to another county. This would both benefit the consumer as well as the emergency services of McCulloch and Coleman Counties that are already very stretched for resources.

**Outcome Measure Valuation:**

According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Shannon Medical Center (SMC) is \$2,193.00 a day with a median charge of \$13,638.00 located in Tom Green County. Further research shows the average cost to transport an individual to a local hospital by local EMS services is \$655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from \$12.50 to \$25+ per hour, so in an average situation this would be an additional \$30-\$75 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around \$17,000 per year. This number may vary from \$15,000-\$20,000 depending on hours of law enforcement time and travel time for EMS services. The given \$17,000 is solely an average and our best estimation based on prior experience. The Center for Life Resources (CFLR) currently provides behavioral health services for clients with Medicaid, Medicare, private insurance and both uninsured and underinsured clients. CFLR does not currently receive any U.S. Department of Health and Human Services for telemedicine services.

This project seeks to provide 84 telemedicine encounters in DY4 and 96 in DY5. We plan to do this where no known or limited services are being provided currently. Due to the nature of these locations and their distinction as mental health professional shortage areas, it is often difficult or even prohibitive for individuals to receive appropriate services in the right setting. Our valuation places priority on patient and community benefit through our pursuit of providing the right care at the right time in the right place. We have attempted to demonstrate the current cost of providing these services and the advantages of providing them locally through our proposed telemedicine project. The data will clearly demonstrate the need to attempt telemedicine services in this area to reduce improve appropriate emergency department usage.

Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly \$17,000 per event. The stated per

event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 84 encounters we intend to provide in DY4 in the current system would cost over 1.4 million dollars ( $84 * 17,000 = 1,428,000$ ). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 3 million dollars ( $96 * 17,000 = 1,632,000 + 1,396,080 = 3,060,000$ ). Given the total four-year incentive payment of \$674,793 the cost savings and value of providing right care in the right setting is a fraction of the cost (22%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings. Similar to other projects in our region we looked at cost utility analysis and quality of adjusted life year (QALY) with respect to the varying level these were valued. Data provided by the Agency of Health Care Research and Quality (AHRQ) gave a range from \$50,000 to \$200,000 per (QALY) in the United States.

<http://www.ahrq.gov/research/iomqrdrrreport/futureqrdrapf1.htm>

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

**Center for Life Resources 133339505.1.1 (Project 1.11.1)  
Related Category 3 Outcomes**

133339505.3.1

IT-9.2

**IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse**

**Center for Life Resources**

**133339505**

**Related Category 1 or 2 projects:**

133339505.1.1

**Starting Point/Baseline:**

**Starting Point/Baseline is TBD for DY2**

**Year 2  
(10/1/2012 – 9/30/2013)**

**Year 3  
(10/1/2013 – 9/30/2014)**

**Year 4  
(10/1/2014 – 9/30/2015)**

**Year 5  
(10/1/2015 – 9/30/2016)**

**Process Milestone 1 [P-1]:**  
Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Data Source:** Program records, agendas and minutes.

**Process Milestone 1 Estimated Incentive Payment: \$0**

**Process Milestone 2 [P-2]:**  
Establish baseline rate

**Data Source:** Anasazi, program records, law enforcement, EMS

**Process Milestone 2 Estimated Incentive Payment: \$0**

**Process Milestone 3 [P-3]:**  
Develop and test data systems  
  
**Data Source:** Anasazi, Program Records, Law Enforcement, EMS

**Process Milestone 3 Estimated Incentive Payment: \$10,000**

**Process Milestone 4 [P-4]:**  
Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Data Source:** QM data reports and Communication documents

**Process Milestone 3 Estimated Incentive Payment: \$ 9,000**

**Outcome Improvement Target 1 [IT-9.2]:** ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse

**Improvement Target:** TBD depending on baseline established during DY 2 and confirmed during DY 3.

**Data Source:** Anasazi, Program Records, Law Enforcement, and EMS

**Process Milestone 3 Estimated Incentive Payment: \$22,000**

**Outcome Improvement Target 1 [IT-9.2]:** ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse

**Improvement Target:** TBD depending on baseline established during DY 2 and confirmed during DY 3.

**Data Source:** Anasazi, Program Records, Law Enforcement, and EMS

**Estimated Incentive Payment: \$43,625**

<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$19,000</b>	<b>Year 4 Estimated Outcome Amount: \$22,000</b>	<b>Year 5 Estimated Outcome Amount: \$43,625</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): \$84,625</b>			

### **Category 3: Quality Improvements**

Coleman County Medical Center (CCMC) Category 1 project IT-9.2 ED Appropriate Utilization (Standalone measure) will be the identifying measure as an end result of our program to expand primary care capacity and thereby reduce non-emergent emergency room visits. This project will be developed with a collaborative regional effort within Region 13 to develop processes, best practices, innovative models and risk assessment tools. Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. CCMC also seeks to transform cost of care by appropriate triage and referral of non-emergent patients to a primary care setting. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, CCMC performing providers seek to improve the health outcomes for targeted patients as well as the total population. Additionally, CCMC will establish Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program to provide health insurance coverage for identified population as well as long term insurance coverage for post-delivery care for children.

Challenges include lack of enough primary care providers to cover both Emergency Room, Clinic and Inpatients in sole County Hospital and Clinic. Lack of physicians further limits the Clinic hours of operation. Emergency room space is severely limited to accommodate ER volumes and Clinic space will have to be expanded to accommodate any additional providers and nurses.

- IT-9.2 ED Appropriate Utilization
- New: 136144610.3.3 (OLD: 136144610.3.1)
- Coleman County Medical Center/136144610.

**Outcome Measure Description:** Reduction in non-emergency care by approximately 550 visits annually by year 5.

#### **Rationale:**

Emergency room visits for non-urgent care result in 300% to 400% increase in costs for Medicare and Medicaid patients as well as insured patients. Additionally, they absorb very limited resources in a rural hospital setting such as CCMC, for non-emergency treatment. Non-emergent patients also reduce nursing and physician staff time to treatment for true emergency patients. Non-

urgent care can be re-directed and re-educated to the right care, in the right clinical setting and at the right time. CCMC will develop additional resources to increase primary and preventive care expansions which will result in improved access and best utilization of appropriate health care resources and care coordination.

- **Outcome Measure Valuation:**

Development of an innovative ER triage and education model; combined with an expansion of our primary care capacity will enable CCMC to reduce cost of care to patients by increasing access to care and providing treatment or right care, in the right clinical setting and at the right time. CCMC will coordinate best practices and innovative models developed with our Regional partners to reduce ER visits and unnecessary costs within the regional healthcare delivery system. CCMC goal is reduction in non-emergency care by approximately 550 visits annually by year 5.

New: 136144610.3.3 (OLD: 136144610.3.1)	IT-9.2	ED Appropriate Utilization	
Coleman County Medical Center		136144610	
<b>Related Category 1 or 2 Projects: 1.1</b>	136144610.1.2 (New) 136144610.1.1 (Old)		
<b>Starting Point/Baseline:</b>	<i>Demonstration Year 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Baseline/Goal: Established baseline rate of 1,135 non-emergent patients presenting to ER annually out of total ER annual visits of approximately 3700.  Data Source: Documentation of Planning and Stakeholder Engagement	<b>Process Milestone 3</b> P- 2 Established baseline rate of 1,135 non-emergent patients presenting to ER annually. Implement the ER emergent care referral model to primary care clinics. Develop referral program data base.  Improvement Target: Reduction in non-emergency ER care by 250 patients annually from baseline of 1,135 non-emergent patients presenting to ER.  Add nurse triage line.  Data Source: Clinic & ER patient registry	<b>Outcome Improvement Target 1</b> IT-9.2  Improvement Target:  Reduction in non-emergency ER care by 450 patients annually from baseline of 1,135 non-emergent patients presenting to ER.  Increase nurse triage line assistance by estimated 100 patients annually. Referral/appointments to primary care clinics for non-emergent care patients within 1.5 days of presentation to ER.  Enhanced capacity to provide urgent care services in the	<b>Outcome Improvement Target 2</b> IT-9.2  Improvement Target:  Reduction in non-emergency ER care by 550 patients annually from baseline of 1,135 non-emergent patients presenting to ER.  Additional increase of number of patients served by nurse triage line to 350 annually.  Data Source: EMR/Clinic Registry  Outcome Improvement Target 1 Estimated Incentive Payment: \$99,304

New: 136144610.3.3 (OLD: 136144610.3.1)	IT-9.2	ED Appropriate Utilization	
Coleman County Medical Center			136144610
<b>Related Category 1 or 2 Projects: 1.1</b>	136144610.1.2 (New) 136144610.1.1 (Old)		
<b>Starting Point/Baseline:</b>	<i>Demonstration Year 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$22,326	Process Milestone 3 Estimated Incentive Payment: \$25,879	primary care clinic setting as an alternate to ER utilization.  Data Source: Clinic & ER patient registry  Outcome Improvement Target 1 Estimated Incentive Payment: \$41,527	
Year 2 Estimated Outcome Amount: Establish criteria for non-emergent ER treatment assignment \$22,326	Year 3 Estimated Outcome Amount: \$25,879	Year 4 Estimated Outcome Amount: \$41,527	Year 5 Estimated Outcome Amount: \$99,304
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): \$189,036			

### **Category 3: Quality Improvements**

CCMC Category 2 project OD-8 IT-8.2 Percentage reduction of Low Birth- weight births (CHIPRA/NQF # 1382)263 (Standalone measure) will be the identifying measure as an end result of our program to develop a patient-centered medical home for this high risk population. This project will be developed with a collaborative regional effort within Region 13 to develop processes, best practices, innovative models and risk assessment tools. Additionally, CCMC will establish Medical Advocacy Services for Healthcare and Medicaid eligibility assistance program to provide health insurance coverage for this identified population as well as long term insurance coverage for post-delivery care for children.

- OD-8 IT-8.2 Percentage reduction of Low Birth-weight births
- 136144610.3.4 (New) 136144610.3.2 (Old)
- Coleman County Medical Center/136144610.

**Outcome Measure Description:** 10% reduction in low birth-weight births in Coleman County by year 5.

**Rationale:** Low birth rate children statistically face long-term problems such as cerebral palsy, intellectual disabilities, visual and hearing impairments and learning difficulties. Among Texas Medicaid –funded newborns, low birth rate and resulting NICU admissions consume 66% of newborn care expenditure. Presently, over 50% of all pregnant women in the county are presenting to Clinics or ER without pre-natal care during their first trimester. We believe by implementation of a medical home model for this at-risk population, will result in earlier pre-natal care which will produce more full term deliveries and higher birth-weights. Additionally, a medical advocacy/Medicaid eligibility assistance program will provide longer term insurance coverage and thus, open access to care. Predominantly lack of prenatal care and resulting low birth rate deliveries are due to the economic barriers of accessing health care.

#### **Outcome Measure Valuation**

Development of a patient center medical home model, coupled with a medical insurance/Medicaid medical advocacy program will result in higher percentages of pre-natal care and reduce barriers to both pre-natal care and longer term infant health care for Coleman County.

Focusing on improving the low-birth weight outcomes will help improve the likelihood of lower pre-term deliveries and improve outcomes for high-risk deliveries.

136144610.3.4 (New) 136144610.3.2 (Old)	OD-8 IT-8.X		Perinatal Outcomes	
Coleman County Medical Center			136144610	
<b>Related Category 1 or 2 Projects: 2.1.3</b>	136144610.2.2 (New) 136144610.2.1 (Old)			
<b>Starting Point/Baseline:</b>				
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Data Source: Documentation of Planning and Stakeholder Engagement  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$23,814	<b>Process Milestone 3</b> P- 2 Establish baseline rates. Implement the medical home model in primary care clinics. Develop referral program data base.  Data Source: Clinic & ER patient registry  Process Milestone 3 Estimated Incentive Payment: \$27,604	<b>Outcome Improvement Target 1</b> IT-8.2  Improvement Target: TBD Reduce County low birth rate by 5% by DY4. Improve the number of eligible patients that are assigned to the medical homes. Enrollment of eligible patients who are maintaining prenatal care visits as scheduled. Referral rate of 50% of potential expectant mothers without insurance to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance.  Data Source: Clinic & ER patient registry	<b>Outcome Improvement Target 2</b> IT-8.2  Improvement Target: TBD Reduce County low birth rate by 10% by DY5 . 40% enrollment in patient centered medical home of pregnant women within first tri-semester. Referral of rate of 75% of potential expectant mothers without insurance to Medical Advocacy Services for Healthcare and Medicaid eligibility assistance. Reminders or direct contact for 75% of pre-natal patients preventive services	

136144610.3.4 (New) 136144610.3.2 (Old)	<i>OD-8 IT-8.X</i>	<b>Perinatal Outcomes</b>	
Coleman County Medical Center			136144610
<b>Related Category 1 or 2 Projects: 2.1.3</b>	136144610.2.2 (New) 136144610.2.1 (Old)		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		Outcome Improvement Target 1 Estimated Incentive Payment: \$44,295	Data Source: EMR/Registry  Outcome Improvement Target 1 Estimated Incentive Payment: \$105,924
Year 2 Estimated Outcome Amount: \$23,814	Year 3 Estimated Outcome Amount: \$27,604	Year 4 Estimated Outcome Amount: \$44,295	Year 5 Estimated Outcome Amount: \$105,924
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$201,637</i>			

### **Category 3: Quality Improvements**

Concho County Hospital (CCH) goal for Category 3 quality improvements is to have the Health and Wellness Promotion Program established and available to all diabetics as well as the general public. The dietician and physical therapist will be working steadily to improve the health of each individual. CCH strives to improve the quality of life for our community and surrounding areas.

**Narrative for each Category 3 Outcome Measure shall include:**

#### **Concho County Hospital Health and Wellness Promotion 091770005.3.1**

##### **OD-1 Primary Care and Chronic Disease Management**

##### **IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure)**

- e. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- f. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
- g. Data Source: EHR, Registry, Claims, Administrative clinical data
- h. Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly \$100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars

- **Identifying Outcome Measure and Provider Information:**

- 3.1 - Implement Evidence-based Health Promotion Programs, Concho County Hospital, 091770005, 091770005.3.1

- **Outcome Measure Description:**

- **P-1 DY2 – Process Milestone:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- **P-2 DY3- Process Milestone:** Establish baseline rates. Targeted population: Diabetic patients with HbA1c poor control (>9.0%)  
**Improvement Target:** IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233-NQF 0059 (Standalone measure)

- **Rationale:** Within the last year, 16% of all patients seen at CCH had Diabetes as their primary diagnosis. Currently, CCH does not provide hands-on treatment for diabetic patients. Treatment is limited to medication therapy and consultations provided by medical staff. This Health and Wellness program will provide additional education on diet and exercise with the onsite staff. The patient will be instructed on the diabetic diet with adherence to their age and culture. A nutritionist will have one-on-one dietary consultation and will follow-up regularly to discuss dietary challenges to include cooking instructions
- **Outcome Measure Valuation:** We value the outcomes for DY2 and DY3 because we want to avoid costly errors and because we need ample time to research and effectively complete the project. The better we do in the planning process, the better the results will be for our clients. The Health and Wellness Center will attempt to educate, embrace, and understand patients' individual needs. We understand the diabetic challenges will be continuous and varying from patient to patient. We plan to individualize each care plan accordingly. Our goal of maintaining a healthy lifestyle for the diabetic patient will be constant and changing. We hope to keep the patient coming back because they want to live healthier and not because they have to. Non-compliant diabetic patients will lose free access to the program and will be replaced. CCH has a fully staffed laboratory, a receptionist, and an EHR system to collect data. These existing systems will help with cost avoidance.

NEW 091770005.3.2 OLD: 091770005.3.1	<b>IT-1.10 Diabetes care</b>	Implement Evidence-based Health Promotion Programs, Concho County Hospital, 091770005, 091770005.3.1	
<i>Concho County Hospital</i>			<i>091770005</i>
<b>Related Category 1 or 2 Projects:</b>	<i>091770005.2.1</i>		
<b>Starting Point/Baseline:</b>	<i>Establish baseline rates in DY 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone P-1 DY2</b>  <b>Estimated Incentive Payment: \$21,066</b>  <b>Data Source:</b> Documentation of planning.	<b>Process Milestone 3 [P-4] P-2 DY3</b>  <b>Improvement Target:</b> Establish Baseline  <b>Estimated Incentive Payment: \$24,419</b>  <b>Data Source: EHR, Registry, Claims, Administrative clinical data</b>  <b>Baseline TBD</b>	<b>Outcome Improvement Target 1</b>  <b>Improvement Target: TBD</b> IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure) <b>Numerator:</b> 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:</b> Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)  <b>Estimated Incentive Payment:</b>	<b>Outcome Improvement Target 2</b>  <b>Improvement Target: TBD</b> IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure) <b>Numerator:</b> 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:</b> Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)  <b>Estimated Incentive Payment:</b>

NEW 091770005.3.2 OLD: 091770005.3.1	<b>IT-1.10 Diabetes care</b>	Implement Evidence-based Health Promotion Programs, Concho County Hospital, 091770005, 091770005.3.1	
<i>Concho County Hospital</i>			<i>091770005</i>
<b>Related Category 1 or 2 Projects:</b>	<i>091770005.2.1</i>		
<b>Starting Point/Baseline:</b>	<i>Establish baseline rates in DY 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		\$39,183  Data Source: EHR, Registry, Claims, Administrative clinical data	\$93,699  Data Source: EHR, Registry, Claims, Administrative clinical data
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$21,066	Year 3 Estimated Outcome Amount: \$24,419	Year 4 Estimated Outcome Amount: \$39,183	Year 5 Estimated Outcome Amount: \$93,699
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$178,367			

### **Category 3: Quality Improvements**

The goal of Category 3 is to assess an outcome of a project implemented under Category 1 or 2. As described in the Program Funding and Mechanics Protocol, each Category 1 and 2 project is required to have an associated Category 3 outcome measure.

#### **Narrative for each Category 3 Outcome Measure shall include:**

- The narrative for each Category 3 Outcome Measure is limited to 3 pages.

#### **Identifying Outcome Measure and Provider Information:**

OD-2 Potentially Preventable Admissions, 138715115.3.2

IT-2.2 ESRD Admission Rate

Heart of Texas Memorial Hospital - 138715115

- **Outcome Measure Description:**

Reduce Potentially Preventable Admissions (PPA) due to complications with ESRD because of travel and noncompliance over the time period by 5% each year or 8 PPA's. With the creation/expansion of a specialty clinic for dialysis, hospital costs for related PPA's should be reduced as research shows there is a \$1:1.7 cost to benefit ratio for the creation of local care clinics for ESRD.

Measurements will be taken from and thru existing hospital data and patient information. Reports will provide the changes over the baseline and in clinic utilization in future years.

138715115.1.9 OD-2 IT-2.2 ESRD Admission Rates:

Metric: Create survey, measure, and report findings.

- A. Numerator: All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease.
- B. Denominator: Discharges in the numerator are assigned to the denominator based on the Metro Area<sup>1</sup> or county of the patient residence, not the Metro Area or county of the hospital where the discharge occurred.
- C. Data Source: EHR, Claims
- D. Rationale/Evidence: Hospitalization rates are an important indicator of patient morbidity and quality of life. On average, dialysis patients are admitted to the hospital twice a year and hospitalizations account for approximately 36 percent of total Medicare expenditures for dialysis patients (U.S. Renal Data System, 2007). Measures of the frequency of hospitalization help efforts to control escalating medical costs, and play an important role in providing cost effective health care.

Data shows, 78% of our patients are Medicaid or indigent. Once a baseline is created, reports will measure changes year over year.

- **Rationale:**

With the prevalence of ESRD patients in our territory and the projected growth rate, the vitality of a dialysis treatment center would reduce unnecessary ER visits (CNA-007), acute stays, and EMS transfers, all related to ESRD and distances traveled. With the current obesity and diabetic levels in our region (CNA-001, 002, 003), disease related issues will continue to rise also.

The study will identify the baseline data for the region. Once the specialty clinic is operational, it is anticipated that the patient experience and quality of life will increase and PPA related care needs will be reduced. For the area, the clinic will allow hospital resources to be used in addressing other community needs.

- **Outcome Measure Valuation:**

The value to the community can be measured thru the reduction in hospital resources dedicated to ESRD. 628 Patients were diagnosed with Renal Failure, related Kidney Disease, or ESRD within the last twelve months at our facility thru the Emergency department or acute stay. The project seeks to provide local treatment for 50 ESRD diagnosed patients in order to reduce the 156 ED and Acute care admissions and/or EMS transfers because of complications of long distance travel for care. 78% are Indigent or Medicaid patients. Average cost ranges from \$5,800 to \$32,000 per inpatient stay. Single ER visit averages \$2,600. The reduction in PPA's would enable the hospital to reallocate resources otherwise tied to ESRD. Research shows a cost/benefit of \$1:1.7 thru local care, increasing compliance, and relieving pressures on EMS and Hospital resources. Our goal is to reduce hospital PPA's by 5% each year or 8 PPA's per year due to travel related complications. In DY1 and DY2 we will be in the construction and opening phases of the specialty clinic. In DY3, it is our intent to begin reducing PPA's. In DY4 and DY5 we have the same annual goal for a total project reduction of 15% or 24 admissions. Initially, the total cost savings could be immense as the number of patients and admissions continues to increase.

**Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:**

- **Identifying Outcome and Provider Information:**

- Heart of Texas Memorial Hospital - 138715115
- Potentially Preventable Admissions – 138715115.3.2, OD-2
- IT-2.2 ESRD Admission Rates
- 138715115.3.2 - 2.28 Expand Specialty Care Capacity

- **Starting Point/Baseline (if applicable):**

Currently without ESRD specialty care, local emergency departments and hospitals see patients with complications from distance and non-compliance issues in their respective care programs. Acute admissions and transfers to tertiary hospitals are the norm for an ESRD patient who presents themselves for care because of complications. A gap assessment regarding ESRD and renal failure care will create the baseline. Measurements of frequency and costs with regards to emergency department utilization, acute care, and EMS transfer rates, will be included. Data will be collected each year for continued monitoring. Continued growth will be essential for the clinic thru referrals as reductions of 5% each year in PPA's has been targeted

- **Process Milestones/Outcome Improvement Targets:**

The data gathered in order to create the baseline and measure the size and scope of the specialty care expansion. It will also dictate the clinic design, equipment purchases,

staff, providers, and training needs. A referral network will be essential for other outside providers. All of which has been factored in to the reduction targets of PPA's.

- **RHP Planning Protocol Reference:**

(P1)After the gap assessment, renovate area and (P11) launch specialty clinic. (P3) Collect data from clinic scheduler, EMR and Administrative Documentation for measurements. (I-23) Increase volume in order to increase reductions in PPA's. (IT-2.2) Measure the reductions from comparison data to baseline with respect to targets.

- **Incentive Payment Amount:**

Incentive payments for the life of the project for category 3 equal \$458,423. See table for details.

<b>PROJECT</b> <b>138715115.3.1</b> <b>(OLD)</b> 138715115.3.3 <b>(NEW)</b>	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>	
<i>Heart of Texas Memorial Hospital</i>			138715115	
<b>Related Category 3</b> <b>Outcome</b> <b>Measure(s):</b>		IT-2.2	<i>Potentially Preventable Admissions</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<b>Milestone 1</b> P1A: Metric: Report on ESRD Incidence and Prevalence in McCulloch County creating baseline.  IT-2.2 ESRD Admission Rates Create baseline and measure current related PPA Hospitalization rates.  <u>Metric P-1</u> Data Source: EMR, Claims  Milestone 1 Estimated Incentive Payment : \$54,143	<b>Milestone 2:</b> P1A (M2): Metric: Report Changes in/from Baseline.  IT-2.2 (M2) ESRD Admission Rates Measure changes to rates and costs. <u>Goal</u> = 5% decrease over baseline.  <u>Metric P-1 (M2)</u> Data Source: EMR, Claims  Milestone 2 Estimated Incentive Payment: \$62,758	<b>Milestone 3:</b> P1A (M3): Metric: Report Changes in/from Milestone 2.  IT-2.2 (M3) ESRD Admission Rates Measure changes to rates and costs. <u>Goal</u> = 5% decrease over (M2).  <u>Metric P-1 (M3)</u> Data Source: EMR, Claims  Milestone 3 Estimated Incentive Payment: \$100,705	<b>Milestone 4:</b> P1A (M4): Metric: Report Changes in/from Milestone 3.  IT-2.2 (M4) ESRD Admission Rates Measure changes to rates and costs. <u>Goal</u> = 5% decrease over (M3).  <u>Metric P-1 (M4)</u> Data Source: EMR, Claims  Milestone 4 Estimated Incentive Payment: \$240,817	

<b>PROJECT</b> <b>138715115.3.1</b> <b>(OLD)</b> 138715115.3.3 <b>(NEW)</b>	<b>1.9.2</b>	<b>1.9.2</b>	<b>ESRD DIALYSIS CENTER</b>	
<i>Heart of Texas Memorial Hospital</i>			138715115	
<b>Related Category 3</b> <b>Outcome</b> <b>Measure(s):</b>		IT-2.2	<i>Potentially Preventable Admissions</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Milestone Bundle Amount: <i>(add incentive payments amounts from each milestone):</i> \$54,143	Year 3 Estimated Milestone Bundle Amount: \$62,758	Year 4 Estimated Milestone Bundle Amount: \$100,705	Year 5 Estimated Milestone Bundle Amount: \$240,817	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add milestone bundle amounts over Years 2-5):</i> \$458,423				

**\$54,143      \$62,758      \$100,705      \$240,817      \$458,423**



### **Pass 3**

#### **Category 3: Innovation and Design**

##### **Outcome Domain:** OD-10 Quality of Life/Functional Status

- Improvement Target: IT-10.1 Quality of Life (standalone measure)
- Unique Project ID Number: 138715115.3.2
- Performing Provider Name/TPI: Heart of Texas Memorial Hospital/138715115

##### **Outcome Measure Description:**

In demonstration year 2, Shannon Medical Center, the subcontractor for the proposed CATCH® in Motion project, will identify community needs, determine resources, and plan the interventions that will be implemented in McCulloch County throughout the waiver period. Once the aspects of the program and the target population are identified, baseline rates will be determined in demonstration year 3. In demonstration years 4 and 5, Quality of Life (QOL) scores will be assessed using a validated assessment tool for quality of life. The percent improvement in QOL scores is TBD.

##### **Rationale:**

The selected process milestones will assist in tailoring a program specific to the needs of McCulloch County. Determining baseline rates in the target population for the intervention, there will be opportunity to improve QOL scores by impacting behavior change and promoting healthy behaviors. According to the CDC, Quality of life is a broad multidimensional concept that usually includes subjective evaluations for both positive and negative aspects of life. The quality of life for children that are obese consist of reduced productivity, lower academic performance, lower self-esteem, and increased absenteeism due to illness. By improving quality of life, the schools and community will reinforce positive behavioral changes and healthy choices that will increase awareness of healthier behaviors.

##### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 2 project valuation to implement an evidence-based health promotion program. Each project was weighted on the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

An assessment tool will be determined to evaluate QOL scores. Depending on the validated assessment tool, there will be a cost involved to access the assessment, as well as the potential for contracting with the University of Texas Health Science Center for data compilation and scoring.

The importance of quality of life in children is essential to daily life as children grow older. By working with children, there is the opportunity to develop lifestyle and behavior changes that will impact the quality of their lifetime.

138715115.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)	
Heart of Texas Memorial Hospital		138715115	
Related Category 1 or 2 Projects::	138715115.2.1		
Starting Point/Baseline:	Determined in Demonstration Year 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> Documentation of planning  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$73,247	<b>Process Milestone 2 P-2</b> Establish baseline rates <u>Data Source:</u> EHR/claims  Process Milestone 3 Estimated Incentive Payment: \$85,531	<b>Outcome Improvement Target 1 IT-10.1 Quality of Life:</b> Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population <u>Target Improvement:</u> TBD <u>Data Source:</u> Provider may select a validated assessment tool for quality of life  <b>Outcome Improvement Target 1 Estimated Incentive Payment:</b> \$137,846	<b>Outcome Improvement Target 2 IT-10.1 Quality of Life:</b> Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population <u>Target Improvement:</u> TBD <u>Data Source:</u> Provider may select a validated assessment tool for quality of life  <b>Outcome Improvement Target 2 Estimated Incentive Payment:</b> \$329,957
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$73,247	Year 3 Estimated Outcome Amount: \$85,531	Year 4 Estimated Outcome Amount: \$137,846	Year 5 Estimated Outcome Amount: \$329,957
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ):			

138715115.3.2	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)	
Heart of Texas Memorial Hospital		138715115	
Related Category 1 or 2 Projects::	138715115.2.1		
Starting Point/Baseline:	Determined in Demonstration Year 3		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
\$626,581			

**Identifying Outcome Measure and Provider Information:**

*Title of Outcome Measure (Improvement Target):* IT-10.2 Activities of Daily Living/Co-occurring Psychiatric and Substance Use Disorder

Unique RHP outcome Identification number: 133340307.3.1

**Identifying Outcome Measure and Provider Information:**

*Title of Outcome Measure (Improvement Target):* IT-10.2 Activities of Daily Living/Co-occurring Psychiatric and Substance Use Disorder

Unique RHP outcome Identification number: 133340307.3.1

**Outcome Measure Description:**

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20)Adult Mental Health or Daily Living Activities (DLA-20) Youth Mental Health (Ages 6-18)

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale

DY4 IT10.2 15% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale

DY5 IT10.2 20% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale

**Rationale:**

Co-occurring Psychiatric and Substance Use Disorder impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

Outcome measures are based on the number of individuals that have begun treatment in the Co-occurring Psychiatric and Substance Use Disorder program and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years

No baseline is set as the measure is associated with the number of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services who show improvement on the DLA-20 compared to the total number receiving Co-occurring Psychiatric and Substance Use Disorder services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:** Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). ~~The proposed program's value is based on a monetary value of \$50,000 per QALY gained due to the intervention multiplied by number of participants.~~ The valuation on this project is based on 20 consumers over the life of the project (new enrollees 4 in DY3; 6 in DY4; and 10 in DY5)

133340307.3.1	OD10 IT-10.2	Activities of Daily Living Co-occurring Psychiatric and Substance Disorder	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			133340307
<b>Related Category 1 or 2 Projects:</b>	133340307.2.1		
<b>Starting Point/Baseline:</b>	Service not currently available		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	<p><b>Outcome Improvement Target 1</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 10% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent Activities of Daily Living Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$6,182</p>	<p><b>Outcome Improvement Target 2</b> IT-10.2: Activities of Daily Living</p> <p>Improvement Target:15% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent Activities of Daily Living Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$10,097</p>	<p><b>Outcome Improvement Target 3</b> IT-10.2: Activities of Daily Living</p> <p>Improvement Target: 20% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent Activities of Daily Living Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$14,378</p>

133340307.3.1	OD10 IT-10.2	Activities of Daily Living Co-occurring Psychiatric and Substance Disorder	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			133340307
<b>Related Category 1 or 2 Projects:</b>	133340307.2.1		
<b>Starting Point/Baseline:</b>	Service not currently available		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: \$6,182	Year 4 Estimated Outcome Amount: \$10,097	Year 5 Estimated Outcome Amount: \$14,378
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$30,657			

**Identifying Outcome Measure and Provider Information:**

*Title of Outcome Measure (Improvement Target):* IT-10.2 Activities of Daily Living/Trauma Informed Care

Unique RHP outcome Identification number: 133340307.3.2

**Outcome Measure Description:**

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health or Daily Living Activities (DLA-20) Youth Mental Health (Ages 6-18)

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT10.2 15% of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT10.2 20% of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

**Rationale:**

Trauma impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help

identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

Outcome measures are based on the number of individuals that have begun treatment in the Trauma Informed Care program and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Trauma Informed Care who show improvement on the DLA-20.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:** Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that are avoided). ~~The proposed program's value is based on a monetary value of \$50,000 per QALY gained due to the intervention multiplied by number of participants.~~ The valuation on this project is based on 25 consumers over the life of the project (number anticipated beginning service by year, DY3 6; DY4 8 DY5 11)

133340307.3.2	OD10 IT-10.2	Activities of Daily Living Trauma Informed Care	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			133340307
<b>Related Category 1 or 2 Projects:</b>	133340307.2.2		
<b>Starting Point/Baseline:</b>	Service not currently available		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	<p><b>Outcome Improvement Target 1</b> IT-10.2: Activities of Daily Living</p> <p>Improvement Target: 10% of individuals receiving Trauma Informed Care have improvement on subsequent Activities of Daily Living (DLA-20)</p> <p>Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$10,130</p>	<p><b>Outcome Improvement Target 2</b> IT-10.2: Activities of Daily Living</p> <p>Improvement Target:15% of individuals receiving Trauma Informed Care have improvement on subsequent Activities of Daily Living (DLA-20)</p> <p>Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$16,079</p>	<p><b>Outcome Improvement Target 3</b> IT-10.2: Activities of Daily Living</p> <p>Improvement Target: 20% of individuals receiving Trauma Informed Care have improvement on subsequent Activities of Daily Living (DLA-20)</p> <p>Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$23,558</p>

133340307.3.2	OD10 IT-10.2	Activities of Daily Living Trauma Informed Care	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			133340307
<b>Related Category 1 or 2 Projects:</b>	133340307.2.2		
<b>Starting Point/Baseline:</b>	Service not currently available		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: \$10,130	Year 4 Estimated Outcome Amount: \$16,079	Year 5 Estimated Outcome Amount: \$23,558
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$49,767</b>			

## Pass 2

### Identifying Outcome Measure and Provider Information:

*Title of Outcome Measure (Improvement Target):* IT-12.5 Activities of Daily Living/Veteran Mental Health Services

Unique RHP outcome Identification number: 133340307.3.3

### Outcome Measure Description:

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health.

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT10.2 15% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT10.2 20% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

### Rationale:

Veteran Mental Health services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For

the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

Outcome measures are based on the number of individuals that are referred from Veteran Peer Support to community based wrap around services ~~Mental Health Veteran services~~ and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years

No baseline is set as the measure is associated with the number of individuals receiving Veteran Mental Health services who show improvement on the DLA-20 compared to the total number receiving Veteran Mental Health services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:** Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). ~~The proposed program's value is based on a monetary value of \$50,000 per QALY gained due to the intervention multiplied by number of participants.~~ The valuation on this project is based on 30 20 consumers over the life of the project (number anticipated beginning service by year, DY3 4; DY4 6 DY5 10)

133340307.3.3	OD10 IT-10.2	Activities of Daily Living Veteran Mental Health Services	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			133340307
<b>Related Category 1 or 2 Projects:</b>	133340307.2.3		
<b>Starting Point/Baseline:</b>	Baseline will be individual DLA20 assessments as individuals enter program		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	<p><b>Outcome Improvement Target 1</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 10% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$8,484</p>	<p><b>Outcome Improvement Target 2</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 15% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$13,902</p>	<p><b>Outcome Improvement Target 3</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 20% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$20,633</p>
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: \$8,484	Year 4 Estimated Outcome Amount: \$13,902	Year 5 Estimated Outcome Amount: \$20,633
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$43,019</b>			

## Pass 2

### **Identifying Outcome Measure and Provider Information:**

*Title of Outcome Measure (Improvement Target):* IT-12.5 Activities of Daily Living/Whole Health Peer Support

Unique RHP outcome Identification number: 133340307.3.4

### **Outcome Measure Description:**

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT10.2 15% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT10.2 20% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

### **Rationale:**

Whole Health Peer Support services impact an individual's mental and physical health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

Outcome measures are based on the number of individuals that have begun treatment in the Whole Health Peer Support program and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years

No baseline is set as the measure is associated with the number of individuals receiving Whole Health Peer Support services who show improvement on the DLA-20 compared to the total number receiving Whole Health Peer Support services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

**Outcome Measure Valuation:** Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The proposed program's value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of \$23.36 for every dollar invested. The project seeks to provide services to a minimum of 50 individuals from the 5 counties served by Hill Country in RHP13 by the end of DY5 (10 in DY3; 15 in DY4 and 25 in DY5)

133340307.3.4	OD10 IT-10.2	Activities of Daily Living Whole Health Peer Support	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)		133340307	
<b>Related Category 1 or 2 Projects:</b>	133340307.2.4		
<b>Starting Point/Baseline:</b>	Baseline will be individual DLA20 assessments as individuals enter program		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	<p><b>Outcome Improvement Target 1</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 10% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$3,000</p>	<p><b>Outcome Improvement Target 2</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 15% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$4,263</p>	<p><b>Outcome Improvement Target 3</b> IT-10.2: <i>Activities of Daily Living</i></p> <p>Improvement Target: 20% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$5,327</p>
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: \$3,000	Year 4 Estimated Outcome Amount: \$4,263	Year 5 Estimated Outcome Amount: \$5,327
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$12,590</b>			

## **Kimble Hospital**

Outcome Measure: OD-2 Potentially Preventable Admissions

IT-2.1 Congestive Heart Failure admission rate (Standalone Measure)

Performing Provider/TPI: Kimble Hospital 206083201

Outcome ID Number: 2060833201.3.1

Kimble Hospital 206083201

Cat 2 Project Identifier: 2.7 Implement Other Evidence-based Disease Prevention Programs

### ***Category 3: Quality Improvements***

**Outcome Measure Description:** Reduce admissions for Congestive Heart Failure for population age 18 and over by 2% over baseline.

**Rationale:** Hospitalizations for Congestive Heart Failure and Diabetes are considered “potentially preventable,” because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. The methodology used to identify “potentially preventable hospitalizations” was developed by the Agency for Healthcare Research and Quality (AHRQ). AHRQ is the lead federal agency responsible for research on healthcare quality costs, outcomes and patient safety.

**Outcome Measure Valuation:** We valued the project at \$178,371 based on the following:

**Project Size:** We currently admit patients to the hospital for Exacerbation of Congestive Heart Failure and Diabetes. We plan to expand our services to the CHF population by purchasing a component to our existing ultrasound machine to provide the service of echocardiograms which will help in managing the patient’s disease. We will expand teaching of CHF and Diabetes to all ED discharges and will provide education in Community Health Fair and Mini Clinics. We expect a decrease in acute admissions with these efforts.

**Project Scope:** We will provide education, publicity, and outreach to increase awareness of Congestive Heart Failure management. We also plan to increase the scope of the populations offered this information. Through these measures we expect to prevent hospitalizations and complications related to Congestive Heart Failure, Diabetes, flu and pneumonia which will improve patient outcomes and reduce costs.

**Populations Served:** This measure will reach out to populations age 18 and over in Kimble County and surrounding communities. The populations will include patients seen in the Emergency Department and Hospital, as well as others attending health fairs and mini clinics.

Community Benefit: The program will reduce the risk of CHF exacerbations and Diabetes complications as well as individuals being infected with flu or pneumonia, resulting in a healthier population and reduced healthcare costs.

Cost Avoidance: DSHS estimated hospital charges in Kimble County related to Congestive Heart Failure to be \$438,811 and Bacterial Pneumonia to be \$928,875 from 2005 - 2010. In 2011, we had 15 admissions for CHF and 40 admissions for Pneumonia. To project cost avoidance for all payers, which is the basis for DSHS database, we anticipate preventing at least 5% hospitalizations over the next 4 years.

Community Need: Disease prevention and management activities will improve education accessibility and lower hospitalization admission rate.

Estimated Local Funding: Funding will be by the Hospital District.

NEW: 2060833201.3.2 OLD: 2060833201.3.1	<b>3.IT-2.1</b>	IT-2.1 Congestive Heart Failure Admission rate	
<b>Kimble Hospital</b>			206083201
<b>Related 2 Project:</b>	<b>2.7 Implement Evidence-based Disease Prevention Programs</b> OLD: 206083201.2.1 NEW: 206083201.2.2		
<b>Starting Point/Baseline:</b>	<b>TBD</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> <b>Milestone P- 1</b> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  <b>Data Source:</b> Performing Provider evidence of plan  <b>Process Milestone 1 Estimated Incentive Payment:</b> \$21,066	<b>Process Milestone 2</b> <b>Milestone P- 3</b> Develop and test data systems  <b>Data Source:</b> Documentation development and testing  <b>Process Milestone2 Estimated Incentive Payment:</b> \$24,418	<b>Outcome Improvement Target 1</b> IT-2.1  <b>Data Source:</b> Medical Records; Claims  <b>Improvement Target:</b> TBD  <b>Estimated Incentive Payment:</b> \$39,185	<b>Outcome Improvement Target 2</b> IT-2.1  <b>Data Source:</b> E.H.R; Claims  <b>Improvement Target:</b> TBD  <b>Estimated Incentive Payment:</b> \$93,702

NEW: 2060833201.3.2 OLD: 2060833201.3.1	<b>3.IT-2.1</b>	IT-2.1 Congestive Heart Failure Admission rate	
<b>Kimble Hospital</b>			206083201
<b>Related 2 Project:</b>	<b>2.7 Implement Evidence-based Disease Prevention Programs</b> OLD: 206083201.2.1 NEW: 206083201.2.2		
<b>Starting Point/Baseline:</b>	<b>TBD</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Year 2</b> Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$21,066	<b>Year 3</b> Estimated Outcome Amount: \$24,418	Year 4 Estimated Outcome Amount: \$39,185	Year 5 Estimated Outcome Amount: \$93,702
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$178,371</b>			

### Category 3: “IDD Behavioral Health Crisis Response System”

- **Identifying Outcome Measure and Provider Information:** ED appropriate utilization (Reduce emergency department visits for Intellectual and Developmental Disabilities [IDD] behavioral health [BH]); 109483102.3.1; MHMR Services for the Concho Valley/109483102
- **Outcome Measure Description:** The outcome measure selected for the “IDD BH Crisis Response System” DSRIP project is emergency department appropriate utilization. The process milestones for demonstration years two through three are P-3, develop and test data systems and P-2, establish baseline rates. The selected outcome improvement target for demonstration years four through five is to reduce emergency department visits for IDD behavioral health. It is expected that outcome improvement targets will be determined in demonstration year three for implementation in demonstration year four. Per CMS and HHSC, Category 3 methodology for targets will be redefined.
- **Rationale:** The decision to propose an IDD BH Crisis Response System and subsequently measure its success with the improvement target of reducing emergency department visits was made for two primary reasons. The first reason is related to MHMR Services for the Concho Valley’s (MHMRCV) mission statement. Specifically, the mission of MHMRCV is “...to offer an array of services and supports which respond to the needs of people with mental illness, intellectual and developmental disabilities, and autism, enabling them to make choices that result in lives of dignity and increased independence.” Through local stakeholder feedback and local quality assurance and utilization management initiatives it became clear to our organization that there was an important and unmet need in our area for community based IDD BH crisis intervention services. The 1115 Medicaid Transformation Waiver presented a unique opportunity to develop a program that is both feasible and viable to support people living in our community to seek treatment for BH crises in the least restrictive environment which in turn will help them to continue to live lives of dignity and increased independence. This organization is committed to promoting community based crisis alternatives to people to continue to encourage lives of dignity and independence versus hospitalization for a crisis if it is not necessary.

The second reason MHMRCV chose to select the improvement target of reducing emergency department visits was because it supports the RHP 13 community needs assessment (CNA) (Identification Number CNA-007). In particular, the CNA indicates that reducing healthcare costs can be accomplished by moving care into the most appropriate setting. In many cases people with IDD who were experiencing a mental health crisis would go to the local emergency department because a community based alternative did not exist. The emergency room was used not because it was appropriate in all cases, but because it was the only alternative. Creating community based IDD BH crisis programs can reduce emergency room utilization by this population. MHMRCV has a history of successful outcomes related to community based crisis interventions for

people who have mental illness. These same principles can be applied to develop and tailor programs that can achieve the same success for people with IDD who are experiencing a BH crisis. The CNA states that reducing inappropriate use of the emergency room can improve the overall quality of the care being delivered to other citizens who have legitimate emergent needs because the timeliness of the responders will be improved.

- **Outcome Measure Valuation:** MHMRCV considered several factors in valuing this project including reductions in costs associated with hospitalizations for developmental disorders, emergency room visits, and law enforcement interventions. The project will also avoid unnecessary commitments/admissions to state supported living centers which will save an average of \$125,507 per year per person according to Legislative Budget Board data on institutional costs.

109483102.3.1	IT-9.2	ED Appropriate Utilization	
MHMR Services for the Concho Valley			109483102
<b>Related Category 1 or 2 Projects:</b>	109483102.1.1		
<b>Starting Point/Baseline:</b>	Per CMS and HHSC, Category 3 methodology for targets will be redefined.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b><u>Process Milestone 1</u></b> P-3: Develop and test data systems.</p> <p><u>Data Source:</u> Identified reports from the local ERs that will be acceptable to track IDD BH utilization of ER use.</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$0</p>	<p><b><u>Process Milestone 2</u></b> P-2: Establish Baseline rates.</p> <p><u>Data Source:</u> Number of IDD individuals who present at the ER with a BH crisis.</p> <p>Process Milestone 2 Estimated Incentive Payment: \$51,290</p>	<p><b><u>Outcome Improvement Target 1</u></b> IT-9.2: ED appropriate utilization; reduce emergency department visits for IDD BH</p> <p><u>Improvement Target:</u> TBD - Per CMS and HHSC, Category 3 methodology for targets will be redefined.</p> <p><u>Data Source:</u> Identified reports from the local ERs that will be acceptable to track IDD BH utilization of ER use.</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$69,682</p>	<p><b><u>Outcome Improvement Target 2</u></b> IT-9.2: ED appropriate utilization; reduce emergency department visits for IDD BH</p> <p><u>Improvement Target:</u> TBD - Per CMS and HHSC, Category 3 methodology for targets will be redefined.</p> <p><u>Data Source:</u> Identified reports from the local ERs that will be acceptable to track IDD BH utilization of ER use.</p> <p>Outcome Improvement Target2 Estimated Incentive Payment: \$151,483</p>

109483102.3.1	IT-9.2	ED Appropriate Utilization	
MHMR Services for the Concho Valley			109483102
<b>Related Category 1 or 2 Projects:</b>	109483102.1.1		
<b>Starting Point/Baseline:</b>	Per CMS and HHSC, Category 3 methodology for targets will be redefined.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: \$0	Year 3 Estimated Outcome Amount: \$51,290	Year 4 Estimated Outcome Amount: \$69,682	Year 5 Estimated Outcome Amount: \$151,483
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$272,455</b>			

### **Category 3: “Expand and Enhance Behavioral Health Services”**

- **Identifying Outcome Measure and Provider Information:** Quality of Life/Functional Status (Quality of Life); 109483102.3.2; MHMR Services for the Concho Valley/109483102
- **Outcome Measure Description:** The outcome measure selected for the “Enhance and Expand Behavioral Health” DSRIP project is Quality of Life. The process milestone for DY 2 – 3 is P-2, establish baseline rates. Since the proposed DSRIP project represents a new population of people being served by MHMRCV, we will need an opportunity to plan and implement the proposed project, select the proper assessment tool for measuring improvement, and collect baseline data. The selected outcome improvement target for DY 4 - 5 is Quality of Life. MHMRCV intends to utilize an evidence based assessment tool to measure improvement in quality of life for the patients we serve as a result of implementing this project. It is expected that outcome improvement targets will be determined in DY 3 for implementation in DY4 and DY5. Per CMS and HHSC, Category 3 methodology for targets will be redefined.
- **Rationale:** According to the Centers for Disease Control and Prevention website, analyzing health related quality of life survey data can identify people with poor perceived health and help to guide interventions to improve their situations and avert more serious consequences ([www.cds.gov/hrqol](http://www.cds.gov/hrqol)). MHMRCV has chosen the quality of life improvement target as a means of measuring its efforts because it focuses on the specific patient response to treatment. The survey results will tell us whether or not the interventions provided were successful from the patient perspective.

In addition, the RHP 13 Community Needs Assessment (CNA) indicates the need to develop a stronger connection between physical and mental health as they are closely related. Utilizing a quality of life assessment tool to measure improvement could provide opportunities to identify physical health issues and an occasion to link patients to further treatment. The patients served as a result of this DSRIP project will have an assigned case manager whose job would include linking patients to other interventions throughout the community. Early intervention for physical health conditions is a more cost effective treatment option. This effective linkage to other supports via case managements supports one of the 1115 Transformation Waiver goals set by HHSC: improve cost effectiveness of care. In addition, measuring quality of life indicators supports the waiver goal of improving coordination of care across providers.

- **Outcome Measure Valuation:** MHMRCV considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral health disorders, emergency room visits, and law enforcement interventions. The project will also result in enhanced quality of life for individuals with behavioral health disorders living in the Concho Valley by providing improved access to behavioral health care.

109483102.3.2	IT-10.1	Quality of Life	
MHMR Services for the Concho Valley			109483102
<b>Related Category 1 or 2 Projects:</b>	109483102.1.2		
<b>Starting Point/Baseline:</b>	Per CMS and HHSC, Category 3 methodology for targets will be redefined.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b><u>Process Milestone 1</u></b> P-2: Establish Baseline rates.</p> <p><u>Data Source:</u> Selection of an evidence based assessment tool to measure quality of life for patients to be served as a result of implementation of DSRIP project “Enhance and Expand BH Services.”</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$0</p>	<p><b><u>Process Milestone 2</u></b> P-2: Establish Baseline rates.</p> <p><u>Data Source:</u> Baseline data collected from using the evidence based assessment tool to measure quality of life for patients served by the end of DY3. Data presented in report form.</p> <p>Process Milestone 2 Estimated Incentive Payment: \$62,245</p>	<p><b><u>Outcome Improvement Target 1</u></b> IT-10.1: Quality of Life, demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population</p> <p><u>Improvement Target:</u> TBD - Per CMS and HHSC, Category 3 methodology for targets will be redefined.</p> <p><u>Data Source:</u> Assessment scores.</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$51,774</p>	<p><b><u>Outcome Improvement Target 2</u></b> IT-10.1: Quality of Life, demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population</p> <p><u>Improvement Target:</u> TBD - Per CMS and HHSC, Category 3 methodology for targets will be redefined.</p> <p><u>Data Source:</u> Assessment scores.</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$112,553</p>

109483102.3.2	IT-10.1	Quality of Life	
MHMR Services for the Concho Valley			109483102
<b>Related Category 1 or 2 Projects:</b>	109483102.1.2		
<b>Starting Point/Baseline:</b>	Per CMS and HHSC, Category 3 methodology for targets will be redefined.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: \$0	Year 3 Estimated Outcome Amount: \$62,245	Year 4 Estimated Outcome Amount: \$51,774	Year 5 Estimated Outcome Amount: \$112,553
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$226,572</b>			

## Pass 2

### Category 3: “Integrate Primary and Behavioral Health Care”

#### Category 3: “Integrate Primary and Behavioral Health Care” – Pass 3B

- **Identifying Outcome Measure and Provider Information:** Quality of Life/Functional Status (Quality of Life); New ID: 109483102.3.4 - Old ID: 109483102.3.3; MHMR Services for the Concho Valley/109483102
- **Outcome Measure Description:** The outcome measure selected for the “Integrate Primary and Behavioral Health Care” DSRIP project is Quality of Life. The process milestone for DY 2 is P-1, project planning. The process milestone P-2, establish baseline rates was selected for DY 2 – 3. Since the proposed DSRIP project represents a new venture for MHMRCV, we will need an opportunity to plan and implement the proposed project, select the proper assessment tool for measuring improvement, and collect baseline data. The selected outcome improvement target for DY 4 - 5 is Quality of Life. MHMRCV intends to utilize an evidence based assessment tool to measure improvement in quality of life for the patients we serve as a result of implementing this project. It is expected that outcome improvement targets will be determined in DY 3 for implementation in DY4 and DY5. Per CMS and HHSC, Category 3 methodology for targets will be redefined.

**Rationale:** Providing an integrated medical home treatment option within the MHMRCV outpatient clinic for the SPMI patient population is important for various reasons. The first is that it targets the Medicaid population. MHMRCV is the state designated safety net provider for the indigent and Medicaid populations that have SPMI and live in Coke, Concho, Crockett, Irion, Reagan, Sterling and Tom Green counties. Improving access to care for Medicaid patients is an HHSC 1115 Waiver goal. Per the CNA document, the Galen Institute indicates that data shows that Medicaid patients are twice as likely to use the emergency department for routine care. In addition, the CNA states that Medicaid patients tend to visit the emergency department more, partly because they tend to be in poorer health overall and because they can't see their primary care provider in a timely fashion, or at all. Additionally, the CNA document indicates that according to the National Association of Community Health Centers, the lack of access to primary care providers is increasingly driving patients to rely on emergency departments for non-urgent care. Due to fewer primary care options available many patients, especially Medicaid beneficiaries and the uninsured, turn to the emergency department for care that could be handled via primary care intervention. The medical home model of care made available via this integration project additionally supports the 1115 Transformation Waiver goal to improve cost effectiveness of care. According to the Centers for Disease Control and Prevention website, analyzing health related quality of life survey data can identify people with poor perceived health and help to guide interventions to improve their situations and avert more serious consequences ([www.cds.gov/hrqol](http://www.cds.gov/hrqol)). Measuring quality of life indicators for our target population provides opportunities to identify preventative health care needs, offer a warm hand off to an in-house primary care practitioner, and supports various waiver goals, including improving coordination of care across providers. MHMRCV has chosen the quality

of life improvement target as a means of measuring its efforts because it focuses on the specific patient response to treatment. The survey results will tell us whether or not the interventions provided were successful from the patient perspective.

- **Outcome Measure Valuation:** MHMR Services for the Concho Valley considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations.

<b>New ID: 109483102.3.4</b> <b>Old ID: 109483102.3.3</b>	<b>IT-10.1</b>	<b>Quality of Life</b>	
<i>MHMR Services for the Concho Valley</i>		<i>109483102</i>	
<b>Related Category 1 or 2 Projects:</b>	<b>New ID: 109483102.2.2 Old ID: 109483102.2.1</b>		
<b>Starting Point/Baseline:</b>	Per CMS and HHSC, Category 3 methodology for targets will be redefined.		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<u><b>Process Milestone 1</b></u> P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.  <u>Data Source:</u> Project plan.  Process Milestone 1 Estimated Incentive Payment: \$11,005  <u><b>Process Milestone 2</b></u> P-2: Establish baseline rates  <u>Data Source:</u> Selection of an evidence based assessment tool to measure quality of life for patients to be served as a result of implementation of DSRIP	<u><b>Process Milestone 3</b></u> P-2: Establish baseline rates  <u>Data Source:</u> Baseline data collected from using the evidence based assessment tool to measure quality of life for patients served by the end of DY3. Data presented in report form.  Process Milestone 3 Estimated Incentive Payment: \$51,374	<u><b>Outcome Improvement Target 1</b></u> IT-10.1: Quality of Life, demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population  <u>Improvement Target:</u> TBD - Per CMS and HHSC, Category 3 methodology for targets will be redefined.  <u>Data Source:</u> Assessment scores.  Outcome Improvement Target 1 Estimated Incentive Payment: \$55,110	<u><b>Outcome Improvement Target 2</b></u> IT-10.1: Quality of Life, demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population  <u>Improvement Target:</u> TBD - Per CMS and HHSC, Category 3 methodology for targets will be redefined.  <u>Data Source:</u> Assessment scores.  Outcome Improvement Target2 Estimated Incentive Payment: \$120,184

<b>New ID: 109483102.3.4</b> <b>Old ID: 109483102.3.3</b>	<b>IT-10.1</b>	<b>Quality of Life</b>	
<i>MHMR Services for the Concho Valley</i>			<i>109483102</i>
<b>Related Category 1 or 2 Projects:</b>	<b>New ID: 109483102.2.2 Old ID: 109483102.2.1</b>		
<b>Starting Point/Baseline:</b>	Per CMS and HHSC, Category 3 methodology for targets will be redefined.		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
project “Enhance and Expand BH Services.”  Process Milestone 2 Estimated Incentive Payment: \$11,005			
Year 2 Estimated Outcome Amount: \$22,010	Year 3 Estimated Outcome Amount: \$51,374	Year 4 Estimated Outcome Amount: \$55,110	Year 5 Estimated Outcome Amount: \$120,084
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$248,678</b>			

### ***Category 3: Quality Improvements***

- **Identifying Outcome Measure and Provider Information:**
  - OD-5 Cost of Care
  - IT-5-1 Improved cost savings
  - 020989201.3.1
  - North Runnels County Hospital 020989201

### ***F. Category 3: Quality Improvements***

- **Identifying Outcome Measure and Provider Information:**
  - OD-5 Cost of Care
  - IT-5-1 Improved cost savings
  - New 020989201.3.3 /Old 020989201.3.1
  - 020989201
  
- **Outcome Measure Description:** Improved cost savings outcome measure; with a CT-Scan we can improve better health to our community which will decrease cost and increases the opportunity to diagnose and treat earlier without having to transport a patient. Therefore, this improves the value in emergency care to diagnose locally and treat immediately. Outcome and overall usage; DY2 baseline and each year after to be determined.
  
- **Rationale:** We selected Cost benefits analysis to determine the positive factors in implementing a CT-Scan department. This will decrease the cost to the patient by increasing the opportunity to diagnose and treat patient at an earlier stage without having to transport. As a result this improves the value in emergency care to diagnose locally and treat immediately. We have done an experiential analysis demonstrating why there is a need of an imaging system in our community. If our doctors order a CT-Scan, the patient then has to travel to another facility to receive this service. This then accumulates more cost to the patient. Again, if the patient is seen in the ED and a CT-Scan is needed, the patient will need to be transported to another facility. We have discovered that this has been a problem due to the overall impact cost to the patient and decreased response time for immediate care. This outcome will help improve the overall health for all patients and including the low-income population.

Example: A patient being treated in the ED having complications needing an abdomen CT-Scan, will have to be transported by ambulance to another facility. Not only has the patient now incurred charges from North Runnels County Hospital, for an ED charge of or around \$650 and an Ambulance cost of around \$1,000 to \$1,200, the patient will also incur new charges if transported to another facility that is around 50-100 miles to the nearest ED. The additional charges could cost up to \$1000 with other pending charges incurred at that facility. An abdomen CT-Scan at can cost up to \$2,000. After all is said and done, the patient would have accrued over \$5,000 in charges.

When North Runnels County Hospital implements a CT-Scan, it will lower the overall cost to the patient with a savings of more than half of what the ED patient would have incurred.

These milestones were selected for the planning process of the CT-Scan Project; to help with the planning and implementation of the project.

Required QI Core measure; is to work in collaboration and put in to place the following initiatives:

Process Measures

- To begin Planning
  - Development
  - Policy & Procedure
  - Develop QI
  - Remodel and redesign Department Space
  - Enhance Service Availability to appropriate Levels of Care.
  - Establish baseline rates Improvement Measure.
- **Outcome Measure Valuation:** North Runnels County Hospital understands that as health care costs rise that we will strive to find better ways to stay increasingly interested in developing accurate ways to measure outcomes. To be achieved towards the improvement of cost containment. This will be done by tracking the total cost per member of the population per month and to track the cost per episode for the hospital and ER utilization rates for cost of care measurement; for the services involved in the diagnosis, management and treatment of specific clinical conditions.

North Runnels Hospital project scope is to reduce health care costs for the patients in our community. North Runnels County Hospital will develop cost-of-care measures by achieving high value to benefit the community. This will help those who get,

give and pay for care. Value is our overall goal of health care delivery, with value defined as the health outcomes achieved per dollar spent. This goal is what matters for our patients served in our community. This will help serve the community better for those that have no way of transportation, any insurance and poverty. This will benefit the patient and will improve the overall health to the patient, including the Medicaid and/or indigent patients.

Our hospital covers the northern district population which covers Winters TX population of 2562 and also the population of the surrounding northern district County. Our goal is to be the preferred provider for our residents in this northern district. With the ability to provide quicker and better service, to be more efficient in an effective way and lower cost to the patient we can meet any new challenges that may arise.

020989201.3.3 Old 020989201.3.1	IT-5.1 Improved cost savings	Improved cost savings	
North Runnels County Hospital			020989201
<b>2.5</b>	<ul style="list-style-type: none"> <li>2.5 Redesign for Cost Containment- Imaging System, 020989201.2.2 New 020989201.2.2/Old 020989201.2.1</li> </ul>		
<b>Starting Point/Baseline:</b>	100		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P- 1</b> Project planning Process Measure: Begin Planning/Development/Policy & Procedure/Develop QA/ Remodel and redesign Department Space/ Enhance Service Availability to appropriate Levels of Care  Data Source: Documentation  Process Milestone 1 Estimated Incentive Payment ( <i>maximum  amount</i> ): \$21, 066  <b>Process Milestone 2 P- 2</b> Establish baseline rates Improvement Measure: TBD  Data Source: Documentation	<b>Process Milestone 3 P- 2</b> Establish baseline rates Improvement Measure: TBD Data Source: Documentation  Process Milestone 3 Estimated Incentive Payment: \$12,209  <b>Outcome Improvement Target  1 OD-5 Cost of Care</b> IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery; Improvement Target: TBD  Measure: total cost for episode of care Data Source: Documentation  <b>Outcome Improvement Target  1 Estimated Incentive</b>	<b>Outcome Improvement Target  2 OD-5 Cost of Care</b> IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery; Improvement Target: TBD  Measure: total cost for episode of care Data Source: Documentation  <b>Outcome Improvement Target  2 Estimated Incentive  Payment: \$39,183</b>	<b>Outcome Improvement Target  3 OD-5 Cost of Care</b> IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery; Improvement Target: TBD  Measure: total cost for episode of care  Data Source: Documentation  <b>Outcome Improvement Target  3 Estimated Incentive  Payment: \$93,699</b>

020989201.3.3 Old 020989201.3.1	IT-5.1 Improved cost savings	Improved cost savings		
North Runnels County Hospital			020989201	
<b>2.5</b>	<ul style="list-style-type: none"> <li>2.5 Redesign for Cost Containment- Imaging System, 020989201.2.2 New 020989201.2.2/Old 020989201.2.1</li> </ul>			
<b>Starting Point/Baseline:</b>	100			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Process Milestone 2 Estimated Incentive Payment:  Year 2 Estimated Outcome Amount: \$21,066	Payment: \$ 12,209  Year 3 Estimated Outcome Amount: \$24,418	Year 4 Estimated Outcome Amount: 39,183	Year 5 Estimated Outcome Amount: \$93,699	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DY's 2-5): \$178,366</b>				

## Pass 2

### Category 3: Quality Improvements

- **Identifying Outcome Measure and Provider Information:**
  - OD-9 Right Care, Right Setting
  - IT- 9.2 ED appropriate utilization
  - 020989201.3.2
  - North Runnels County Hospital 020989201

### G. Category 3: Quality Improvements

- **Identifying Outcome Measure and Provider Information:**
  - OD-9 Right Care, Right Setting
  - IT- 9.2 ED appropriate utilization
  - 020989201.3.1
  - 020989201

**Outcome Measure Description:** Right Care, Right setting; North Runnels County Hospital plans to expand and improve access to the residents of Runnels County and the surrounding areas by adding another primary health care provider. With more healthcare coverage in the clinic this will help alleviate the problem of providing care to patients that can not be seen because the current physicians are booked. This will reduce patient ED visits for non-emergency care.

**Challenges:** One of the challenges faced is educating the residents of North Runnels County Hospital that are adapted to going to the ED for non-emergent care.

**Rationale:** North Runnels County Hospital Right Care, Right setting to better serve and help the patients in the community. This will decrease the cost to the patient by increasing the opportunity to diagnose and treat patient at an earlier stage without them having to go to the ED. As a result this improves the value in emergency care to diagnose locally and treat immediately.

These milestones were selected for the planning process of adding another Primary Care Provider; to help with the planning and implementation of the project.

#### **Process Measures**

- Enhance Service Availability to appropriate Levels of Care.
- Establish baseline rates Improvement Measure.

**Outcome Measure Valuation:** North Runnels County Hospital expects to reduce non-emergent emergency department visits for patients. Our plan is to redirect non-emergent patients to use the Clinic instead of the ED. This attempt will be done by educating the community and help the patient to understand the cost. We understand this will be a challenge. These existing systems will help with cost avoidance.

North Runnels County Hospital understands that as health care costs rise that we will strive to find better ways to stay increasingly interested in developing accurate ways to measure outcomes. North Runnels Hospital project scope is to reduce health care costs for the patients in our community. North Runnels County Hospital attains to achieve high value of care to benefit the community to help those who get, give and pay for care. This will help serve the community better for those that have no way of transportation, any insurance and poverty.

Our hospital covers the northern district population which covers Winters TX population of 2562 and also the population of the surrounding northern district County. Our goal is to be the preferred provider for our residents in this northern district. With the ability to provide quicker and better service, to be more efficient in an effective way and lower cost to the patient we can meet any new challenges that may arise.

020989201.3.2	IT- 9.2	ED appropriate utilization	
North Runnels County Hospital			020989201
1.1 Expand primary care capacity	o 1.1.2 Expand Existing primary care capacity 020989201.1.1		
<b>Starting Point/Baseline:</b>	TBD		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p>Process Milestone 1 P- 1 Project planning Process Measure: Begin Planning P-2 Establish baseline: TBD Data Source: Documentation</p> <p>Outcome Improvement Target 1 OD-9 Right Care, Right Setting IT-9.2 2 ED appropriate utilization Reduce Emergency Department visits for non-emergency care visits. Baseline: TBD Data Source: Documentation</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$ 8,700</p>	<p>Process Milestone 2 P- 1 Project planning Process Measure: Begin Planning P-2 Establish baseline :TBD Data Source: Documentation</p> <p>Outcome Improvement Target 2 OD-9 Right Care, Right Setting IT-9.2 2 ED appropriate utilization Reduce Emergency Department visits for non-emergency care visits. Baseline: TBD Data Source: Documentation</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$ 9,469</p>	<p>Outcome Improvement Target 3 OD-9 Right Care, Right Setting IT-9.2 2 ED appropriate utilization Reduce Emergency Department visits for non-emergency care visits. Data Source: Documentation Baseline: TBD</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$14,798</p> <p>Year 4 Estimated Outcome Amount: 14,798</p>	<p>Outcome Improvement Target 4 OD-9 Right Care, Right Setting IT-9.2 2 ED appropriate utilization Reduce Emergency Department visits for non-emergency care visits. Data Source: Documentation Baseline: TBD</p> <p>Outcome Improvement Target 4 Estimated Incentive Payment: \$36,937</p> <p>Year 5 Estimated Outcome Amount: \$36,937</p>

020989201.3.2	IT- 9.2	ED appropriate utilization		
North Runnels County Hospital			020989201	
1.1 Expand primary care capacity	o 1.1.2 Expand Existing primary care capacity 020989201.1.1			
<b>Starting Point/Baseline:</b>	TBD			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Year 2 Estimated Outcome Amount: \$8,700	Year 3 Estimated Outcome Amount: \$9,469			
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DY's 2-5): \$69,904</i>				

### **Category 3: Quality Improvements**

- **Identifying Project and Provider Information:**

- OD-9 Right Care, Right Setting, IT-9.2 ED Appropriate Utilization
- 130616905.3.1
- Pecos County Memorial Hospital/130616905

### **Category 3: Quality Improvements**

- **Identifying Project and Provider Information:**

- OD-9 Right Care, Right Setting, IT-9.2 ED Appropriate Utilization
- 130616905.3.7 Pass 3b (130616905.3.1)
- Pecos County Memorial Hospital/130616905

- **Outcome Measure Description:**

IT-9.2 ED Appropriate Utilization

- Rate 1: All Emergency Department visits by Terrell County residents
- Rate 2: Pediatric Emergency Department visits by Terrell County residents
- Rate 3: Emergency Department visits for target conditions
  - CHF
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease/Hypertension
  - COPD
  - Asthma

- **Process Milestones:**

DY 2:

P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-2 – Establish baseline rates

- **Outcome Improvement Targets for each year:**

DY 4:

- IT-9.2 Rate 1: Reduce all ED visits by TBD below baseline
- IT-9.2 Rate 2: Reduce pediatric ED visits by TBD below baseline
- IT-9.2 Rate 3: Reduce ED visits for target conditions by TBD below baseline
  - CHF
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease/Hypertension
  - COPD
  - Asthma

DY 5:

- IT-9.2 Rate 1: Reduce all ED visits by 5% below baseline

- IT-9.2 Rate 2: Reduce pediatric ED visits by 5% below baseline
- IT-9.2 Rate 3: Reduce ED visits for target conditions by 5% below baseline
  - CHF
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease/Hypertension
  - COPD
  - Asthma

- **Rationale:**

As supported by 1.1, access to primary and preventive care in HPSA and frontier counties in Texas remains the greatest community need and priority to achieve the ability to reduce potentially preventable acute care costs. Though the total population is low, the aging population is one of the fastest growing in costs. Access to annual health checkups for a full screening and administration of immunizations can prevent expensive episodic care for diabetes, pneumonia, the flu, and/or congestive heart failure through our ED. By providing additional primary care capacity, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with non-emergent care treatment in the ED. We will establish baseline rates and then targets for DY4 and DY5 for a reduction in non-emergent ED utilization for residents from Terrell County.

- **Outcome Measure Valuation:**

By providing access to care we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings as opposed to more expensive visits to our ED. We will provide the 1,000 Terrell County residents primary and preventive care. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. The plan projects a decrease in ED visits by 5 patients per year (or 5% per year). The result of the decrease in ED visits also assumes a corresponding decrease in Medicaid and/or other governmental funding sources for high-cost services in the ED. The average cost per ED visit, based on Pecos County Memorial Hospital's charges, is \$1,000 per visit. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. Our expectations include a reduction in non-emergent ED claims from Terrell County from the patients being seen and treated through our expanded primary care clinic setting. In addition, we are working with Terrell County, so we will be receiving local funding to assist in supporting this initiative.

New 130616905.3.7 Old 130616905.3.1	OD-9 IT-9.2	IT-9.2 ED Appropriate Utilization	
Pecos County Memorial Hospital			130616905.3.1
<b>Related Category 1 or 2 Projects::</b>	New 130616905.1.3/ Old 130616905.1.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$70,318	<b>Process Milestone 2</b> P- 2 Establish baseline rates  Data Source: <b>EMR/Registry</b>  Process Milestone 3 Estimated Incentive Payment: \$108,678	<b>Outcome Improvement Target 1</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: Reduce ED visits from Terrell Co. zip code by 5 from DY3  Data Source: EMR/Registry  Outcome Improvement Target 1 Estimated Incentive Payment: \$145,325	<b>Outcome Improvement Target 2</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: Reduce ED visits from Terrell Co. zip code by 5 from DY4  Data Source: EMR/Registry  Outcome Improvement Target 2 Estimated Incentive Payment: \$271,696

New 130616905.3.7 Old 130616905.3.1	OD-9 IT-9.2	IT-9.2 ED Appropriate Utilization	
Pecos County Memorial Hospital			130616905.3.1
<b>Related Category 1 or 2 Projects::</b>	New 130616905.1.3/ Old 130616905.1.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$70,318	Year 3 Estimated Outcome Amount: \$108,678	Year 4 Estimated Outcome Amount: \$145,325	Year 5 Estimated Outcome Amount: \$271,696
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$596,017			

### **Category 3: Quality Improvements**

- **Identifying Project and Provider Information:**

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
- 130616905.3.2
- Pecos County Memorial Hospital/130616905

### **Category 3: Quality Improvements**

- **Identifying Project and Provider Information:**

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
- New ID: 130616905.3.8 3B
- Old ID: 130616905.3.2
- Pecos County Memorial Hospital/130616905

- **Outcome Measure Description:**

IT-3.2 Congestive Heart Failure 30day readmission rate

- Rate 1: Number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission
- Rate 2: Number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission

- **Process Milestones:**

DY 2:

P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-2 – Establish baseline rates

- **Outcome Improvement Targets for each year:**

DY 4:

- IT-3.2 Rate 1: Reduce 30 day readmissions from the index CHF admissions by TBD below baseline
- IT-3.2 Rate 2: Reduce admissions for patients discharged from the hospital with a principal diagnosis of CHF and with a complete claims history for the 12 months prior to admission by TBD

DY 5:

- IT-3.2 Rate 1: Reduce 30 day readmissions from the index CHF admissions by TBD below baseline
- IT-3.2 Rate 2: Reduce admissions for patients discharged from the hospital with a principal diagnosis of CHF and with a complete claims history for the 12 months prior to admission by TBD

- **Rationale:**

As supported by 2.2, expand chronic care management models, emphasizing the quality and availability of after-care for cardiac patients remains an important community need which will result in a reduction of potentially preventable acute care costs. The aging of the population will be an increasing factor as “baby boomers” reach ages when cardiovascular disease is most prevalent. By providing an outpatient delivery system to coordinate care for patients with chronic cardiovascular disease, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with readmissions of these patients for this condition. We will establish baseline rates and then targets for DY4 and DY5 for a reduction in readmission rates within 30 days for patients with cardiovascular disease.

- **Outcome Measure Valuation:**

By providing access to specialty care associated with cardiovascular disease, we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings as opposed to more expensive inpatients stays for readmissions for this condition. We will provide Pecos County residents as well as residents from surrounding communities, specialty care for cardiovascular disease. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. Our expectations include a reduction in readmissions of patients with chronic cardiovascular disease. In addition, as a county hospital, we will receive tax appropriations to help fund this initiative.

New 130616905.3.8 Old 130616905.3.2	OD-3 IT-3.2	Congestive Heart Failure (CHF) 30 day readmission rate	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	New 130616905.2.3/ Old 130616905.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$23,439	<b>Process Milestone 2</b> P- 2 Establish baseline rates  Data Source: <b>EMR/Registry</b>  Process Milestone 3 Estimated Incentive Payment: \$36,226	<b>Outcome Improvement Target 1</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: TBD per CMS guidelines  Data Source: EMR/Registry  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$48,441	<b>Outcome Improvement Target 2</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: TBD per CMS guidelines  Data Source: EMR/Registry  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$90,565

New 130616905.3.8 Old 130616905.3.2	<i>OD-3 IT-3.2</i>	Congestive Heart Failure (CHF) 30 day readmission rate	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	New 130616905.2.3/ Old 130616905.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$23,439	Year 3 Estimated Outcome Amount: \$36,226	Year 4 Estimated Outcome Amount: \$48,441	Year 5 Estimated Outcome Amount: \$90,565
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$198,671</i>			

**Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects**

### **Category 3: Quality Improvements**

- **Identifying Project and Provider Information:**

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
- New ID: 130616905.3.9 3b
- Old ID: 130616905.3.3
- Pecos County Memorial Hospital/130616905

- **Outcome Measure Description:**

IT-3.6 CAD 30day readmission rate

- Rate 1: Number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index CAD admission
- Rate 2: Number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of CAD and with a complete claims history for the 12 months prior to admission

- **Process Milestones:**

DY 2:

P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-2 – Establish baseline rates

- **Outcome Improvement Targets for each year:**

DY 4:

- IT-3.6 Rate 1: Reduce 30 day readmissions from the index CAD admissions by TBD below baseline
- IT-3.6 Rate 2: Reduce admissions for patients discharged from the hospital with a principal diagnosis of CAD and with a complete claims history for the 12 months prior to admission by TBD

DY 5:

- IT-3.6 Rate 1: Reduce 30 day readmissions from the index CAD admissions by TBD below baseline
- IT-3.6 Rate 2: Reduce admissions for patients discharged from the hospital with a principal diagnosis of CAD and with a complete claims history for the 12 months prior to admission by TBD

- **Rationale:**

As supported by 2.2, expand chronic care management models, emphasizing the quality and availability of after-care for cardiac patients remains an important community need which will result in a reduction of potentially preventable acute care costs. The aging of the population will be an increasing factor as “baby boomers” reach ages when

cardiovascular disease is most prevalent. By providing an outpatient delivery system to coordinate care for patients with chronic cardiovascular disease, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with readmissions of these patients for this condition. We will establish baseline rates and then targets for DY4 and DY5 for a reduction in readmission rates within 30 days for patients with cardiovascular disease.

- **Outcome Measure Valuation:**

By providing access to specialty care associated with cardiovascular disease, we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings as opposed to more expensive inpatients stays for readmissions for this condition. We will provide Pecos County residents as well as residents from surrounding communities, specialty care for cardiovascular disease. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. Our expectations include a reduction in readmissions of patients with chronic cardiovascular disease. In addition, as a county hospital, we will receive tax appropriations to help fund this initiative.

New 130616905.3.9 Old 130616905.3.3	OD-3 IT-3.6	Coronary Artery Disease (CAD) 30 day readmission rate	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	New 130616905.2.3/ Old 130616905.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$23,439	<b>Process Milestone 2</b> P- 2 Establish baseline rates  Data Source: <b>EMR/Registry</b>  Process Milestone 3 Estimated Incentive Payment: \$36,226	<b>Outcome Improvement Target 1</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: TBD per CMS guidelines  Data Source: EMR/Registry  Outcome Improvement Target 1 Estimated Incentive Payment: \$48,441	<b>Outcome Improvement Target 2</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: TBD per CMS guidelines  Data Source: EMR/Registry  Outcome Improvement Target 2 Estimated Incentive Payment: \$90,565

New 130616905.3.9 Old 130616905.3.3	<i>OD-3 IT-3.6</i>	Coronary Artery Disease (CAD) 30 day readmission rate	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	New 130616905.2.3/ Old 130616905.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$23,439	Year 3 Estimated Outcome Amount: \$36,226	Year 4 Estimated Outcome Amount: \$48,441	Year 5 Estimated Outcome Amount: \$90,565
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$198,671</i>			

### **Category 3: Quality Improvements**

- **Identifying Project and Provider Information:**

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
- New ID: 130616905.3.10 3b
- Old ID: 130616905.3.4
- Pecos County Memorial Hospital/130616905

- **Outcome Measure Description:**

IT-3.3 Chronic Obstructive Pulmonary Disease 30day readmission rate

- Rate 1: Number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission
- Rate 2: Number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission

- **Process Milestones:**

DY 2:

P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-2 – Establish baseline rates

- **Outcome Improvement Targets for each year:**

DY 4:

- IT-3.9 Rate 1: Reduce 30 day readmissions from the index COPD admissions by TBD below baseline
- IT-3.9 Rate 2: Reduce admissions for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission by TBD

DY 5:

- IT-3.9 Rate 1: Reduce 30 day readmissions from the index COPD admissions by TBD below baseline
- IT-3.9 Rate 2: Reduce admissions for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission by TBD

- **Rationale:**

As supported by 2.2, expand chronic care management models, emphasizing the quality and availability of after-care for cardiac patients remains an important community need which will result in a reduction of potentially preventable acute care costs. The aging of the population will be an increasing factor as “baby boomers” reach ages when cardiovascular disease is most prevalent. By providing an outpatient delivery system to

coordinate care for patients with chronic cardiovascular disease, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with readmissions of these patients for this condition. We will establish baseline rates and then targets for DY4 and DY5 for a reduction in readmission rates within 30 days for patients with cardiovascular disease.

- **Outcome Measure Valuation:**

By providing access to specialty care associated with cardiovascular disease, we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings as opposed to more expensive inpatients stays for readmissions for this condition. We will provide Pecos County residents as well as residents from surrounding communities, specialty care for cardiovascular disease. Since over 50% of these residents are over 45 years old, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. Our expectations include a reduction in readmissions of patients with chronic cardiovascular disease. In addition, as a county hospital, we will receive tax appropriations to help fund this initiative.

New 130616905.3.10 Old 130616905.3.4	OD-3 IT-3.9	Chronic Obstructive Pulmonary Disease (COPD) 30 day readmission rate	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	New 130616905.2.3/ Old 130616905.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$23,439	<b>Process Milestone 2</b> P- 2 Establish baseline rates  Data Source: <b>EMR/Registry</b>  Process Milestone 3 Estimated Incentive Payment: \$36,226	<b>Outcome Improvement Target 1</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: TBD per CMS guidelines  Data Source: EMR/Registry  Outcome Improvement Target 1 Estimated Incentive Payment: \$48,441	<b>Outcome Improvement Target 2</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: TBD per CMS guidelines  Data Source: EMR/Registry  Outcome Improvement Target 2 Estimated Incentive Payment: \$90,565

New 130616905.3.10 Old 130616905.3.4	OD-3 IT-3.9	Chronic Obstructive Pulmonary Disease (COPD) 30 day readmission rate	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	New 130616905.2.3/ Old 130616905.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$23,439	Year 3 Estimated Outcome Amount: \$36,226	Year 4 Estimated Outcome Amount: \$48,441	Year 5 Estimated Outcome Amount: \$90,565
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$198,671			

Pass 2

**Category 3: Quality Improvements**

**Pecos County Memorial Hospital**

**Fast Track Program**

- **Identifying Project and Provider Information:**
  - OD-9 Right Care, Right Setting, IT-9.2 ED Appropriate Utilization
  - 130616905.3.5
  - Pecos County Memorial Hospital/130616905

Pass 2

**Category 3: Quality Improvements**

**Pecos County Memorial Hospital**

**Fast Track Program**

- **Identifying Project and Provider Information:**
  - OD-9 Right Care, Right Setting, IT-9.2 ED Appropriate Utilization
  - 130616905.3.5
  - Pecos County Memorial Hospital/130616905
- **Outcome Measure Description:**

IT-9.2 ED Appropriate Utilization for Medicaid/Uninsured within target population:

  - Rate 1: Non-urgent patients
  - Rate 2: Self Pay patients
  - Rate 3: After Clinic Hours patients
- **Process Milestones:**

DY 2:  
P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:  
P-2 – Establish baseline rates
- **Outcome Improvement Targets for each year:**

DY 4:

  - IT-9.2 Rate 1: Reduce all ED visits by TBD below baseline of 330 visits
  - IT-9.2 Rate 2: Reduce target ED visits by TBD below baseline of 330 visits
  - IT-9.2 Rate 3: Reduce target ED visits by TBD below baseline of 330 visits

DY 5:

  - IT-9.2 Rate 1: Reduce all ED visits by TBD below baseline of 252 visits
  - IT-9.2 Rate 2: Reduce target ED visits by TBD below baseline of 252 visits
  - IT-9.2 Rate 3: Reduce target ED visits by TBD below baseline of 252 visits
- **Rationale:**

As supported by 1.1, access to primary and preventive care in HPSA and frontier counties in Texas remains the greatest community need and priority to achieve the ability to reduce potentially preventable emergency care costs. In addition to this, as the baby

boomer population ages, healthcare is becoming one of the fastest growing costs for our area as well as for our entire nation. It is, therefore, imperative that we address this by providing additional primary care capacity. This way, our patients and their families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction of costs associated with non-emergent care treatment in the ED. We will establish baseline rates and then targets for DY4 and DY5 for a reduction in non-emergent ED utilization for residents of Pecos County.

- **Outcome Measure Valuation:**

By providing access to care we will improve patient health outcomes, improve preventive health and screenings, and achieve patient access in low cost settings as opposed to more expensive visits to our ED. We will provide the 9,000 plus residents of our county primary and preventive care. In 2011, of the 6,632 patients seen in our ED, 4,841 of those were non-emergent. Since 33.5% of these residents are 45 years and older, there is a higher incidence of more expensive treatments to the aged and disabled populations as referenced by multiple sources. Delays in care can also increase the acuity of acute care episodes if a patient had been seen and treated earlier. Our expectations include a reduction in non-emergent ED claims, a reduction in private pay patient ED claims, and a reduction in after-hours ED claims from the patients being seen and treated through our expanded primary care clinic setting.

130616905.3.5	OD-9 IT-9.2	IT-9.2 ED Appropriate Utilization	
Pecos County Memorial Hospital			130616905
<b>Related Category 1 or 2 Projects::</b>	130616905.1.2		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of Planning and Stakeholder Engagement  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$54,742	<b>Process Milestone 2</b> P- 2 Establish baseline rates  Data Source: <b>EMR/Registry</b>  Process Milestone 3 Estimated Incentive Payment: \$85,180	<b>Outcome Improvement Target 1</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: 330  Data Source: EMR/Registry  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$114,219	<b>Outcome Improvement Target 2</b> IT-9.2 ED appropriate utilization  Reduce all ED visits (including ACSC)271  Improvement Target: 252  Data Source: EMR/Registry  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$199,270
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$54,742	Year 3 Estimated Outcome Amount: \$85,180	Year 4 Estimated Outcome Amount: \$114,219	Year 5 Estimated Outcome Amount: \$199,270
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): \$453,411			

### **Pass 3**

#### **Category 3: Innovation and Design**

##### **Outcome Domain:** OD-10 Quality of Life/Functional Status

- Improvement Target: IT-10.1 Quality of Life (standalone measure)
- Unique Project ID Number: 130616905.3.6
- Performing Provider Name/TPI: Pecos County Memorial Hospital/130616905

##### **Outcome Measure Description:**

In demonstration year 2, Shannon Medical Center, the subcontractor for the proposed CATCH® in Motion project, will identify community needs, determine resources, and plan the interventions that will be implemented in Pecos County throughout the waiver period. Once the aspects of the program and the target population are identified, baseline rates will be determined in demonstration year 3. In demonstration years 4 and 5, Quality of Life (QOL) scores will be assessed using a validated assessment tool for quality of life. The percent improvement in QOL scores is TBD.

##### **Rationale:**

The selected process milestones will assist in tailoring a program specific to the needs of Pecos County. Determining baseline rates in the target population for the intervention, there will be opportunity to improve QOL scores by impacting behavior change and promoting healthy behaviors. According to the CDC, Quality of life is a broad multidimensional concept that usually includes subjective evaluations for both positive and negative aspects of life. The quality of life for children that are obese consist of reduced productivity, lower academic performance, lower self-esteem, and increased absenteeism due to illness. By improving quality of life, the schools and community will reinforce positive behavioral changes and healthy choices that will increase awareness of healthier behaviors.

##### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 2 project valuation to implement an evidence-based health promotion program. Each project was weighted on the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

An assessment tool will be determined to evaluate QOL scores. Depending on the validated assessment tool, there will be a cost involved to access the assessment, as well as the potential for contracting with the University of Texas Health Science Center for data compilation and scoring.

The importance of quality of life in children is essential to daily life as children grow older. By working with children, there is the opportunity to develop lifestyle and behavior changes that will impact the quality of their lifetime.

130616905.3.6	IT-10.1	Quality of Life/Functional Status: Quality of Life (standalone measure)	
Pecos County Memorial Hospital			130616905
Related Category 1 or 2 Projects::	130616905.2.2		
Starting Point/Baseline:	Determined in Demonstration Year 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> Documentation of planning  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$73,247	<b>Process Milestone 2 P-2</b> Establish baseline rates <u>Data Source:</u> EHR/claims  Process Milestone 3 Estimated Incentive Payment: \$85,531	<b>Outcome Improvement Target 1 IT-10.1 Quality of Life:</b> Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population <u>Target Improvement:</u> TBD <u>Data Source:</u> Provider may select a validated assessment tool for quality of life  <b>Outcome Improvement Target 1 Estimated Incentive Payment:</b> \$137,846	<b>Outcome Improvement Target 2 IT-10.1 Quality of Life:</b> Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population <u>Target Improvement:</u> TBD <u>Data Source:</u> Provider may select a validated assessment tool for quality of life  <b>Outcome Improvement Target 2 Estimated Incentive Payment:</b> \$329,957
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$73,247	Year 3 Estimated Outcome Amount: \$85,531	Year 4 Estimated Outcome Amount: \$137,846	Year 5 Estimated Outcome Amount: \$329,957
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): \$626,581			

## RHP 13

### Category 3: Quality Improvements

**Identifying Outcome Measure and Provider Information:** Patient Satisfaction 138364812.3.1; Project 3.IT-6.1.Permian Basin Community Centers (PBCC)/138364812.

## RHP 13

### Category 3: Quality Improvements

**Identifying Outcome Measure and Provider Information:** Patient Satisfaction 138364812.3.1; Project 3.IT-6.1.Permian Basin Community Centers (PBCC)/138364812.

**Outcome Measure Description:** PBCC selects Patient Satisfaction as a desired outcome for individuals served in **Project 1.9.2 –Expand Specialty Care**. Process milestones include project planning for purposes of engaging local stakeholders, identifying current capacity and needed resources, determining timelines, and documenting a solid implementation plan. Project planning will be PBCC’s main focus relating to expanding specialty care services in DY 2. Starting in DY 3, PBCC will conduct Plan Do Study Act (PDSA) activities. Outcome improvement targets were established for DY 4 and 5 focusing on improvement in patient satisfaction scores. Percentage targets were set at 30% and 40% in DY 4 and 5 respectively. The focus will be to ensure that individuals are getting timely care, receiving effective communication from their physicians, have adequate access, are involved in their treatment, and that their overall health and functioning is improved to the fullest extent possible. In addition to the Rationale (stated below) for selecting Patient Satisfaction as an Outcome measure, this measure was also selected by PBCC because PBCC has the ability to produce that data at this time.

As stated in the description of PBCC Project 1.1, Option 1.9.2, treating the behavioral health needs of this targeted population will reduce Potentially Preventable Hospital Admissions and Readmissions. However, currently, PBCC does not have access to hospital admission data and so cannot report the improvement that will be realized. PBCC hopes to partner with the region’s hospitals to develop this reporting capability.

**Rationale:** Patient satisfaction surveys are designed to produce comparable data on the patients’ perspectives of care that allows for objective and meaningful comparisons between institutions on domains that are important to individuals. Public reporting and sharing of survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

A recent study reported the association between patient satisfaction and mortality rates after adjusting for clinical quality. Higher patient satisfaction was associated with lower mortality even after controlling for adherence to evidence-based practice guidelines, demonstrating that patients can judge the quality of clinical care they receive. Patient satisfaction is not about making patients “happy”. It is about improving the patients experience to facilitate health and medical outcomes. When patients are satisfied, trust is enhanced. When patients trust their physician, they are more likely to disclose information, follow advice and adhere to treatment plans. Improving patient satisfaction also helps to ensure that people don’t avoid getting the

care they need which could prevent larger health issues in the future. (Press Ganey, “How Patient Satisfaction Correlates with Clinical Quality” by Maxwell Drain, MA, April 12, 2010).

PBCC will be working with other Community Centers in learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIE’s or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

#### **Outcome Measure Valuation**

PBCC used the method of cost-utility analysis for valuing its Outcome Measure of OD 6 Patient Satisfaction related to Project 1.9.2 (Expanding Specialty Care). This method measures the cost of the proposed program in dollars and the health consequences in utility-weighted units. The valuation applies **quality-adjusted life-years (QALYs)** analysis that combines health quality (utility) with length of time in a particular health state. **See Attachment 3 in the Addendum.** This valuation was based on an economic evaluation model and extensive literature review conducted by professor at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.

For this project, the intervention of providing mental health services to individuals with no current access to care (since they do not meet public health funding eligibility due to diagnostic criteria) was assumed to bring a QALY gain of .335. To this QALY was applied a monetary value of \$50,000 per life-year gained, for a valuation of \$670,000 annually for the estimated number of 40 indigent persons to be served. By increasing the QALY, Patient Satisfaction would increase and hospitalizations and mortality rates would decrease.

In addition to the above, two more valuation calculation were explained in the Valuation section of Project 1.9.2 that substantiate that this Outcome Measure should be valued at no less than the \$77,168 requested as potential incentive payment.

138364812.3.1	3.IT-6.1	<b>PATIENT SATISFACTION</b>	
Permian Basin Community Centers			138364812
<b>Related Category 1 or 2 Projects:</b>	138364812.1.1		
<b>Starting Point/Baseline:</b>	PBCC's baseline for project 1.1 is zero as there are no specialty behavioral health clinics for indigent or underfunded individuals in the area as of October 1, 2012; therefore, there is no patient satisfaction data to assess.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1: ( P-1)</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$0	<b>Process Milestone 2: (P-4)</b> Conduct Plan Do Study ACT (PDSA) cycles to improve data collection and intervention activities Data Source: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles  Process Milestone 2 Estimated Incentive Payment: \$17,560	<b>Outcome Improvement Target 1:</b> OD-6 Improvement Target: IT-6.1) 30% 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 evidence based tool. Data Source: Patient survey  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$18,762	<b>Outcome Improvement Target 2 OD-6</b> Improvement Target: IT-6.1 40% 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 evidence-based tool. Data Source: Patient survey  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$40,846

138364812.3.1	3.IT-6.1	<b>PATIENT SATISFACTION</b>	
Permian Basin Community Centers		138364812	
<b>Related Category 1 or 2 Projects:</b>	138364812.1.1		
<b>Starting Point/Baseline:</b>	PBCC's baseline for project 1.1 is zero as there are no specialty behavioral health clinics for indigent or underfunded individuals in the area as of October 1, 2012; therefore, there is no patient satisfaction data to assess.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$0	Year 3 Estimated Outcome Amount: \$17,560	Year 4 Estimated Outcome Amount: \$18,762	Year 5 Estimated Outcome Amount: \$40,846
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$77,168			



**Reagan Memorial Hospital – 121806703**  
**OD-6 Patient Satisfaction –RHP Project**  
New:121806703.3.2; Old:121806703.3.1

- **Category 3 - Outcome Measure Description:** Reagan Memorial Hospital (RMH) will survey patients in the hospital's new clinic, Reagan Memorial Hospital Clinic (RMHC), in Big Lake, Texas to determine patient satisfaction. The target of this project is to set a baseline in the first year of clinic operation, and then improve patient satisfaction by 3% over the baseline satisfaction scores at the end of the project (DY5).
- **Rationale/Evidence:** Region 13 seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Advanced projects like palliative care and increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients receive quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

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

**Outcome Measure Valuation:** By participating in the DSRIP process, the providers of Regional Healthcare Partnership Region 13 (RHP 13) will take major steps to address the needs of its citizens through an improved and innovative healthcare delivery system. This goal is addressed with the accomplishment of this project. This project is directly related to the Category 1 project 121806703.3.2.

The measure for the project will be:

2. Do their doctors communicate well?

The patient surveys will be the source of the data for determining percent improvement in targeted patient satisfaction domain. The percent improvement in the targeted patient

domain will serve as the numerator and number of patients who were administered the survey will serve as the denominator. DY2 will be an implementation year and a process measure will be used to gauge successful implementation of surveys. DY3 will serve as the baseline. DY4-5 will have the combined goal of improving the baseline by 3%.

New:121806703.3.2 Old:121806703.3.1	IT-6.1	Patient Satisfaction	
Reagan Memorial Hospital Clinic			121806703
<b>Related Category 1 or 2 Projects::</b>	121806703.1.1		
<b>Starting Point/Baseline:</b>	DY 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: <b>Documentation of planning</b>  Process Milestone 1 estimated incentive payment: \$21,066.00	<b>Process Milestone 2 P-2</b> Establish baseline rates  Data Source: <b>Patient survey</b>  Process Milestone 2 estimated incentive payment: \$24,418.00	<b>Outcome Improvement Target 2 IT-6.1:</b> 2 % improvement over baseline satisfaction scores (2)how well their doctors communicate  Numerator: Percent improvement in targeted patient satisfaction domain Denominator: number of patients who were administered the survey  Data Source: <b>Patient survey</b>  Outcome Improvement Target 2 estimated incentive payment: \$39,183.00	<b>Outcome Improvement Target 3 IT-6.1:</b> 3% improvement over baseline satisfaction scores (2)how well their doctors communicate  Numerator: Percent improvement in targeted patient satisfaction domain Denominator: number of patients who were administered the survey  Data Source: <b>Patient survey</b>  Outcome Improvement Target 3 estimated Incentive payment: \$93,700.00

Year 2 <b>Estimated Outcome</b> Amount \$21,066	Year 3 Estimated Outcome Amount: \$24,418	Year 4 Estimated Outcome Amount: \$39,183	Year 5 Estimated Outcome Amount: \$93,700
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$178,367</i>			

### **Category 3: Quality Improvements**

- **Identifying Outcome Measure and Provider Information:**

Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measures

RHP outcome identification: 0227636-01.3.1

Performing Provider: San Angelo-Tom Green County Health Department (0227636-01)

### **H. Category 3: Quality Improvements**

- **Identifying Outcome Measure and Provider Information:**

Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measures

RHP outcome identification: 0227636-01.3.1

Performing Provider: San Angelo-Tom Green County Health Department (0227636-01)

- **Outcome Measure Description:**

Outcome Measure, IT-12.5 Other USPSTF-endorsed screening outcome measures, reasons that if a community, an entity, a local health department, the San Angelo-Tom Green County Health Department, offers primary care and prevention, testing, treatment and education for *Chlamydia*, admissions and/or visits through the Emergency Room would decrease, thereby, keeping the costs down to both the individual and to the hospital.

Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plan

Process Milestone 2: P-2 Establish baseline rates

Process Milestone 3: P-3 Offer the STD Clinic and expand the hours of the clinic, which may include evening and/or weekend hours should the need exist

Outcome Improvement Target 1: IT-12.5 Other USPSTF-endorsed screening outcome measures. Target for DY4 is to increase the number of Chlamydia associated initial visits to 700 and follow-up visits to 300 from DY3.

Outcome Improve Target 2: IT-12.5 Other USPSTF-endorsed screening outcome measures. Target for DY 5 is to increase the number of Chlamydia associated initial visits by 5% from Year 4, which translates to 735 initial visits and 315 follow-up visits.

- **Rationale:**

Outcome Improvement Targets for this projected were based on the need for a Sexually Transmitted Disease Clinic in Tom Green County, and more specifically, because the outcomes are measurable. To reiterate the need for such a project, there currently is no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties, the number of STDs are relatively high in Tom Green County, 3131 Chlamydia confirmed positive cases, were reported to Department of State Health Services in 2011, and the cost of an Emergency Room visit for a Chlamydia related issue currently ranges from \$133. For an uninsured or underinsured individual, that is a high cost for testing and/or examination.

The establishment of one STD Clinic is obtainable and measurable. By fulfilling the Outcomes as described, the San Angelo Health Department will be able to translate IT-

12.5 Other USPSTF-endorsed screening outcome measures into a Solid Number of individuals seeking testing, treatment and education for Chlamydia.

- **Outcome Measure Valuation:** Again, to reiterate the need for such a project, no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties exists and the number of Chlamydia confirmed positive cases are relatively high as reported to the Department of Health Services via various providers. The Health Department, in 2011 saw 791 patients for an initial STD visit, and 414 follow-up visits, along with performing 924 STD tests.

Therefore, by DY4, the San Angelo-Tom Green County Health Department projects to have 700 STD-related visits and 300 STD-follow-up visits, and in DY5, the Health Department expects to increase the STD related visits and follow-up visits by 5%, which amounts to 735 STD initial visits and 315 follow-up visits.

**Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:**

- **Identifying Outcome and Provider Information:**  
Planning Protocol: 0227936-01.3.1  
Performing Provider: San Angelo-Tom Green County Health Department (0227936-01)  
Related Category 1: Infrastructure Development  
Project Title: Sexually Transmitted Disease Clinic  
RHP Identifier: 0227936-01.1.1, Expand Primary Care Capacity
- **Starting Point/Baseline (if applicable):**  
Currently, a Sexually Transmitted Disease Clinic does not exist at the San Angelo-Tom Green County Health Department and no individuals are being tested, treated or receiving education for Chlamydia, a sexually transmitted disease.
- **Process Milestones/Outcome Improvement Targets:** See table below
- **RHP Planning Protocol Reference:**  
Year 2 = Outcome Improvement Target 1: P-1  
Year 3 = Outcome Improvement Target 2: P-5, P-4  
Year 4 = Outcome Improvement Target 3: I-12  
Year 5 = Outcome Improvement Target 4: I-12
- **Incentive Payment Amount:** Year 2 = \$4,167, Year 3 = \$8,333, Year 4 = \$8,333, Year 5 = \$16,667; TOTAL = \$37,500

OD-12	IT-12.5	Other USPSTF-endorsed screening outcome measures	
San Angelo-Tom Green County Health Department			0227936-01
<b>Related Category 1 or 2 Projects::</b>	1.1 Expand Primary Care Capacity		
<b>Starting Point/Baseline:</b>	Zero (0) established Sexually Transmitted Disease Clinic / Zero (0) number of patients for STD visits		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p><b>Process Milestone 1:</b> P-1 Project planning – engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plan</p> <p>Improvement Target: 9/30/13</p> <p>Data Source: Department of State Health Services Reports of Sexually Transmitted Disease Rates in Tom Green County.</p> <p>Goals: Establish STD Clinic to be ready for operation FY14 (DY3)</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment (<i>maximum amount</i>): \$4167</p>	<p><b>Process Milestone 2:</b> P-2 Establish baseline rates</p> <p>Improvement Target: 10/1/13 – 9/30/14</p> <p>Data Source: Schedules, daily logs, Department of State Health Services Reports of Sexually Transmitted Disease</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$ 4167</p> <p><b>Process Milestone 3:</b> P-3 Offer the STD Clinic and expand the hours of the clinic, which may include evening and/or weekend hours should the need exist</p> <p>Improvement Target: 9/1/13</p> <p>Data Source: Work schedules,</p>	<p><b>Outcome Improvement Target 1:</b> IT-12.5 Other USPSTF-endorsed screening outcome measures</p> <p>Goal: Increase the number of visits for <i>Chlamydia</i> screening to 700 initial visits and 300 follow-up visits based on Year 3 figures.</p> <p>Improvement Target: 10/1/14 - 9/30/15</p> <p>Data Source: Schedules, daily logs</p> <p>Outcome Improvement Target 4 Estimated Incentive Payment: \$8333</p>	<p><b>Outcome Improvement Target 5:</b> I-12 Other USPSTF-endorsed screening outcome measures</p> <p>Goal: Increase the number of visits for <i>Chlamydia</i> screening by 5% based on Year 4 figures. This translates to 735 initial visits and 315 follow-up visits.</p> <p>Improvement Target: 10/1/15- 9/30/16</p> <p>Data Source: Schedules, daily logs</p> <p>Outcome Improvement Target 5 Estimated Incentive Payment: \$16667</p>

<i>OD-12</i>	<i>IT-12.5</i>	<i>Other USPSTF-endorsed screening outcome measures</i>	
<i>San Angelo-Tom Green County Health Department</i>			<i>0227936-01</i>
<b>Related Category 1 or 2 Projects::</b>	<i>1.1 Expand Primary Care Capacity</i>		
<b>Starting Point/Baseline:</b>	<i>Zero (0) established Sexually Transmitted Disease Clinic / Zero (0) number of patients for STD visits</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	daily logs, other documentation Outcome Improvement Target 3 Estimated Incentive Payment: \$4167		
Year 2 Estimated Outcome Amount: \$4167	Year 3 Estimated Outcome Amount: \$8333	Year 4 Estimated Outcome Amount: \$8333	Year 5 Estimated Outcome Amount: \$16667
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$37,500</i>			

- **Identifying Outcome Measure and Provider Information:**

Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measures

RHP outcome identification: 0227636-01.3.2

Performing Provider: San Angelo-Tom Green County Health Department (0227636-01)

- **Outcome Measure Description:**

Outcome Measure, IT-12.5, Other USPSTF-endorsed screening outcome measures, reasons that if a community, an entity, a local health department, the San Angelo-Tom Green County Health Department, offers primary care and prevention, testing, treatment and education for *Gonorrhea*, admissions and/or visits through the Emergency Room would decrease, thereby, keeping the costs down to both the individual and to the hospital.

Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plan

Process Milestone 2: P-2 Establish baseline rates

Process Milestone 3: P-3 Offer the STD Clinic and expand the hours of the clinic, which may include evening and/or weekend hours should the need exist

Outcome Improvement Target 1: IT-12.5 Other USPSTF-endorsed screening outcome measures. Target for DY4 is to increase the number of Gonorrhea associated initial visits to 700 and follow-up visits to 300 from Year 3.

Outcome Improve Target 2: IT-12.5 Other USPSTF-endorsed screening outcome measures. Target for Year 5 is to increase the number of Gonorrhea associated initial visits by 5% from Year 4, which translates to 735 initial visits and 315 follow-up visits.

**Rationale:**

Outcome Improvement Targets for this project were based on the need for a Sexually Transmitted Disease Clinic in Tom Green County, and more specifically, because the outcomes are measurable. To reiterate the need for such a project, there currently is no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties, the number of STDs are relatively high in Tom Green County, 702 Gonorrhea confirmed positive cases, were reported to Department of State Health Services in 2011, and the cost of an Emergency Room visit for a Gonorrhea related issue currently ranges from \$133. For an uninsured or underinsured individual, that is a high cost for testing and/or examination. The establishment of one STD Clinic is obtainable and measurable. By fulfilling the Outcome as described, the San Angelo Health Department will be able to translate IT-12.5 Other USPSTF-endorsed screening outcome measures into a Solid Number of individuals seeking testing, treatment and education for Gonorrhea.

- **Outcome Measure Valuation:** Again, to reiterate the need for such a project, no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties exists and the number of Gonorrhea confirmed positive cases are

relatively high as reported to the Department of Health Services via various providers. The Health Department, in 2011 saw 791 patients for an initial STD visit, and 414 follow-up visits, along with performing 924 STD tests.

Therefore, by DY4, the San Angelo-Tom Green County Health Department projects to have 700 STD-related visits and 300 STD-follow-up visits, and in DY5, the Health Department expects to increase the STD related visits and follow-up visits by 5%, which amounts to 735 STD initial visits and 315 follow-up visits.

**Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:**

- **Identifying Outcome and Provider Information:**

Planning Protocol: 0227936-01.3.2

Performing Provider: San Angelo-Tom Green County Health Department (0227936-01)

Related Category 1: Infrastructure Development

Project Title: Sexually Transmitted Disease Clinic

RHP Identifier: 0227936-01.1.1, Expand Primary Care Capacity

- **Starting Point/Baseline (if applicable):**

Currently, a Sexually Transmitted Disease Clinic does not exist at the San Angelo-Tom Green County Health Department and no individuals are being tested, treated or receiving education for Gonorrhea, sexually transmitted disease.

- **Process Milestones/Outcome Improvement Targets:** See table below

- **RHP Planning Protocol Reference:**

Year 2 = Outcome Improvement Target 1: P-1

Year 3 = Outcome Improvement Target 2: P-5, P-4

Year 4 = Outcome Improvement Target 3: I-12

Year 5 = Outcome Improvement Target 4: I-12

- **Incentive Payment Amount:** Year 2 = \$4,167, Year 3 = \$8,333, Year 4 = \$8,333, Year 5 = \$16,667; TOTAL = \$37,500

OD-12	IT-12.5	Other USPSTF-endorsed screening outcome measures	
San Angelo-Tom Green County Health Department			0227936-01
<b>Related Category 1 or 2 Projects::</b>	1.1 Expand Primary Care Capacity		
<b>Starting Point/Baseline:</b>	Zero (0) established Sexually Transmitted Disease Clinic / Zero (0) number of patients for STD visits		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p><b>Process Milestone 1:</b> P-1 Project planning – engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plan Improvement Target: 9/30/13 Data Source: Department of State Health Services Reports of Sexually Transmitted Disease Rates in Tom Green County. Number of STD visits to the ER Identify current capacity and needed resources, determine timeliness and document implementation plans. Identify space requirements / access</p> <p>Process Milestone 1 Estimated</p>	<p><b>Process Milestone 2:</b> P-2 Establish baseline rates. Improvement Target: 10/1/13 – 9/30/14 Data Source: Schedules, daily logs, other payroll / work schedule documentation Process Milestone 2 Estimated Incentive Payment: \$ 4167</p> <p><b>Process Milestone 3:</b> P-3 Offer the STD Clinic and expand the hours of the clinic, which may include evening and/or weekend hours should the need exist. Improvement Target: 9/1/13 Data Source: Work schedules, daily logs, other documentation</p>	<p><b>Outcome Improvement Target 1:</b> IT-12.5 Other USPSTF-endorsed screening outcome measures  Goal: Increase the number of visits for <i>Gonorrhea</i> screening to 700 initial visits and 300 follow-up visits based on Year 3 figures.  Improvement Target: 10/1/14 - 9/30/15 Data Source: Schedules, daily logs</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$8333</p>	<p><b>Outcome Improvement Target 2:</b> IT-12.5 Other USPSTF-endorsed screening outcome measures  Goal: Increase the number of visits for <i>Gonorrhea</i> screening by 5% based on Year 4 figures. This translates to 735 initial visits and 315 follow-up visits.  Improvement Target: 10/1/15- 9/30/16 Data Source: Schedules, daily logs</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$16667</p>

<i>OD-12</i>	<i>IT-12.5</i>	<i>Other USPSTF-endorsed screening outcome measures</i>	
<i>San Angelo-Tom Green County Health Department</i>			<i>0227936-01</i>
<b>Related Category 1 or 2 Projects::</b>	<i>1.1 Expand Primary Care Capacity</i>		
<b>Starting Point/Baseline:</b>	<i>Zero (0) established Sexually Transmitted Disease Clinic / Zero (0) number of patients for STD visits</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Incentive Payment ( <i>maximum amount</i> ): \$4167	Process Milestone 3 Estimated Incentive Payment: \$4167		
Year 2 Estimated Outcome Amount: \$4167	Year 3 Estimated Outcome Amount: \$8333	Year 4 Estimated Outcome Amount: \$8333	Year 5 Estimated Outcome Amount: \$16667
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): \$37,500			

- **Identifying Outcome Measure and Provider Information:**

Outcome Measure: IT-12.5 Other USPSTF-endorsed screening outcome measures

RHP outcome identification: 0227636-01.3.3

Performing Provider: San Angelo-Tom Green County Health Department (0227636-01)

- **Outcome Measure Description:**

Outcome Measure, IT-12.5, Other USPSTF-endorsed screening outcome measures, reasons that if a community, an entity, a local health department, the San Angelo-Tom Green County Health Department, offers primary care and prevention, testing, treatment and education for *Syphilis*, admissions and/or visits through the Emergency Room would decrease, thereby, keeping the costs down to both the individual and to the hospital.

Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plan

Process Milestone 2: P-2 Establish baseline rates

Process Milestone 3: P-3 Offer the STD Clinic and expand the hours of the clinic, which may include evening and/or weekend hours should the need exist

Outcome Improvement Target 1: IT-12.5 Other USPSTF-endorsed screening outcome measures. Target for DY4 is to increase the number of Syphilis associated initial visits to 700 and follow-up visits to 300 from Year 3.

Outcome Improve Target 2: IT-12.5 Other USPSTF-endorsed screening outcome measures. Target for Year 5 is to increase the number of Syphilis associated initial visits by 5% from Year 4, which translates to 735 initial visits and 315 follow-up visits.

**Rationale:**

Outcome Improvement Targets for this projected were based on the need for a Sexually Transmitted Disease Clinic in Tom Green County, and more specifically, because the outcomes are measurable. To reiterate the need for such a project, there currently is no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties, the number of STDs are relatively high in Tom Green County, 23 Early Syphilis cases, were reported to Department of State Health Services in 2011, and the cost of an Emergency Room visit for a Syphilis related issue currently ranges from \$143. For an uninsured or underinsured individual, that is a high cost for testing and/or examination.

The establishment of one STD Clinic is obtainable and measurable. By fulfilling the Outcome as described, the San Angelo Health Department will be able to translate IT-12.5 Other USPSTF-endorsed screening outcome measures into a Solid Number of individuals seeking testing, treatment and education for Syphilis.

- **Outcome Measure Valuation:** Again, to reiterate the need for such a project, no Sexually Transmitted Disease Clinic to serve the residents of Tom Green and the surrounding counties exists and the number of Early Syphilis cases are relatively high as

reported to the Department of Health Services via various providers. The Health Department, in 2011 saw 791 patients for an initial STD visit, and 414 follow-up visits, along with performing 924 STD tests.

Therefore, by DY4, the San Angelo-Tom Green County Health Department projects to have 700 STD-related visits and 300 STD-follow-up visits, and in DY5, the Health Department expects to increase the STD related visits and follow-up visits by 5%, which amounts to 735 STD initial visits and 315 follow-up visits.

**Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:**

- **Identifying Outcome and Provider Information:**

Planning Protocol: 0227936-01.3.3

Performing Provider: San Angelo-Tom Green County Health Department (0227936-01)

Related Category 1: Infrastructure Development

Project Title: Sexually Transmitted Disease Clinic

RHP Identifier: 0227936-01.1.1, Expand Primary Care Capacity

- **Starting Point/Baseline (if applicable):**

Currently, a Sexually Transmitted Disease Clinic does not exist at the San Angelo-Tom Green County Health Department and no individuals are being tested, treated or receiving education for Syphilis, sexually transmitted disease.

- **Process Milestones/Outcome Improvement Targets:** See table below

- **RHP Planning Protocol Reference:**

Year 2 = Outcome Improvement Target 1: P-1

Year 3 = Outcome Improvement Target 2: P-5, P-4

Year 4 = Outcome Improvement Target 3: I-12

Year 5 = Outcome Improvement Target 4: I-12

- **Incentive Payment Amount:** Year 2 = \$4,167, Year 3 = \$8,333, Year 4 = \$8,333, Year 5 = \$16,667; TOTAL = \$37,500

OD-12	IT-12.5	Other USPSTF-endorsed screening outcome measures	
San Angelo-Tom Green County Health Department			0227936-01
<b>Related Category 1 or 2 Projects::</b>	1.1 Expand Primary Care Capacity,		
<b>Starting Point/Baseline:</b>	Zero (0) established Sexually Transmitted Disease Clinic / Zero (0) number of patients for STD visits		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1:</b> P-1 Project planning – engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plan</p> <p>Improvement Target: 9/30/13</p> <p>Data Source: Department of State Health Services Reports of Sexually Transmitted Disease Rates in Tom Green County. Number of STD visits to the ER</p> <p>Identify current capacity and needed resources, determine</p>	<p><b>Process Milestone 2:</b> P-2 Establish baseline rates</p> <p>Improvement Target: 10/1/13 – 9/30/14</p> <p>Data Source: Schedules, daily logs, other payroll / work schedule documentation</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$ 4167</p> <p><b>Process Milestone 3:</b> P-4 Expand the hours of a primary care clinic, which may include evening and/or weekend hours should the need exist</p>	<p><b>Outcome Improvement Target 1:</b> IT-12.5 Other USPSTF-endorsed screening outcome measures</p> <p>Goal: Increase the number of visits for <i>Syphilis</i> screening to 700 initial visits and 300 follow-up visits based on Year 3 figures.</p> <p>Improvement Target: 10/1/14 - 9/30/15</p> <p>Data Source: Schedules, daily logs</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$8333</p>	<p><b>Outcome Improvement Target 2:</b> IT-12.5 Other USPSTF-endorsed screening outcome measures</p> <p>Goal: Increase the number of visits for <i>Syphilis</i> screening by 5% based on Year 4 figures. This translates to 735 initial visits and 315 follow-up visits.</p> <p>Improvement Target: 10/1/15- 9/30/16</p> <p>Data Source: Schedules, daily logs</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$16667</p>

<i>OD-12</i>	<i>IT-12.5</i>	<i>Other USPSTF-endorsed screening outcome measures</i>	
<i>San Angelo-Tom Green County Health Department</i>			<i>0227936-01</i>
<b>Related Category 1 or 2 Projects::</b>	<i>1.1 Expand Primary Care Capacity,</i>		
<b>Starting Point/Baseline:</b>	<i>Zero (0) established Sexually Transmitted Disease Clinic / Zero (0) number of patients for STD visits</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
timeliness and document implementation plans. Identify space requirements / access  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$4167	Improvement Target: 9/1/13 Data Source: Work schedules, daily logs, other documentation  Process Milestone 3 Estimated Incentive Payment: \$4167		
Year 2 Estimated Outcome Amount: \$4167	Year 3 Estimated Outcome Amount: \$8333	Year 4 Estimated Outcome Amount: \$8333	Year 5 Estimated Outcome Amount: \$16667
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): \$37,500			

**ED Appropriate Utilization – RHP Project 179272301.3.1  
Schleicher County Medical Center/179272301**

Identifying Outcome Measure:

IT-9.2 ED Appropriate Utilization (Standalone measure)

Outcome Measure Description:

**Year 2:** Schleicher County Medical Center will spend the initial year in planning for the transition of the current primary care clinic to the Patient-Centered Medical Home Model. This process will include a gap analysis and feasibility study to determine procedural steps and special needs of the program moving forward.

**Year 3:** Once the program initiative is underway the focus will shift to the training and education of staff on PCMH best practices. Appropriate education materials, seminars and workshops will lay a solid foundation helping staff members deliver a positive patient experience leading to increased satisfaction, care coordination, and ultimately access to care. Data baseline will be established at close of year.

**Year 4:** With the staff properly educated, the existing primary care clinic will undergo the transformation process to a PCMH. The PCMH framework in place will generate positive patient experiences in conjunction with demonstrably better care coordination. Strengthened primary care will within a relatively short time reduce emergency department visits. A 5% overall reduction in ED utilization is expected within this timeframe over the baseline as patients are educated and recognize the PCMH as their 'home base' for healthcare.

**Year 5:** Throughout the final year of implementation there will continue to be process refinement as the PCMH strives to achieve NCQA recognition. The continued patient experience and education process will continue to reduce any unnecessary reliance on the ED safety net. Another 5% reduction in ED visits is expected over this time period, resulting in a 10% net reduction over the baseline.

Rationale:

Non emergent visits to the emergency department are more costly to both the provider and the patient when compared with the cost of being seen in a clinic setting. The transfer of patients relying on the ED for health care to a reliance on clinic providers will result in a better quality of care for the patient as well as lower costs. Schleicher County Medical Center this can be done through community and provider education. As such Schleicher County Medical Center has chosen appropriate utilization of the ED as an outcome measure.

Outcome Measure Valuation:

The creation of the PCMH project will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider.

Schleicher County Medical Center used a basic valuation tool to measure the efficacy of potential project. The tool was centered on the following questions:

- Does the project meet the waiver goals?
- Does the project address a pressing community need?
- Which population is being served?
- What is the project investment (Resources needed)?

After receiving input from outside consultation and visiting with local stakeholders, the PCMH Project was deemed to be a top priority in strengthening the health delivery system of Schleicher County. PCMH development is a multi-year transformational effort an innovative way to deliver care. By providing the right care at the right time and in the right setting, over time, patients in Schleicher County will hopefully see their overall health improve, rely less on costly ED visits and incur fewer avoidable hospital stays.

<b>OLD: 179272301.3.1</b> <b>NEW: 179272301.3.2</b>	3. IT 9-2	ED Appropriate Utilization	
Schleicher County Medical Center			179272301
<b>Related Category 1 or 2 Projects:</b>	179272301.2.1		
<b>Starting Point/Baseline:</b>	TBD		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Process Milestone 1 Estimated Incentive Payment: \$4,972	<b>Process Milestone 3 [P-4]</b> Establish average number of non emergent ED visits over the years 2010, 2011, and 2012 Data Source: ED records  Process Milestone 3 Estimated Incentive Payment: \$5,763	<b>Outcome Improvement Target 2 [IT-1.1]:</b> Improvement Target: TBD based on data collected in year 3 Data Source: ED Visits  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$9,247	<b>Outcome Improvement Target 3 [IT-1.1]:</b> Improvement Target: TBD based on data collected in year 3 Data Source: ED Visits  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$22,113
Year 2 Estimated Outcome Amount: \$4,972	Year 3 Estimated Outcome Amount: \$5,763	Year 4 Estimated Outcome Amount: \$9,247	Year 5 Estimated Outcome Amount: \$22,113
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$42,095</b>			

### **Category 3: Quality Improvements**

**Outcome Domain:** OD – 9 Right Care, Right Setting

- Improvement Target: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits
- Unique Project ID Number: 137226005.3.1
- Related Cat 1 Project: 137226005.1.1
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Outcome Measure Description:**

The process milestone for this outcome measure is to establish baseline rates. Shannon plans to establish baseline rates throughout Demonstration Year 2 since that is the opening year for the North Urgent Care Clinic. The purpose of this outcome measure in Demonstration Years 3-5 is to track Pediatric Asthma visits to the ED. Shannon will seek to reduce ED utilization by promoting right care, right setting encouraging the use of the North Urgent Care Clinic for non-emergent care. The percent improvement for this outcome measure is TBD.

#### **Rationale:**

By determining the baseline rates in demonstration year 2, Shannon will set benchmarks for improving protocol and trainings for patients, families, and staff for children that present asthma related conditions. In demonstration years 3-5, Shannon will reduce Pediatric/Young Adult Asthma Emergency Department visits. The percent improvement is TBD.

During fiscal year 12, 56% of the level 1, 2, or 3 ED visits related to Pediatric/Young Adult Asthma were from patients that reside in 76903. Shannon believes there is potential to improve this rate substantially with the addition of the pediatrician and the expanded hours at the North Urgent Care Clinic.

#### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 1 project valuation for Expanding Primary Capacity. Each Category 1 and 2 project was weighted the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

By increasing access to care for patients with pediatric/young adult asthma, there will be an increased community benefit because parents will have an accessible, more affordable alternative for their child's care. This measure will require collaborative efforts between pediatricians and staff, urgent care staff, and ED staff to promote right care in the right setting at the right time.

137226005.3.1	IT.9-3	Right Care, Right Setting: Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (standalone measure)	
Shannon Medical Center			137226005
<b>Related Category 1 or 2 Projects::</b>	137226005.1.1		
<b>Starting Point/Baseline:</b>	Baseline will be determined in Demonstration Year 2		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-2</b> Establish baseline rates <u>Data Source:</u> EHR, Claims  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 162,819.00	<b>Outcome Improvement Target 1</b> IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 <u>Numerator:</u> Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period <u>Denominator:</u> all patients ages 2-20 diagnosed with asthma during the measurement period <u>Improvement Target:</u> TBD <u>Data Source:</u> EHR, Claims  Outcome Improvement Target 1 Estimated Incentive Payment: \$ 188,729.00	<b>Outcome Improvement Target 2</b> IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 <u>Numerator:</u> Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period <u>Denominator:</u> all patients ages 2-20 diagnosed with asthma during the measurement period <u>Improvement Target:</u> TBD <u>Data Source:</u> EHR, Claims  Outcome Improvement Target 2 Estimated Incentive Payment: \$ 302,844.00	<b>Outcome Improvement Target 3</b> IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 <u>Numerator:</u> Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period <u>Denominator:</u> all patients ages 2-20 diagnosed with asthma during the measurement period <u>Improvement Target:</u> TBD <u>Data Source:</u> EHR, Claims  Outcome Improvement Target 3 Estimated Incentive Payment: \$ 724,194.00

137226005.3.1	IT.9-3	Right Care, Right Setting: Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (standalone measure)	
Shannon Medical Center			137226005
<b>Related Category 1 or 2 Projects::</b>	137226005.1.1		
<b>Starting Point/Baseline:</b>	Baseline will be determined in Demonstration Year 2		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: \$ 162,819.00	Year 3 Estimated Outcome Amount: \$ 188,729.00	Year 4 Estimated Outcome Amount: \$ 302,844.00	Year 5 Estimated Outcome Amount: \$ 724,194.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$ 1,378,585.00			

### **Category 3: Innovation and Design**

#### **Outcome Domain:** OD-6 Patient Satisfaction

- Improvement Target: IT-6.1 Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)
- Unique Project ID Number: 137226005.3.2
- Related Cat 2 Project: 137226005.2.1
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Outcome Measure Description:**

In demonstration year 2, Shannon will engage stakeholders, determine resources, and establish timelines, as well as, begin to implement processes to improve patient satisfaction. In demonstration year 3, Shannon will disseminate lessons learned and best practices to Physicians, Healthcare Providers, and Hospital Administrators. The outcome improvement target will focus on doctor communication. In demonstration year 4 and 5, Shannon's goal is to see an improvement in HCAHPS scores related to doctor communication. The percent improvement Shannon would like to see by the end of the waiver is to be determined.

#### **Rationale:**

HCAHPS is a standardized survey that reflects customer/patient satisfaction to understand patients' perspectives on hospital care. This Patient Satisfaction improvement target will focus on proactive care for the patients based on how well a patient's doctor communicates.

The HCAHPS scores related to doctor communication will be utilized to determine if Shannon is meeting the outcome improvement targets for improving patient satisfaction.

#### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 2 project valuation to Improve the Patient Experience. Each Category 1 and 2 project was weighted the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

By working with the doctors to incorporate patient-centered care by improving their communication, listening to the patient, explaining information, and answering questions in a respectful manner, the patient's satisfaction should increase resulting in overall improved patient health and compliance. These efforts will reach all patients served throughout Region 13 and impact the overall experiences of care at Shannon.

137226005.3.2	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)	
Shannon Medical Center		137226005	
Related Category 1 or 2 Projects::	137226005.2.1		
Starting Point/Baseline:	Baseline will be determined based on data from July 1, 2011 through June 30, 2012		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> Documentation of planning  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 113,973.00	<b>Process Milestone 2 P-5</b> Disseminate findings, including lessons learned and best practices, to stakeholders <u>Data Source:</u> Hospital Documentation  Process Milestone 2 Estimated Incentive Payment: \$ 132,110.00	<b>Outcome Improvement Target 1 IT-6 .1:</b> Percent improvement over baseline of patient satisfaction scores <u>Improvement Target:</u> (2) how well their doctors communicate <u>Numerator:</u> Percent improvement in targeted patient satisfaction domain <u>Denominator:</u> number of patients who were administered the survey Data Source: Patient survey <u>Target Improvement:</u> TBD  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$ 211,991.00	<b>Outcome Improvement Target 2 IT-6 .1:</b> Percent improvement over baseline of patient satisfaction scores <u>Improvement Target:</u> (2) how well their doctors communicate <u>Numerator:</u> Percent improvement in targeted patient satisfaction domain <u>Denominator:</u> number of patients who were administered the survey Data Source: Patient survey <u>Target Improvement:</u> TBD  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$ 506,936.00

137226005.3.2	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate (standalone measure)	
Shannon Medical Center		137226005	
Related Category 1 or 2 Projects::	137226005.2.1		
Starting Point/Baseline:	Baseline will be determined based on data from July 1, 2011 through June 30, 2012		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$ 113,973.00	Year 3 Estimated Outcome Amount: \$ 132,110.00	Year 4 Estimated Outcome Amount: \$ 211,991.00	Year 5 Estimated Outcome Amount: \$ 506,936.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$ 965,010.00			

### **Category 3: Quality Improvements**

#### **Outcome Domain: OD-6 Patient Satisfaction**

- Improvement Target: IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information
- Unique Project ID Number: 137226005.3.3
- Related Cat 2 Project: 137226005.2.2
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Outcome Measure Description:**

In demonstration year 2, project planning will include determining the three Rapid Improvement activities, identifying the resources needed, and establishing the timeline for implementation. Throughout demonstration year 3, Shannon will develop lessons learned and best practices by incorporating LEAN principles to identify areas of improvement. The expected outcomes in demonstration years 4 and 5 for LEAN will be enhanced access to proactive/timely care to improve customer/patient satisfaction by the end of the waiver.

#### **Rationale:**

HCAHPS is a standardized survey that reflects customer/patient satisfaction to understand patients' perspectives on hospital care. This Patient Satisfaction improvement target will focus on proactive care for the patients including timely care, appointments, and information. The HCAHPS scores related to timely care will be utilized to determine if Shannon is meeting the outcome improvement targets for LEAN which in turn will determine if there is an improvement in patient satisfaction.

#### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 2 project valuation to Apply Process Improvement Methodology to Improve Quality/Efficiency. Each Category 1 and 2 project was weighted the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

Since this measure is focused on patient satisfaction, all populations will see a shift to more proactive, quality care. By incorporating Lean methodologies at Shannon to improve in quality, satisfaction, financial, and time based-improvements, Shannon will implement care, appointments, and information in a timelier manner as a result of the software integrated through this project. An overall system-wide initiative, will lead to improvements in care that result in patient satisfaction.

137226005.3.3	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
Shannon Medical Center			137226005
<b>Related Category 1 or 2 Projects::</b>	137226005.2.2		
<b>Starting Point/Baseline:</b>	Baseline will be determined based on data from July 1, 2011 through June 30, 2012		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> Documentation of planning  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 105,832.00	<b>Process Milestone 2: P-5</b> Disseminate findings, including lessons learned and best practices, to stakeholders <u>Data Source:</u> Hospital Documentation  Process Milestone 3 Estimated Incentive Payment: \$ 122,674.00	<b>Outcome Improvement Target 1</b> IT-6 .1 Percent improvement over baseline of patient satisfaction scores (TBD) <u>Improvement Target:</u> (1) are getting timely care, appointments, and information <u>Numerator:</u> Percent improvement in targeted patient satisfaction domain <u>Denominator:</u> number of patients who were administered the survey <u>Data Source:</u> Patient survey  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$ 196,849.00	<b>Outcome Improvement Target 2</b> IT-6 .1 Percent improvement over baseline of patient satisfaction scores (TBD) <u>Improvement Target:</u> (1) are getting timely care, appointments, and information <u>Numerator:</u> Percent improvement in targeted patient satisfaction domain <u>Denominator:</u> number of patients who were administered the survey <u>Data Source:</u> Patient survey  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$ 470,726.00

137226005.3.3	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
Shannon Medical Center			137226005
<b>Related Category 1 or 2 Projects::</b>	137226005.2.2		
<b>Starting Point/Baseline:</b>	Baseline will be determined based on data from July 1, 2011 through June 30, 2012		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: \$ 105,832.00	Year 3 Estimated Outcome Amount: \$122,674.00	Year 4 Estimated Outcome Amount: \$ 196,849.00	Year 5 Estimated Outcome Amount: \$ 470,726.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5):</i> \$ 896,081.00			

### **Category 3: Innovation and Design**

#### **Outcome Domain:** OD-13 Palliative Care

- Improvement Target: IT-13.4 Proportion admitted to the ICU in the last 30 days of life
- Unique Project ID number: 137226005.3.4
- Related Cat 2 Project: 137226005.2.3
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Outcome Measure Description:**

Shannon Medical Center will identify and expand current resources as an Advanced Practice Nurse gains her certification in demonstration year 2. Shannon will seek to establish baseline rates for trainings and the patient/family experience survey in demonstration year 3 once the comprehensive Palliative Care program has been implemented. The outcome measure for this proposed project is to identify the proportion of palliative care patients admitted to the ICU in the last 30 days of life. The percent reduction Shannon would like to see by the end of the waiver is TBD.

#### **Rationale:**

The selected process milestones will allow Shannon Medical Center to identify current capacity and add the necessary resources for staff, as well as determine baseline rates to fully develop the comprehensive Palliative Care program through staff training and patient/family experience surveys. These baseline rates will be used to improve patient and family experience and increase M.D. and staff awareness through educational initiatives, as well as, to develop a survey tool during the waiver period that will evaluate and improve the overall palliative care program which will lead to a more robust program. By tracking patients with cancer, which is an area Shannon is interested in for Cancer Committee Accreditation, this improvement target will be indicative of the overall effectiveness and flow of the program. Palliative care patients will benefit from vigorous treatment of pain and will be less likely to suffer from undesirable symptoms. Palliative care professionals will assist with difficult decision making so that patients will be adequately prepared to understand the normal process of the disease state, less likely to seek futile burdensome interventions, and more likely to make treatment decisions based on personal goals of care with an emphasis on quality of life.

#### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 2 project valuation for Use of Palliative Care Programs. Each Category 1 and 2 project was weighted the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

The investment will require the addition of an Advanced Practice Nurse and a Palliative Care Physician, as well as, additional training and resources for clinicians and staff. In addition, the scope of the project includes hosting an annual Palliative Care Symposium to provide resources and training for Region 13 to better serve the patient's needs during end-of-life. Expanding end-of-life options beyond ICU and more appropriately addressing a patient's end-of-life needs will guarantee the patient's last days of life are more comfortable, less stressful, and less costly to the patient and family. By preventing unnecessary and lengthy ICU stays in patients nearing the end of life, patients and families will avoid unnecessary aggressive treatments, thus decreasing the financial and emotional burdens.

137226005.3.4	IT-13.4	Palliative Care: Proportion admitted to the ICU in the last 30 days of life (standalone measure)	
Shannon Medical Center			137226005
<b>Related Category 1 or 2 Projects::</b>	137226005.2.3		
<b>Starting Point/Baseline:</b>	Establish baseline rates in Demonstration Year 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> documentation of planning  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 138,396.00	<b>Process Milestone 3 P-2</b> Establish baseline rates <u>Data Source:</u> EHR/claims  Process Milestone 3 Estimated Incentive Payment: \$ 160,420.00	<b>Outcome Improvement Target 1</b> Outcome Improvement Target 1: IT-13.4 Proportion admitted to the ICU in the last 30 days of life <u>Numerator:</u> Patients who died from cancer and had >1 ER visit in the last 30 days of life <u>Denominator:</u> patients who died from cancer <u>Data Source:</u> EHR, claims <u>Target Improvement:</u> TBD Outcome Improvement Target 1 Estimated Incentive Payment: \$ 257,418.00	<b>Outcome Improvement Target 2</b> Outcome Improvement Target 1: IT-13.4 Proportion admitted to the ICU in the last 30 days of life <u>Numerator:</u> Patients who died from cancer and had >1 ER visit in the last 30 days of life <u>Denominator:</u> patients who died from cancer <u>Data Source:</u> EHR, claims <u>Target Improvement:</u> TBD Outcome Improvement Target 2 Estimated Incentive Payment: \$ 615,565.00

137226005.3.4	IT-13.4	Palliative Care: Proportion admitted to the ICU in the last 30 days of life (standalone measure)	
Shannon Medical Center			137226005
<b>Related Category 1 or 2 Projects::</b>	137226005.2.3		
<b>Starting Point/Baseline:</b>	Establish baseline rates in Demonstration Year 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
2Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$ 138,396.00	Year 3 Estimated Outcome Amount: \$ 160,420.00	Year 4 Estimated Outcome Amount: \$ 257,418.00	Year 5 Estimated Outcome Amount: \$ 615,565.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): \$ 1,171,799.00			

## **Pass 3B**

### **Category 3: Innovation and Design**

#### **Outcome Domain:** OD-1 Primary Care and Chronic Disease Management

- Improvement Target: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) (standalone measure)
- Old Unique Project ID Number: 137226005.3.5
- New Unique Project ID Number: 137226005.3.7
- Related Old Cat 1 Project: 137226005.1.2
- Related New Cat 1 Project: 137226005.1.4
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Outcome Measure Description:**

Shannon Medical Center will identify and expand current resources as the staff at the Shannon Clinic determines their current capacity and the need for expansion to implement the registry in demonstration year 2. Also, planning will take place to determine the resources needed to proactively educate patients. In demonstration year 3, Shannon will establish baseline rates to determine the outcome achievements that will be met in demonstration years 4 and 5. The outcome improvement selected for this proposed project is diabetes care, hbA1c poor control. Shannon will use the registry to track and seek improvements in patients with hbA1c's greater than 9.0%. Shannon will implement the education programs determined in demonstration year 2 to see improvements in diabetes care which is a community need in Region 13. The percent outcome improvement target is to be determined.

#### **Rationale:**

Providers, clinicians, and staff will be able to understand and track patients with chronic conditions more closely using the disease management registry. By implementing process milestone 8, creating protocols for registry-driven reminders and reports regarding key health indicator monitoring and management, Shannon will be able to drive change with clinicians and staff ensuring hemoglobin A1c's are ordered frequently and monitored to adjust medication as needed. To optimally manage patients with diabetes, there are interventions that need to occur beyond the regular outpatient visit. The registry will assist the provider and a case manager in managing patients by diagnosis, on an individual level as well as in comparison to other patients with diabetes.

#### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 1 project valuation for Implementing a Chronic Disease Management Registry. Each Category 1 and 2 project was weighted on the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

The investment in this project includes implementing a new form of technology that will be functioning throughout the clinic over the next 5 years. This will require purchase of the

software, training on the software, and training for the clinicians and staff to reach optimal implementation and use of the software. By implementing this registry, clinicians and staff will have the opportunity to be more efficient and track patients with chronic conditions more closely. However, there must be an additional piece to reach optimal change to better the health for the patients. For this reason, Shannon will also expand resources to proactively educate patients with uncontrolled diabetes. Through the registry and education, Shannon seeks to engage and educate patients, as well as facilitate more efficient clinic interactions to encourage more patient compliance. In turn, this will address the community need of the high rates of adult diabetes by reducing barriers such as financial resources and lack of access to care.

Old ID: 137226005.3.5 New ID: 137226005.3.7	IT-1.10	Primary Care and Chronic Disease Management Diabetes care: HbA1c poor control (>9.0%) (standalone measure)	
Shannon Medical Center			137226005
Related Category 1 or 2 Projects::	Old ID: 137226005.1.2 New ID: 137226005.1.4		
Starting Point/Baseline:	Baseline rates will be determined in demonstration year 3		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> documentation of planning  Process Milestone 1 Estimated Incentive Payment: \$ 179,225.00	<b>Process Milestone 3 P-2</b> Establish baseline rates <u>Data Source:</u> EHR/claims  Process Milestone 3 Estimated Incentive Payment: \$ 209,161.00	<b>Outcome Improvement Target 1</b> IT-1.10 HbA1c poor control (>9.0%) <u>Target Improvement:</u> TBD <u>Numerator:</u> Percentage of patients 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) who had hemoglobin A1c control >9.0% <u>Denominator:</u> Members 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) <u>Data Source:</u> EHR, registry, claims, administrative clinical data  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$ 336,559.00	<b>Outcome Improvement Target 2</b> IT-1.10 HbA1c poor control (>9.0%) <u>Target Improvement:</u> TBD <u>Numerator:</u> Percentage of patients 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) who had hemoglobin A1c control >9.0% <u>Denominator:</u> Members 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) <u>Data Source:</u> EHR, registry, claims, administrative clinical data  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$ 807,365.00

Old ID: 137226005.3.5 New ID: 137226005.3.7	IT-1.10	Primary Care and Chronic Disease Management Diabetes care: HbA1c poor control (>9.0%) (standalone measure)	
Shannon Medical Center			137226005
Related Category 1 or 2 Projects::	Old ID: 137226005.1.2 New ID: 137226005.1.4		
Starting Point/Baseline:	Baseline rates will be determined in demonstration year 3		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: \$ 179,225.00	Year 3 Estimated Outcome Amount: \$ 209,161.00	Year 4 Estimated Outcome Amount: \$ 336,559.00	Year 5 Estimated Outcome Amount: \$ 807,365.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5): \$ 1,532,310.00</i>			

## **Pass 2**

### **Category 3: Innovation and Design**

#### **Outcome Domain: OD-6 Patient Satisfaction**

- Improvement Target: IT-6.1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)
- Unique Project ID Number: Pass 2.137226005.3.6
- Related Cat 1 Project: 137226005.1.3
- Performing Provider Name/TPI: Shannon Medical Center/137226005

#### **Outcome Measure Description:**

In demonstration year 2, Shannon seeks to identify current resources and engage stakeholders to provide specialty services in the surrounding rural areas with the Shannon service area. Also, Shannon will work with physicians and staff to implement the patient survey that will be administered. The survey is sent to all patients and focuses on the following: continuity and coordination of care, doctor-patient communication, office staff, timely access to care, and overall ratings. Shannon will use the results of the survey to improve upon timely access to care, appointments, and information. In demonstration year 3, Shannon will establish baseline rates from patient satisfaction survey data. In demonstration years 4 and 5, Shannon will continue training physicians and staff on patient-centered care and will incorporate the new referral process to expand specialty care. Shannon will seek to improve upon patient satisfaction scores over baseline for timely care, appointments, and information. The outcome improvement target percent is to be determined.

#### **Rationale:**

The survey used is a standardized survey that reflects customer/patient satisfaction to understand patients' perspectives on primary and specialty care. This Patient Satisfaction improvement target will focus on proactive care for the patients including timely care, appointments, and information. The scores related to timely care will be utilized to determine if Shannon is meeting the outcome improvement targets for access to specialty care which in turn will determine if there is an improvement in patient satisfaction.

#### **Outcome Measure Valuation:**

The outcome measure valuation for this project was based on the valuation methodology used to determine the related Category 2 project valuation to Apply Process Improvement Methodology to Improve Quality/Efficiency. Each Category 1 and 2 project was weighted on the following: achieves regional waiver goals, addresses community needs, the project scope, and the project investment.

Since this measure is focused on patient satisfaction, all populations will see a shift to more proactive, quality care. By expanding specialty care to rural areas, Shannon seeks to improve in quality, satisfaction, financial, and time based-improvements. An improved and formalized referral system will lead to improvements in care that result in patient satisfaction. Also, there will be less burden on the patient related to travel for appointments and treatment.

137226005.3.6	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
Shannon Medical Center			137226005
Related Category 1 or 2 Projects::	137226005.1.3		
Starting Point/Baseline:	Establish baseline rates in demonstration year 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 P-1</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Data Source:</u> Documentation of planning  Process Milestone 1 Estimated Incentive Payment: \$ 71,690.00	<b>Process Milestone 2 P-2</b> Establish baseline rates <u>Data Source:</u> EHR/claims  Process Milestone 3 Estimated Incentive Payment: \$ 83,664.00	<b>Outcome Improvement Target 1</b> IT-6 .1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information <u>Improvement Target:</u> TBD <u>Numerator:</u> Percent improvement in targeted patient satisfaction domain <u>Denominator:</u> number of patients who were administered the survey <u>Data Source:</u> Patient survey  <b>Outcome Improvement Target 1</b> Estimated Incentive Payment: \$ 134,623.00	<b>Outcome Improvement Target 2</b> IT-6 .1 Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information <u>Improvement Target:</u> TBD <u>Numerator:</u> Percent improvement in targeted patient satisfaction domain <u>Denominator:</u> number of patients who were administered the survey <u>Data Source:</u> Patient survey  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$ 322,946.00

137226005.3.6	IT-6.1	Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (standalone measure)	
Shannon Medical Center			137226005
Related Category 1 or 2 Projects::	137226005.1.3		
Starting Point/Baseline:	Establish baseline rates in demonstration year 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Year 2 Estimated Outcome Amount: \$ 71,690.00	Year 3 Estimated Outcome Amount: \$ 83,664.00	Year 4 Estimated Outcome Amount: \$ 134,623.00	Year 5 Estimated Outcome Amount: \$ 322,946.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> <i>(add outcome amounts over DYs 2-5):</i> \$ 612,923.00			

### **Category 3: Quality Improvements**

- **Identifying Outcome Measure and Provider Information:** 121781205.3.2, OD-2, Potential Preventable Admission, IT-2.13 Other Admission Rate, - Lillian M. Hudspeth Memorial Hospital 121781205.
- **Outcome Measure Description:** The Community Paramedic Program is a new concept in community healthcare. The program first developed in Nova Scotia has only been developed in the United States in just a few areas. Since there are no established programs estimates of patient volume and cost savings are estimated. The program services patients with a wide array of issues that range from frequent abuse of the ED to non-compliance of their disease and injury prevention. FY2 will establish a baseline. Patient utilization and cost savings will be measured to previous utilization with data coming from the EHR. Based on the Nova Scotia model we estimate a goal of cost reduction 5% FY3, 10% FY4, and 15% FY5.
- **Rationale:** Since the Hospital District utilizes an integrated EHR, data is easily obtained on previous utilization and cost. Medicare savings are based on the CMS cost per patient. Baseline establishment in FY2 with hard data extrapolation in FY3-FY5.
- **Outcome Measure Valuation:** As defined in the narrative, the extreme rural nature of our community, age of the population, ethnic risk factors and uninsured population provides opportunity to make an impact in the health outcomes of this population. The target county population is greater than 4000. The valuation will look at ED abuse, non-compliance with chronic health issues and injury prevention.

#### **Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:**

- **Identifying Outcome and Provider Information:** Community Paramedic Program, 121781205.2.1, 2.9 Established/Expand a Patient Care Navigation Program 2.92, Lillian M. Hudspeth Memorial Hospital, 121781205 Category 3 OD-5 Potential Preventable Admissions, IT-2.13 Other Admission Rate. Lillian M. Hudspeth Memorial Hospital 121781205.
- **Starting Point/Baseline (if applicable):** ED visits and preventable admissions.

#### **Process Milestones/Outcome Improvement Targets:**

**Community Paramedic Program, Conservative Estimates**

	Current	Year 2	Year 3	Year 4	Year 5	4-Year Total
<b>Total Direct Charges</b>		\$303,912	\$352,227	\$355,915	\$304,939	\$1,316,993
<b>Total Uses of Funds</b>		\$303,912	\$352,227	\$355,915	\$304,939	\$1,316,993
<b><u>SAVINGS</u></b>						
<b><u>Current Program Census</u></b>						
<b>Number of Program Participants</b>	#	420	420	420	420	1,680
<b>Baseline</b>						
<b>Total PBPY Cost of Care of Program Participants</b>	\$	\$9,174	\$9,174	\$9,174	\$9,174	\$6,881
	#VALUE!	\$3,853,080	\$3,853,080	\$3,853,080	\$3,853,080	\$11,559,240
<b>Total Affected Spend</b>		Est. Baseline	5.0%	10.0%	15.0%	
<b><u>Proposed Expansion</u></b>						
<b>Number of New Participants Targeted ( Home bound Medicare)</b>		120	90	94	99	304
<b>Number of New Participants Targeted ( non-home bound Medicare)</b>		420	420	441	463	
<b>Baseline</b>						
<b>Total PBPY Cost of Care of Program Participants</b>	\$	\$9,174	\$9,174	\$9,174	\$9,174	\$47,832
<b>Total Affected Spend</b>		\$4,953,960	\$4,678,740	\$4,908,090	\$5,153,495	\$14,540,790
<b>% Reduction in Total Cost of Care from Funding</b>		Est. Baseline	5.0%	10.0%	15.0%	
<b>Savings</b>		\$990,792	\$935,748	\$981,618	\$1,030,699	\$2,908,158

- **RHP Planning Protocol Reference:** See Chart
- **Incentive Payment Amount:** See Chart

121781205.3.1	2.13	Potential Preventable Admissions	
Lillian M. Hudspeth Memorial Hospital			121781205
<b>Related Category 1 or 2 Projects:</b>	121781205.2.1		
<b>Starting Point/Baseline:</b>			
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [RHP PP Process Milestone – P-Y]:</b> The evidence consists of pre and post-implementation comparison with ED visits and admissions, along with estimates of the cost savings. Data Source: EHR  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$33766	<b>Process Milestone 2 [P-4]</b> Data Source: EHR  Process Milestone 2 Estimated Incentive Payment: \$39141.00  <b>Outcome Improvement Target 1 [IT-1.1]:</b> Improvement Target: TBD Data Source: EHR  Outcome Improvement Target 1 Estimated Incentive Payment: \$39141	<b>Outcome Improvement Target 2 [IT-1.1]:</b> Improvement Target: TBD Data Source: EHR  Outcome Improvement Target 2 Estimated Incentive Payment: \$62808	<b>Outcome Improvement Target 3 [IT-1.1]:</b> Improvement Target: TBD Data Source: EHR  Outcome Improvement Target 3 Estimated Incentive Payment: \$150194
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): \$ 33,766	Year 3 Estimated Outcome Amount: \$39,141	Year 4 Estimated Outcome Amount: \$62,808	Year 5 Estimated Outcome Amount: \$150,194
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$285,910</b>			

<i>121781205.3.1</i>	<i>2.13</i>	<i>Potential Preventable Admissions</i>		
<i>Lillian M. Hudspeth Memorial Hospital</i>			<i>121781205</i>	
<b>Related Category 1 or 2 Projects:</b>	<i>121781205.2.1</i>			
<b>Starting Point/Baseline:</b>				
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	

## RHP 13

### **Category 3: Quality Improvements**

- **Identifying Outcome Measure and Provider Information:** 130725806.3.1
- **Project title:** West Texas Centers Telemedicine Expansion
- **Improvement Target/ Outcome Measure:** OD-6: Patient Satisfaction; IT-6.1; Percent Improvement Over Baseline of patient satisfaction scores
- **Performing Provider/TPI:** West Texas Centers/ 130725806  
**Outcome Measure Description:** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected improvement target IT-6-1(pg 398 of protocol): Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.  
Our Center will additionally be working with other Community Centers in a learning collaborative to select a small set of outcomes measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in the local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.
- **Rationale:** Runnels County is a designated Health Professional Shortage Area (HPSA), with a very rural population. The closest major medical center or any behavioral health care other than West Texas Centers is sixty miles. West Texas Centers is the only provider of behavioral health services in the county. Without telemedicine it would not be possible to provide the psychiatric services which are currently being provided. Current capacity however; does not meet the demands of the rural area. This expansion of telemedicine will enable West Texas Centers to increase access to services via the increase in capacity achieved through further broadband connectivity and acquisition of newer, more advanced telecommunication connections and software. All process measures were chosen to identify baseline data, obtain public feedback and provide

time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

- **Outcome Measure Valuation:** Outcome evaluation consideration included West Texas Center's current telemedicine system costs and estimated costs of achieving all project goals. Additionally, consideration was given to current crisis response times in Runnels County, patient satisfaction with current telemedicine technology/services, availability of other behavioral health providers and length of waiting time for psychiatric services at Runnels Count Mental Health Clinic. Provider has adopted the regional valuation set forth by RHP 13. Based on this methodology stakeholder feedback will be obtained during DY2 however; full valuation is associated with the category 1 milestones during this year. DY 3 valuation is associated with establishing capability to obtain necessary stakeholder feedback, analysis and testing of current systems. 10 percent of the provider allocation is distributed equally each year, DY 3 and DY 4, with 20% for DY 5, across the applicable domains. This improvement target related to improved patient satisfaction was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

130725806.3.1	IT-6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers			130725806
Related Category 1 or 2 Projects:	130725806.1.1		
Starting Point/Baseline:	Establishments of Outcome Improvement Targets Pending Further CMS Guidance		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p>Process Milestone 1: P-1(Cat 3, pg 363) Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</p> <p>Data Source: Project planning and implementation documentation demonstrates plan, do study, act quality improvement cycles. Meeting sign in sheets; procurement documents; Network provider meetings; public forums.</p> <p>Process Milestone P-1 Estimated Incentive Payment \$0.00</p>	<p>Process Milestone P-3(Cat 3, pg. Pg, 363, P-3) Develop and test systems to capture baseline information, select consumer survey documents, conduct baseline patient satisfaction survey to achieve baseline and begin new provider education on systems.</p> <p>Data Source: Provider feedback, customer satisfaction surveys and computer based training documents.</p> <p>Process Milestone P-2 Estimated Incentive Payment \$12,849.00</p>	<p>Outcome Improvement Target 1</p> <p>Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information.</p> <p>Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.</p>	<p>Outcome Improvement Target 2</p> <p>Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information.</p> <p>Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.</p>

130725806.3.1	IT-6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers			130725806
Related Category 1 or 2 Projects:	130725806.1.1		
Starting Point/Baseline:	Establishments of Outcome Improvement Targets Pending Further CMS Guidance		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		Outcome Improvement Target 1 Estimated Incentive Payment: \$13,746.00	Outcome Improvement Target 2 Estimated Incentive Payment: \$29,882.00
Year 2 Estimated Outcome Amount: 0.00	Year 3 Estimated Outcome Amount: \$12,848.00	Year 4 Estimated Outcome Amount: \$13,744.00	Year 5 Estimated Outcome Amount: \$29,879.00
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD \$56,471.00</b>			

## Pass 2

### Category 3: Quality Improvements

- **Outcome Measure Title:** OD-6: Patient Satisfaction, 130725806.3.2; IT-6.1 Percent Improvement over baseline of patient satisfaction scores;
- **Performing Provider:** West Texas Center /130725806
- **Project title:** West Texas Centers Mobile Crisis Outreach Team Expansion  
**Outcome Measure Description:** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected improvement target IT-6-1(pg 398 of protocol): Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.  
Our Center will additionally be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.
- **Rationale:** All West Texas Center counties in RHP 13 are designated Health Professional Shortage Areas (HPSAs), with a very rural population. In FY 2012 West Texas Centers received over 150 crisis calls for the RHP 13 West Texas Center counties with over 100 being legitimate “go mobile” response situations. The current Mobile Crisis Outreach team is responding to calls throughout the very rural and vast coverage area of the West Texas RHP 13 counties. Additional assessment of the West Texas Centers crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. West Texas Centers currently provides these crisis services with only one Mobile Crisis Outreach staff member shared between other West

Texas Center service areas outside the RHP 13 WTC counties. This person is responsible for responding to the crisis call within one hour of notification on a 24/7 call rotation. With the availability of additional Mobile Crisis Outreach staff it is expected that we would be able to reduce our crisis response time and intervene in behavioral health crisis prior to the consumer being booked into the jail, admitted to the ER or taken to a psychiatric hospital for admission. All process measures were chosen to identify baseline data, obtain public feedback and provide time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

- **Outcome Measure Valuation:** Provider has adopted the regional valuation set forth by RHP 13. Based on this methodology stakeholder feedback will be obtained during DY2 however; full valuation is associated with the category 1 milestones during this year. DY 3 valuation is associated with establishing capability to obtain necessary stakeholder feedback, analysis and testing of current systems. 10 percent of the provider allocation is distributed equally each year, DY 3 and DY 4, with 20% for DY 5, across the applicable domains. Consideration was given to current crisis response times in the project Counties and patient satisfaction with current crisis services. Outcome evaluation consideration included West Texas Center's current crisis system costs and estimated costs of achieving all project goals. Project is of medium size due to this being an expansion of the current crisis network. All process measures were chosen to identify baseline data, obtain public feedback and provide time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

130725806.3.2	3 IT.6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers		130725806	
Related Category 1 or 2 Projects	130725806.1.2		
Starting Point/Baseline	Establishments of Outcome Improvement Targets Pending Further CMS Guidance		
<b>Year 2 (10/1/2012-9/30/2013)</b>	<b>Year 3 (10/1/13-9/30/14)</b>	<b>Year 4 (10/1/14-9/30/15)</b>	<b>Year 5 (10/1/15-9/30/16)</b>
<p>Process Milestone P-1(Cat 3, pg 363, P-1) Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</p> <p>Data Source: Project planning and implementation documentation demonstrates plan, do study, act quality improvement cycles.</p> <p>Process Milestone 1 Estimated Incentive Payment: \$0.00</p>	<p>Process Milestone P-3(Cat 3, pg. Pg, 363, P-3) Develop and test systems to capture baseline information, select consumer survey documents, conduct baseline patient satisfaction survey to achieve baseline and begin new provider education on systems.</p> <p>Data Source: Provider feedback, customer satisfaction surveys and computer based training documents.</p> <p>Process Milestone 2 Estimated Incentive Payment: \$5,035.00</p>	<p>Outcome Improvement Target 1</p> <p>Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1 Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information.</p> <p>Improvement Target: Patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to</p>	<p>Outcome Improvement Target 2</p> <p>Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1 Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information.</p> <p>Improvement Target: Patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodology.</p> <p>Data Source/baseline: DY 3 Patient</p>

		<p>be determined pending further CMS guidance regarding Category 3 methodology.</p> <p>Data Source/baseline: DY 3 Patient Satisfaction Surveys</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$5,401.00</p>	<p>Satisfaction Surveys</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$11,778.00</p>
Year 2 Estimated Outcome Amount: \$.0.00	Year 3 Estimated Outcome Amount: \$5,035.00	Year 4 Estimated Outcome Amount: \$5401.00	Year 5 Estimated Outcome Amount: \$11,778.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : \$22,214.00			

## Category 4 Projects

**Category 4: Population-Focused Improvements (Hospitals only)**

Population-focused improvements are “pay for reporting” measures reported by hospitals that demonstrate the impact of delivery system reform investments made under the demonstration. With limited exceptions, all hospital Performing Providers shall report on all Category 4 population-focused improvement measures described in Attachment I: RHP Planning Protocol and categorized in six domains:

- Domain 1: Potentially Preventable Admissions (8 measures)
- Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
- Domain 3: Potentially Preventable Complications (64 measures)
- Domain 4: Patient-Centered Healthcare (2 measures)
- Domain 5: Emergency Department (1 measure)

For each hospital Performing Provider, the following information should be included:

- Coleman County Medical Center: TPI 136144610

**Domain Descriptions:**

- Region 13 and Coleman County Medical Center (CCMC) seeks to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. Coleman County assessment of community needs identified a vulnerable low income population, high Medicaid population and a high uninsured population. 27.10% of the Coleman County population live below the poverty level compared to the regional poverty level of 16.6%. Death rates from all causes are 962.4 compared to Texas of 808.8. As a region, collaborations support primary and preventive care expansions which are the backbone for improved access and care coordination. Increased access to specialty care will further advance accessibility in the community including integration with Community Mental Health Providers. CCMC and RHP 13 also seeks to transform care by bending the cost curve. We believe it is foundational to ensuring patients received quality, patient centered care without exacerbating inefficiencies in the healthcare system. With defined target populations, RHP 13 performing providers seek to improve the health outcomes for targeted patients as well as the total population.

Coleman County Medical Center has identified the following DSRIP projects.

New: 136144610.1.2, 1.1 Expand Primary Care Old: 136144610.1.1, 1.1  Coleman County Medical Center 136144610	Improve access to primary and preventive care by enhancing access points, expanding clinic space, adding primary care providers, providing non-emergent	IT-9.2 ED appropriate utilization – reduction of ED visits
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	<p>transportation, nurse advice line and increasing hours in order to reduce emergency department utilization.</p> <p>We believe that increasing access to and the capacity of primary care will reduce Potentially Preventable Admissions. Reducing PPAs is also expected to increase efficiencies and timeliness in our Emergency Department for our more critical patients.</p>	
<p>(New) 136144610.2.2, 2.1 Enhance/Expand Medical Homes (Old) 136144610.2.1, 2.1  Coleman County Medical Center 136144610</p>	<p>Implement an evidence-based prenatal care model through a medical home initiative to provide prenatal care with resulting improvements in low birth-weight births.</p>	<p>136144610.3.4 IT-8.2 Percentage of Low Birth-weight births</p>

- Domain Valuation:** Coleman County Medical Center has adopted the regional valuation set forth by RHP 13. Based on this methodology, 5 percent of the total valuation in DY 2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

Coleman County Medical Center will be participating in all of the Category 4 Participation Measures through the implementation of Healthcare Data Integration program with the Texas A&M University System Health Science Center to the extent that we have statistically significant patient data. CCMC will be participating in optional Domain 6 reporting within Category 4, which will enhance our tracking and reporting of prenatal and postpartum care.

Domain	Description
Potentially Preventable	CCMC is initiating a projects to Expand Primary Care Capacity 136144610.1.2 (New) 136144610.1.1 (Old). We believe that

<b>Admissions</b>	increasing access to primary care will reduce PPAs.
<b>Potentially Preventable Readmissions - 30 days</b>	Though we will report this measure, we do not have a DSRIP project directly related to PPR.
<b>Potentially Preventable Complications</b>	Though we will report this measure, we do not have a DSRIP project directly related to PPCs.
<b>Patient-Centered Healthcare</b>	Though we will report this measure, we do not have a DSRIP project directly related to PCHs.
<b>Emergency Department</b>	<p>Though we will report this measure, we do not have a DSRIP project directly related to the intent of Category 4 ED departure time for admitted patients.</p> <p>However, indirectly we believe that increasing access to and the capacity of primary care 136144610.1.2 (New) 136144610.1.1 (Old), combined with IT-9.2 ED Appropriate Utilization 136144610.3.3 (New) 136144610.3.1 (Old); it is expected to increase efficiencies and timeliness in our Emergency Department for our more critical patients.</p>
<b>Children and Adult Core Measures (OPTIONAL)</b>	<p>CCMC is electing to participate in this optional core measure.</p> <p>Directly Applicable to New: 136144610.22 (Old: 136144610.2.1) Enhance/Expand Medical Homes</p> <p>Related Category 3 Outcome Measure IT-8.2 Percentage of Low Birth-weight births (standalone measure)</p>

<b>Category 4: Population-Focused Measures</b> Coleman County Medical Center 136144610				
	<b>Year 2</b> <b>(10/1/2012 –</b> <b>9/30/2013)</b>	<b>Year 3 (10/1/2013 –</b> <b>9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 –</b> <b>9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 –</b> <b>9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$23,071	\$0		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Domain 1 - Estimated Maximum Incentive Amount	Semi-annual reporting of: Congestive Heart Failure Admission rate Diabetes Admission Rates Behavioral Health and Substance Abuse Admission rate Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission rate Hypertension Admission rate Pediatric Asthma	\$13,371	\$11,443	\$12,438

	Bacterial pneumonia immunization Influenza Immunization			
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Domain 2 - Estimated Maximum Incentive Amount	Congestive Heart Failure (HF): 30-Day Readmissions Diabetes: 30-Day Readmissions Behavioral health & Substance Abuse: 30-Day Readmissions Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions Stroke: 30-Day Readmissions Pediatric Asthma: 30-Day Readmissions All-Cause: 30-Day Readmissions	\$13,371	\$11,443	\$12,438

<b>Domain 3: Potentially Preventable Complications (PPCs)</b>				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Domain 3 - Estimated Maximum Incentive Amount	Risk-adjusted PPC rates for the 64 PPCs		\$11,443	\$12,438
<b>Domain 4: Patient Centered Healthcare</b>				
<i>Patient Satisfaction - HCAHPS</i>				
Measurement period for report	6 mo.	DY 2	DY 3	DY 4
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<i>Medication Management</i>				
Measurement period for report	6 mo.	DY 2	DY 3	DY 4
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Domain 4 - Estimated Maximum Incentive Amount		13,371	\$11,443	\$12,438
<b>Domain 5: Emergency Department</b>				
Measurement period for report	6 mo.	DY 2	DY 3	DY 4
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Domain 5 - Estimated Maximum Incentive Amount		13,371	\$11,443	\$12,438
<b><u>OPTIONAL</u> Domain 6: Children and Adult Core Measures Coleman County Medical Center: TPI 136144610 is Participating</b>				

<b><i>Frequency of ongoing prenatal care</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<b><i>Timeliness of prenatal care</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<b><i>Cesarean rate for low-risk first birth women</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<b><i>Percent of live births weighing &lt;2500 grams</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<b><i>Pediatric central-line associated bloodstream infection (CLASBI) rates</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<b><i>Elective delivery prior to 39 weeks completed gestation</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
<b><i>Appropriate use of antenatal steroids</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-	10/1/2015-

			9/30/2015	9/30/2016
<b><i>Postpartum Care Rate</i></b>				
Measurement period for report	6 mo.			
Planned Reporting Period: 1	10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Domain 6 - Estimated Maximum Incentive Amount		0.00	0.00	0.00
<b>Grand Total Payments Across Category 4</b>	\$23,071	\$53,484	\$57,215	\$62,190

## **Kimble Hospital**

Performing Provider Name/TPI: Kimble Hospital/206083201

## **Kimble Hospital**

Performing Provider Name/TPI: Kimble Hospital/206083201

### **Category 4: Population-Focused Improvements (Hospitals only)**

Population-focused improvements are “pay for reporting” measures reported by Kimble Hospitals to demonstrate the impact of delivery system reform investments made under the demonstration.

Domain 1: Potentially Preventable Admissions (8 measures)

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Domain 3: Potentially Preventable Complications (64 measures)

Domain 4: Patient-Centered Healthcare (2 measures)

Domain 5: Emergency Department (1 measure)

- **Domain Descriptions:**

Kimble Hospital has identified the following DSRIP projects.

- I. Pass 3B OLD: 206083201.2.1 NEW: 206083201.2.2: Disease Prevention Strategies

- 2.7.6 Implement Other Evidence-based Disease Prevention Programs

Targeted Outcome Improvements for select populations include the following Category 3 measures.

- I. OD-2- Potentially Preventable Admissions
  - IT-2.1 Congestive Heart Failure Admission rate

Category 4 domains and measures will be impacted by interventions targeting patients who have a high-risk of admission, readmission, and ED utilization in the different specialty areas. PPCs will also be impacted as Kimble Hospital continues to build its commitment to fight infection and complication through the Immunizations, Congestive Heart Failure and Diabetes Interventions. Kimble Hospital will be able to track quality metrics in category 4 regarding the outcomes and improve processes identified for the following chronic conditions; Diabetes, CHF, through Category 2 Evidence-based Disease Prevention Programs. A reporting process will be implemented quarterly with the project teams for data generated by Category 4 metrics. The initial data from all of the metrics in Category 4 will help Kimble Hospital establish a baseline which will make it possible to capture impact through DY5. We will provide reports to HHSC to ensure compliance with the reporting requirements.

Potentially preventable admissions and Potentially Preventable Readmissions contain viable metrics in Category 4 specifically related to CHF. The outreach education program will impact Domains 1 and 2 through increased patient assistance and guidance to primary and preventive care when appropriate in lieu of hospitalization. The educators of this program will be specifically trained in identifying and providing assistance and creating behavior change for patients who present with these specific

diseases. Having the education programs in place along with the equipment need to screen will not only address our patient's needs but will also impact their outcomes by bridging gaps in care, improve access and increase utilization of PCP services. We will use these metrics to monitor the success and impact of our Evidence-based Disease Prevention Programs going forward

Domain 3, Potentially Preventable Complications apply to the chronic diseases and initiatives we are tracking in Category 2 CHF and Diabetes. Kimble Hospital's focus on reducing complications of care will result in cost savings and will increase quality as well as improved patient experiences. Many of the metrics in Category 4 will be adopted into Kimble Hospital's outreach and education programs.

Domain 4 related to Patient Satisfaction and Medication Management is expected to be impacted as patients are more engaged and direct their treatment plans. Domain 5 related to Emergency room patients will be impacted by the number of patients that return to the Emergency room for exacerbation of CHF as well as complications of diabetes related to uncontrolled blood sugars. Patient not needing or using the Emergency room for exacerbation of CHF or Complications of Diabetes will reduce stress on this service as well as provide better utilization of services and better outcomes for our patient populations.

Reporting for each domain will begin reporting DY 3 10/1/2014 and continue until DY 5 9/30/2017.

**Domain Valuation:**

Kimble Hospital has adopted the regional valuation set forth by RHP13. Based on this methodology, 5 percent of the total valuation in DY 2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. RHP 13 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

<b>Category 4: Population-Focused Measures</b>				
Kimble Hospital /TPI 206083201				
IGT Entity DY-2 through DY-5 Kimble Hospital District / TIN 17416223430001				
	<b>Year 2 (10/1/2013 – 9/30/2014)</b>	<b>Year 3 (10/1/2014 – 9/30/2015)</b>	<b>Year 4 (10/1/2015 – 9/30/2016)</b>	<b>Year 5 (10/1/2016 – 9/30/2017)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$10,533	\$4,883		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		\$4,884	\$5,224	\$5,678
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		\$4,884	\$5,224	\$5,678
<b>Domain 3: Potentially Preventable Complications (PPCs)</b>				
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			\$5,224	\$5,678
<b>Domain 4: Patient Centered Healthcare</b>				
<b>Patient Satisfaction - HCAHPS</b>				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
<b>Medication Management</b>				

Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		\$4,884	\$5,224	\$5,678
<b>Domain 5: Emergency Department</b>				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		\$4,884	\$5,224	\$5,678
<b>OPTIONAL Domain 6: Children and Adult Core Measures</b>				
<b><i>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
<b><i>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		\$ 0.00	\$0.00	\$0.00
<b>Grand Total Payments Across Category 4</b>				
	\$ 10,533	\$24,419	\$ 26,120	\$ 28,390

**Domain Descriptions:**

**Domain 1: Potentially Preventable Admissions (PPAs)**

Implementation of a primary care medical home model in Schleicher County will give the Schleicher County residents an option for care other than the emergency department at a hospital. The model will allow physicians to plan and monitor all their care in an effort to diagnose illnesses early enough to provide treatment without hospitalization. The PCMH model will reduce the number of PPAs seen at the hospital.

**Domain 2: Potentially Preventable Readmissions**

Having patients discharged from a hospital to a PCMH would allow the patients primary care provider to monitor their recovery personally in their own clinic. The PCMH model itself will help reduce potentially preventable readmissions due to the provider managing the patients overall care personally. The PCMH model would reduce the number of Potentially Preventable Readmissions.

**Domain 3: Potentially Preventable Complications (PPC)**

Discharge of a patient from a hospital to a PCMH where the healthcare is completely patient centered will allow providers to closely monitor and educate patients upon discharge to help prevent preventable complications. The increased time providers will be able to spend with the patients in this way will reduce the number of PPCs seen.

**Domain 4: Patient Centered Healthcare**

Implementation of the PCMH model will allow providers to spend more time on each patient to truly manage the patients care. The increased focus on the patient by the provider should not only result in better quality of care but higher patient satisfactions scores.

**Domain 5: Emergency Department**

Implementation of a primary care medical home model in Schleicher County will give the Schleicher County residents an option for care other than the emergency department at a hospital. The model will allow physicians to plan and monitor all their care in an effort to diagnose illnesses early enough to provide treatment without hospitalization or a trip to the emergency department, thereby, resulting in a decrease in non emergent visits to the emergency department. Such a decrease might indicate

that implementation of a PCMH modeled clinic was positively affecting the population by handling the resident's non emergent needs.

**Valuation:**

Preferred Hospital has adopted the regional valuation set forth by RHP 13. Based on this methodology, 5 percent of the total valuation in DY 2 is associated with establishing capability to file and collect the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

<b>Category 4: Population-Focused Measures</b> Schleicher County Medical Center				
	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$2,485	\$1,153		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 2		(April 1 – September 30)	(April 1 – September 30)	(April 1 – September 30)
Domain 1 - Estimated Maximum Incentive Amount		\$1,153	\$1,233	\$1,340
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 2		(April 1 – September 30)	(April 1 – September 30)	(April 1 – September 30)
Domain 2 - Estimated Maximum Incentive Amount		\$1,153	\$1,233	\$1,340
<b>Domain 3: Potentially Preventable Complications (PPCs)</b> Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 2			(April 1 – September 30)	(April 1 – September 30)
Domain 3 - Estimated Maximum Incentive Amount			\$1,233	\$1,340
<b>Domain 4: Patient Centered Healthcare</b>				

**Category 4: Population-Focused Measures**

Schleicher County Medical Center

	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b><i>Patient Satisfaction - HCAHPS</i></b>				
Measurement period for report				
Planned Reporting Period: 2		(April 1 – September 30)	(April 1 – September 30)	(April 1 – September 30)
<b><i>Medication Management</i></b>				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		\$1,153	\$1,233	\$1,340
<b><i>Domain 5: Emergency Department</i></b>				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		\$1,153	\$1,233	\$1,340
<b><u>OPTIONAL</u> <i>Domain 6: Children and Adult Core Measures</i></b>				
<b><i>Frequency of ongoing prenatal care</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<b><i>Timeliness of prenatal care</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<b><i>Cesarean rate for low-risk first</i></b>				

**Category 4: Population-Focused Measures**

Schleicher County Medical Center

	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b><i>birth women</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<b><i>Percent of live births weighing &lt;2500 grams</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<b><i>Pediatric central-line associated bloodstream infection (CLASBI) rates</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<b><i>Elective delivery prior to 39 weeks completed gestation</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<b><i>Appropriate use of antenatal steroids</i></b>				
Measurement period for report				

<b>Category 4: Population-Focused Measures</b> Schleicher County Medical Center				
	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Planned Reporting Period: 1 or 2				
<b><i>Postpartum Care Rate</i></b>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		\$	\$	\$
<b>Grand Total Payments Across Category 4</b>	\$2,286	\$5,765	\$6,165	\$6,700

#### **Category 4: Shannon Medical Center/137226005**

Domain 1: Potentially Preventable Admissions (8 measures)

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Domain 3: Potentially Preventable Complications (64 measures)

Domain 4: Patient-Centered Healthcare (2 measures)

Domain 5: Emergency Department (1 measure)

#### **Domain Descriptions:**

Shannon Medical Center has identified the following DSRIP projects:

- II. 137226005.1.1: North Urgent Care Clinic
  - 1.1 Expand Primary Care Capacity
- III. 137226005.1.2: Disease Management Registry
  - 1.3 Implement a Chronic Disease Management Registry
- IV. 137226005.1.3: Expand Specialty Care in Rural Areas
  - 1.9 Expand Specialty Care
- V. 137226005.2.1: Patient Experience
  - 2.4 Redesign to Improve Patient Experience
- VI. 137226005.2.2: LEAN
  - 2.8 Apply Process Improvement Methodology to Improve Quality/Efficiency
- VII. 137226005.2.3: Palliative Care
  - 2.10 Use of Palliative Care Programs

Targeted Outcome Improvements for select populations include the following Category 3 measures:

- II. OD-9 Right Care, Right Setting
  - IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits
- III. OD-1 Primary Care and Chronic Disease Management
  - IT-1.10 Diabetes care: HbA1c poor control (>9.0%)
- IV. OD-6 Patient Satisfaction
  - IT-6.1 Percent Improvement over baseline of patient satisfaction scores  
(1) are getting timely care, appointments, and information
- V. OD-6 Patient Satisfaction
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores  
(2) how well their doctors communicate
- VI. OD-6- Patient Satisfaction
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores  
(1) are getting timely care, appointments, and information
- VII. OD- 13 Palliative Care

- IT-6.1 Percent improvement over baseline of patient satisfaction scores
  - (2) how well their doctors communicate

Category 4 domains and measures will be impacted by interventions targeting patients who have a high-risk of admission, chronic diseases, readmission, and ED utilization in different specialty areas. The following systems will have an impact on PPAs, PPCs, and 30-day readmissions. Proventix Systems, Inc. is an outcomes-driven technology to help healthcare providers deliver the highest quality of care. It helps protect patients, visitors, customers and workers by reducing the human and economic losses associated with illness by providing tools and services for quality compliance monitoring, active point-of-care communication, and successful behavior modification. The Rothman Index provides a universal metric tool for patient assessment that pinpoints patients that are experiencing declining health states. Plus, Shannon has added a Midas+ Software System which helps in quality and case management [bed management] including improving patient safety and reducing length of stay. Shannon will report in reporting period 2 using the data generated by Category 4 metrics. The initial data from all of the metrics in Category 4 will help Shannon to establish a baseline which will make it possible to capture impact through DY5. We will provide reports to HHSC to ensure compliance with the reporting requirements.

Shannon will seek to reduce ED utilization by promoting right care, right setting encouraging the use of the North Urgent Care Clinic for non-emergent care. Category 4 reporting of PPAs for pediatric asthma will be monitored given its relationship to the North Urgent Care Clinic.

Shannon will seek to impact Potentially Preventable Complications through Patient Experience and Palliative Care. Patient experience could impact PPCs because higher patient satisfaction during a hospital stay could increase patient compliance and follow-up care to eliminate further complications. Palliative Care could decrease PPCs by eliminating unnecessary costs and admissions for patients at end-of-life.

Shannon foresees improvements in the admit decision time to ED departure time for admitted patients through implementing Lean and Patient Experience projects. By implementing Lean methodologies, Shannon expects to identify delays, waste, and the problems they create in timely delivery of care.

All projects have components that will drive improvements in the category 4 reporting domains by transforming healthcare in innovative ways by reducing PPAs, PPRs, PPCs, ED visits, and improving patient-centered healthcare.

#### **Domain Valuation:**

Shannon Medical Center, the safety net provider for Region 13, has adopted the regional valuation set forth by RHP13. Based on this methodology, 5 percent of the total valuation in DY 2 is associated with establishing capability to file and collected the necessary reports. 10 percent of the provider allocation is then distributed equally each year, DY 3, DY 4 and DY 5, across the applicable domains. RHP 13 implemented a regional valuation tool to weight projects regarding their ability to meet the waiver goals and transform health care and impact the health of the total population. Using this tool and guidelines set forth in the DSRIP

Program Funding and Mechanics Protocol, the valuation for Category 4 identifies appropriate percentages of funds per year, then divides this across the reporting domains equally. Category 4 reporting domains will advance transparency initiatives for patient centered, value based purchasing and reflect upon the total population changes the 1115 Transformation Waiver will facilitate.

<b>Category 4: Population-Focused Measures</b> <i>Shannon Medical Center/137226005</i>				
	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$385,968	\$179,351		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		\$179,351	\$192,037	\$208,952
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		\$179,351	\$192,037	\$208,952
<b>Domain 3: Potentially Preventable Complications (PPCs)</b> 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			\$192,037	\$208,952
<b>Domain 4: Patient Centered Healthcare</b>				
<b>Patient Satisfaction - HCAHPS</b>				
Measurement period for report		10/1/13 - 9/30/14	10/1/14 - 9/30/15	10/1/15 - 9/30/16
Planned Reporting Period: 1 or 2		2	2	2
<b>Medication Management</b>				
Measurement period for report		10/1/13 - 9/30/14	10/1/14 - 9/30/15	10/1/15 - 9/30/16

Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		\$179,351	\$192,037	\$208,952
<b>Domain 5: Emergency Department</b>				
Measurement period for report		10/1/13 - 9/30/14	10/1/14 - 9/30/15	10/1/15 - 9/30/16
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		\$120,486	\$129,213	\$140,449
<b>Grand Total Payments Across Category 4</b>				
	\$260,511	\$603,930	\$646,065	\$702,245

**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.

<b>Signature</b>	<b>Name</b>	<b>Organization</b>
<i>See Addendum for Final with Signatures.</i>		

## **Section VII. Addendums**

- *Section VI. RHP 13 Signature Page*
- *Private hospital certifications*
  - *Shannon Medical Center*
- *Supporting Documentation*
  - *PBCC Addendum*
- *RHP 13 Newsletter*
- *Pass 3B Documentation and Workbooks*
- *Pass3 Workbooks and the Anchor Workbook*