Texas Healthcare Transformation & Quality Improvement Program

Regional Healthcare Partnership (RHP) Plan for RHP 2
HHSC Plan Review Resubmission – March 1, 2013

The University of Texas Medical Branch at Galveston
Anchor, Region 2

Table of Contents - - Clean Version

Section I: RHP Organization ..... Pages 1-12

Section II: Executive Overview of RHP Plan ..... Pages 13-46

Section III: Community Needs Assessment ..... Pages 47-62

Section IV: Stakeholder Engagement ..... Pages 63-69

Section V: DSRIP Projects
- Plan Development ..... Pages 70-72
- Project Valuation ..... Pages 73-74
- Category 1: Infrastructure Development ..... Pages 75-426
- Category 2: Program Innovation & Redesign ..... Pages 427-798
- Category 3: Quality Improvements ..... Pages 799-1150
- Category 4: Population-Focused Improvements ..... Pages 1151-1231

Section VI: RHP Participation Certifications ..... Page 1232

Section VII: Addendums
- A. Private Hospital Certifications ..... Page 1233
- B. DSRIP Projects Considered But Not Selected ..... Pages 1234-1251
- C. Collaboration Letters (Pass 1 and Pass 2) ..... Page 1252
- D. Affiliation Agreements ..... Page 1253
- E. County Medical Society Letters of Support ..... Page 1254
- F. CNA - Additional Information ..... Pages 1255-1278

SECTION I:

RHP Organization

Section I: RHP Organization

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Anchoring Entity						
Region 2 Anchor	094092602	3723723723-7-000	State Owned Hospital	University of Texas Medical Branch at Galveston	Thomas J. Riley, MBA Craig S. Kovacevich, MA	301 University Boulevard Galveston, TX 77555-0140 thriley@utmb.edu 409.772.6637 cskovace@utmb.edu 409.766.4047
IGT Entities						
Community Center (MHMR)	096166602	1741684198-3-003	MHMR	Spindletop Center	Chalonnes Hoover	655 S. 8th Street Beaumont, TX 77701 Chalonnes.hoover@stmhmr.org 409.784.5668
Community Center (MHMR)	136367307	1751442393-2-000	MHMR	The Burke Center	Susan Rushing	2001 South Medford Lufkin, TX 75901 susanr@burke-center.org 936.639.1141
Community Center (MHMR)	135222109	1741607987-3-000	MHMR	The Gulf Coast Center	Pat Wareing	123 Rosenberg, #600 Galveston, TX 77550 patw@gulfcoastcenter.org 409.763.2373
Community Center (MHMR)	081844501	1760032662-7-001	MHMR	Tri-County Services	Cindy Sill	P O Box 3067 Conroe, TX 77305 cindys@tricountyservices.org 936.521.6119

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
IGT Entities (Continued)						
Health District	Galveston, Location 019054801 Texas City Location 019053001	1741665318-0-007	County	Galveston County Health District	Mark Guidry, MD, MPH	9850-A E.F. Lowry Expressway, #A108 Texas City, TX 77591 mguidry@gchd.org 409.938.7221
Health District	N/A	1202797853-0-000	County	Liberty County Hospital District 1	Bruce Stratton	P.O. Box 10247 Liberty, TX 77575 cbsesq@strattonlawfirm.com 936-336-5766
Health District	200683501	1751656334-7-003	County	Sabine County Hospital District	Phil Yocom	2301 Highway 83 West Hemphill, Texas 75948 philyocom@yahoo.com 936-275-6206
Hospital District	130959304	1746025069-3-001	Public Hospital	Matagorda Regional Medical Center	Steven L. Smith	104 Seventh Street Bay City, Texas 77414 ssmith@matagordageneral.org 979-245-6383
Public Hospital	121805903	1741612400-0-000	Public Hospital	Angleton-Danbury Medical Center	Paula Tobon-Stevens	132 Hospital Drive Angleton, TX 77515 stevensp@admc.org 979.848.9172
Public Hospital	131030203	1756000602-9-008	Public	Nacogdoches Memorial Hospital	Tim Hayward	1204 Mound Street Nacogdoches, TX 77591 haywardt@nacmem.org 936.568.8523

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
IGT Entities (Continued)						
State Owned Hospital	094092602	3723723723-7-000	State Owned Hospital	University of Texas Medical Branch at Galveston	Donna K. Sollenberger	301 University Boulevard Galveston, TX 77555-0128 dksoll@utmb.edu 409.772.6116
State Owned Hospital (Physician Group Practice Affiliated with an Academic Institution)	094092602	3723723723-7-000	State Owned Hospital	University of Texas Medical Branch at Galveston	Rex McCallum, MD	301 University Boulevard Galveston, TX 77555-0133 remccall@utmb.edu 409.772.3639
Performing Providers						
Community Center (MHMR)	096166602	1741684198-3-003	MHMR	Spindletop Center	Chalonnes Hoover	655 South 8th Street Beaumont, TX 77701 Chalonnes.hoover@stmhmr.org 409.784.5668
Community Center (MHMR)	135222109	1741607987-3-000	MHMR	The Gulf Coast Center	Pat Wareing	123 Rosenberg, #6 Galveston, TX 77550 patw@gulfcoastcenter.org 409.763.2373
Community Center (MHMR)	1396792420	1751442393-2-000	MHMR	The Burke Center	Susan Rushing	2001 South Medford Lufkin, TX 75901 susanr@burke-center.org 936.639.1141

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Performing Providers (Continued)						
Community Center (MHMR)	081844501	17600326627-001	MHMR	Tri-County Services	Cindy Sill	P O Box 3067 Conroe, TX 77305 cindys@tricountyservices.org 936.521.6119
Health District	Galveston 019054801 Texas City 019053001	1741665318-1-000	County	Galveston County Health District	Mark Guidry, MD, MPH	9850-A E.F. Lowry Expressway, #A108 Texas City, TX 77591 mguidry@gchd.org 409.938.7221
Hospital District	136381405	1746067306-8-001	Public Hospital	Tyler County Hospital	Sandra Wright	1100 West Bluff Woodville, TX 75979 swright@tchospital.us 409.283.6400
Private Hospital	094148602	1741303720-5-020	Private Hospital	Baptist Hospitals of Southeast Beaumont	Gary Troutman	3080 College Street Beaumont, TX 77701 Gary.troutman@bhset.net 409.212.5003
Private Hospital	112671602	1741385192-8-004	Private Hospital	Brazosport Regional Health System	Chuck Jeffress	100 Medical Drive Lake Jackson, TX 77566 chuckjeffress@brhstx.org 979.297.4411 x1802
Private Hospital	112706003	1760591590-3-001	Private Hospital	CHRISTUS-Jasper Memorial Hospital	Deborah Wiegand	1275 Marvin Hancock Drive Jasper, TX 75951 Deborah.wiegand@christushealth.org 409.384.5461 x1872
Private Hospital	138296208	1760591590-3-002	Private Hospital	CHRISTUS Hospital-(St. Elizabeth and St. Mary)	Bill Hecht	2830 Calder Avenue Beaumont, TX 77702 bill.hecht@christushealth.org 409.899.7105

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Performing Providers (Continued)						
Private Hospital	139172412	1750755367-9-023	Private Hospital	Memorial Medical Center of East Texas-Lufkin	Kristi Gay	P.O. Box 1447 Lufkin, TX 75902 KGay@memorialhealth.org 936-631-6702
Private Hospital	200683501	1261955689-2-003	Private Hospital	Preferred Hospital Leasing, Hemphill, dba Sabine County Hospital	Diana Taylor	2301 Highway 83 West Hemphill, TX 75948 dtaylor@sabinecountyhospital.com 409.787.3523
Private Hospital	284333601	1800490207-0-000	Private Hospital	Liberty Dayton Regional Medical Center	Jim Koulovatos	1353 North Travis Liberty, TX 77575 jekoul@libertydaytonrmc.com 936.336.7316
Public Hospital	121805903	1741612400-0-000	Public Hospital	Angleton-Danbury Medical Center	Paula Tobon-Stevens	132 Hospital Drive Angleton, TX 77515 stevensp@admc.org 979.848.9172
Public Hospital	131030203	1756000602-9-008	Public Hospital	Nacogdoches Memorial Hospital	Jane Ann Bridges	1204 Mound Street Nacogdoches, TX 77591 bridgesj@nacmem.org 936.568.8523
Performing Providers (Continued)						

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
State Owned Hospital	094092602	3723723723-7-000	State Owned Hospital	University of Texas Medical Branch	Donna K. Sollenberger	301 University Boulevard Galveston, TX 77555-0128 dksoll@utmb.edu 409.772.6116
State Owned Hospital (Physician Group Practice Affiliated with an Academic Institution)	109372601	3723723723-7-457	State Owned Hospital	University of Texas Medical Branch	Rex McCallum, MD	301 University Boulevard Galveston, TX 77555-0133 remccall@utmb.edu 409.772.3639
UC-Only Hospitals						
Private Hospital	136488705	174130372-5-012	Private Hospital	Baptist Hospitals/SETX Orange Hospital	Jarren Garrett	608 Strickland Drive Orange, TX 77630 Jarren.garrett@bhset.net 409.883.9361
Private Hospital	137279905	1593215798-3-001	Private Hospital	Cleveland Regional Medical Center	James Anderson	300 East Crockett Cleveland, TX 77327 James.anderson@chs.net 281.593.2195
Private Hospital	121807504	1621801360-1-006	Private Hospital	HCA Mainland Medical Center	Michael Ehrat	6801 E. F. Lowry Expressway Texas City, TX 77591 michael.ehrat@hcahealthcare.com 409.938.5162

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
UC-Only Hospitals (Continued)						
Private Hospital	112697102	1760436439-2-003	Private Hospital	Memorial Medical Center-Livingston	Kristi Gay	1201 West Frank Street Lufkin, TX 75904 kgay@memorialhealth.org 936.631.6702
Private Hospital	130734007	1752663904-6-006	Private Hospital	Memorial Medical Center-San Augustine	Kristi Gay	1201 West Frank Street Lufkin, TX 75904 kgay@memorialhealth.org 936.631.6702
Private Hospital	163925401	1270060569-9-007	Private Hospital	The Medical Center of Southeast Texas	William "Buddy" Whiddon	2555 Jimmy Johnson Boulevard Port Arthur, TX 77642 WDWhiddon@iasishealthcare.com 409.853.5746
Private Hospital	094164302	1621762559-7-001	Private Hospital	Woodland Heights Medical Center	Sam Minkowitz	505 South John Redditt Drive Lufkin, TX 75904 sam.minkowitz@woodlandheights.net 936.637.8504
Public Hospital	020988401	1741498067-6-001	Public Hospital	Sweeny Community Hospital	William Barnes	305 North McKinney Street Sweeny, TX 77480 wbarnes@sweenyhospital.org 979.548.1598
Other Stakeholders						
County Governments	n/a	n/a	Government Entity	Angelina County	Wes Suiter	P.O. Box 908 Lufkin, TX 75902 wsuiter@angelinacounty.net 936.634.5413

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Other Stakeholders (Continued)						
County Governments	n/a	n/a	Government Entity	Brazoria County	Joe King	111 East Locust Street Angleton, TX 77515 joek@brazoria-county.com 979.388.1200
County Governments	n/a	n/a	Government Entity	Galveston County	Mark Henry	722 Moody Galveston, TX 77550 mark.henry@co.galveston.tx.us 409.766.2244
County Governments	n/a	n/a	Government Entity	Hardin County	Billy Caraway	300 Monroe Street Kountze, TX 77625 billy.caraway@co.hardin.tx.us 409.246.5120
County Governments	n/a	n/a	Government Entity	Jasper County	Mark Allen	121 North Austin, #106 Jasper, TX 75951 Mark.allen.@co.jasper.tx.us 409.384.2612
County Governments	n/a	n/a	Government Entity	Jefferson County	Jeff Branick	1149 Pearl Street Beaumont, TX 77701 jbranick@co.jefferson.tx.us 409.835.8466
County Governments	n/a	n/a	Government Entity	Liberty County	Craig McNair	1923 Sam Houston Street Liberty, TX 77575 936.336.4665
County Governments	n/a	n/a	Government Entity	Nacogdoches County	Joe English	101 West Main, #170 Nacogdoches, TX 75961 jenglish@co.nacogdoches.tx.us 936.560.7755

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Other Stakeholders (Continued)						
County Governments	n/a	n/a	Government Entity	Newton County	Truman Dougherty	109 Court Street Newton, TX 75966 Truman.dougharty@co.Newton.tx.us 409.379.5691
County Governments	n/a	n/a	Government Entity	Orange County	Carl Thibideaux	123 South 6th Street Orange, TX 77630 cthibodeaux@co.orange.tx.us 409.882.7070
County Governments	n/a	n/a	Government Entity	Polk County	John Thompson	101 West Church Street, #300 Livingston, TX 77351 jan.shandley@co.polk.tx.us 936.327.6813
County Governments	n/a	n/a	Government Entity	Sabine County	Charles Watson	PO Box 716 Hemphill, TX 75948 Charles.watson@co.sabine.tx.us 409-787.3543
County Governments	n/a	n/a	Government Entity	San Augustine County	Samye Johnson	100 West Columbia, #105 San Augustine, TX 75972 countyjudge@co.san-augustine.tx.us 936.275.2762
County Governments	n/a	n/a	Government Entity	San Jacinto County	Fredrick Faulkner	1 State Highway 150, Room 5 Coldspring, TX 77331 fritz.faulkner@co.san-jacinto.tx.us 936.653.4331
County Governments	n/a	n/a	Government Entity	Shelby County	Rick Campbell	200 San Augustine, Box 6 Center, TX 75935 countyjudge@co.shelby.tx.us 936.598.3863

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Other Stakeholders (Continued)						
County Governments	n/a	n/a	Government Entity	Tyler County	Jacques Blanchette	100 West Bluff, #102 Woodville, TX 75979 judge@co.tyler.tx.us 409.283.2141
County Medical Society	n/a	n/a	n/a	Brazoria County Medical Society	Rajesh V Dalal, MD	192 Abner Jackson Parkway Lake Jackson, TX 77566-5160 979.285.0007
County Medical Society	n/a	n/a	n/a	Galveston County Medical Society	David C. Nickeson, MD	6807 E.F. Lowry Expressway, #303 Texas City, TX 77591-2548 409.935.2995
County Medical Society	n/a	n/a	n/a	Hardin-Tyler	Harrypersad Singh, MD	PO Box 728 Silsbee, TX 77656-0728 409.385.7352
County Medical Society	n/a	n/a	n/a	Jasper-Newton	Ronnie A. McMurry, MD	2041 S Wheeler Street Jasper, TX 75951-5603 409.384.8171
County Medical Society	n/a	n/a	n/a	Jefferson	Robert B. Berndt, MD	755 N 11th Street, P360 Beaumont, TX 77702 409.838.5214
County Medical Society	n/a	n/a	n/a	Liberty-Chambers	George Stokes, MD	200 Boothe Street, #100 Cleveland, TX 77328 281.592.2888
County Medical Society	n/a	n/a	n/a	Nacogdoches-San Augustine	Gerard J Ventura, MD	4848 NE Stallings Drive, #207 Nacogdoches, TX 75965-1266 936.569.0050

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Other Stakeholders (Continued)						
County Medical Society	n/a	n/a	n/a	Orange	William M Rutledge, Jr., MD	610 Strickland Drive, 200 Orange, TX 77630-4784 409.883.3201
County Medical Society	n/a	n/a	n/a	Polk-San Jacinto	Charlene Smith, MD	410 E Church Street, A Livingston, TX 77351-2966 936.327.3937
Federally Qualified Health Centers (FQHC)	Galveston 1871766584 Texas City 1578588406	Galveston & Texas City 1741665318-1-000	Federal	Coastal Health & Wellness	Mark Guidry, MD, MPH	9850-A E.F. Lowry Expressway, #A108 Texas City, TX 77591 mguidry@gchd.orgg 409.938.7221
Federally Qualified Health Centers (FQHC)	1255367090	1752184369-2-001	Federal	East Texas Community Health Services	Robin Moore	1401 S. University Drive Nacogdoches, TX 75961 rmoore.etchs@tachc.org 936.560.5413
Federally Qualified Health Centers (FQHC)	1912904897	76-0289927	Federal	Gulf Coast Health Centers	Timothy Sayles	103 East Gibson, 110 Jasper, TX 75951 tsayles@gulfcoasthc.org 409.983.1161
Federally Qualified Health Centers (FQHC)	1225059686	1562508501-2-000	Federal	Health Center of Southeast Texas	Steven Racciato	1651 S. Byrd Avenue Shepherd, TX 77371 fqhc1@sbcglobal.net 281.592.2224
Federally Qualified Health Centers (FQHC)	1124296843	1320086739-1-003	Federal	Health Opportunities for People of East Texas	Jean Diebolt	157 Wall Street Tenaha, TX 75974 ceo@hopeprojectceotexas.org 936.248.4648

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Other Stakeholders (Continued)						
Health Department	n/a	n/a	County	Angelina CO & Cities Health District	Sharon Shaw	503 Hill Street Lufkin, TX 75904 936.633.0605
Health Department	n/a	n/a	County	Beaumont Public Health Department	Sherry Ulmer, RN	950 Washington Boulevard Beaumont, TX 77705 4409.654.3603
Health Department	n/a	n/a	County	Brazoria County Health Department	Cathy Sbrusch, RN, BSN, CIC	432 East Mulberry Angleton, TX 77515-4736 979.864.1484
Health Department	n/a	n/a	County	Hardin County Health Department	Mary Pastor, MD	P O Box 820 Kountze, TX 77625 409.246.5188
Health Department	n/a	n/a	County	Jasper/Newton County Health District	Danny Brackin, CPA	139 West Lamar Street Jasper, TX 75951 409.384.6829
Health Department	n/a	n/a	County	Orange County Health Department	Sheila Cole	2014 North 10th Street Orange, TX 77630 409.883.6119
Health Department	n/a	n/a	County	Port Arthur City Health Department	Yoshi D. Alexander	449 Austin Avenue Port Arthur, TX 77641 409.983.8832

SECTION II:

Executive Overview of RHP Plan

Section II: Executive Overview of RHP Plan

Overview:

Region 2 targets a coordinated system of care that seeks to advance the health of the population, improve the patient experience and utilize resources in a more efficient, effective and equitable manner. To achieve this transformation, the regional stakeholders have developed four priority goals to address over the waiver period:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that include health promotion and disease prevention.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through a learning collaborative that promotes best practices and the development of innovative solutions.
- Grow the health system resources for our region by expanding and enhancing training of the healthcare workforce at all levels of our future healthcare system.

Region 2 Described:

Region 2 is comprised of 16 counties covering almost 14,500 square miles and is home to approximately 1.46 million individuals. This mixed urban and rural region has some of the most rapidly growing communities in the state of Texas. The region is also the home of one Indian Reservation, the Alabama-Coushatta Tribes of Texas located in Livingston.

Demographically, the population is approximately 59% White, 20% Hispanic, 16% Black, and 5% fall into "a*ll other*" categories. This varies from both the state of Texas (44% White, 39% Hispanic, 12% Black, and 5% other) and the United States (63% white, 17% Hispanic, 12% Black, and 8% other)[1].

There are over 367,000 uninsured individuals in our region (25.19% of the total population) which is higher in percentage than that of Texas (24%) and the United States (16%). Almost 12.5% of the population is on Medicaid which is lower on average than that of Texas (13.3%) and of the United States (15.1%)[2].

More than 50% the counties in our region are designated as Health Professional Shortage Areas (HPSAs) in Primary Care and/or Mental Health. There are a total of 18 federally designated Medically Underserved Areas (MUAs) and five federally designated Medically Underserved

[1] 2012 estimates from The Nielsen Company.
[2] 2012 estimates provided by Truven (previously Thomson-Reuters).

Populations (MUPs) in our region. The majority of our counties fall below both the state and national ratios for physicians (both primary and specialty care) per 100,000 population.

The region contains one academic health center, three safety net hospitals, five Federally Qualified Health Centers (FQHCs), eight hospital districts, seven public health districts, twenty rural health clinics, four community centers (MHMR's) and sixteen county indigent care programs. There are gaps in access to care as well as variations in clinical practice and outcomes to care. The region has an acute shortage of mental and behavioral health resources coupled with large numbers of homeless and incarcerated. This region has some of the highest health care costs in the nation.

Key health challenges in the region include the high prevalence of chronic disease, notably: diabetes, obesity, heart and vascular related diseases/disorders and asthma. The high mortality and morbidity rates for mental and behavioral health contribute to the high Emergency Department (ED) utilization rate. The majority of communities throughout the region experience higher than national rates for all cancer groups. Additionally, two counties in the region report the highest rates of mesothelioma in the state. Finally, birth outcome measures in the region fare far worse than those for the state of Texas and of the United States.

Region 2 Approach:

In order to promote the development of a vision for the future of healthcare delivery within the region, the member organizations formed a structure to aid in communication, collaboration and decision-making. This structure is comprised of communication channels, a region-wide meeting structure, and a dedicated steering committee representing leadership from all key stakeholder groups. This Regional Steering Committee (RSC) meets bi-weekly and actively communicates with one another and with other providers in the region. In the role of regional anchor, the University of Texas Medical Branch (UTMB) has served as facilitator for meetings, communication, and the management of information, analysis and decision support.

An extensive community needs assessment (CNA) project was undertaken to better understand the current state of health and health services at the regional, county and local level. Based on the information contained in the CNA, the regional partners determined it was important to frame our efforts on primary care and prevention (including mental and behavioral health) and care management strategies. Projects were developed by local provider groups at the community level and were presented to the RSC. They were then further refined based on the feedback from the RSC and other stakeholders in the region. The final selection of projects for the regional health plan sought to protect and support the stability of the existing health care safety net infrastructure while seeking new ways to allocate resources to address challenges and improve the health of the entire region.

Region 2 Initiatives:

Many regional projects target expansion of access to primary care and prevention services. The focus of these projects centers on developing medical homes, incorporating additional levels of

providers (such as advanced practice nurses or community health workers), and co-locating physical and mental/behavioral health services. Education and training of future members of the healthcare workforce is also included in the proposed new models of care delivery.

Projects aimed at chronic disease management include the development of chronic disease management registries and care transition programs. Technology-assisted services to expand access to specialist services and improve communications among providers are included in these efforts.

Two regional projects are planned as key infrastructure for the region:

- Texas Regional Health Line – a Registered Nurse staffed healthcare triage and advice line that directs patients to the appropriate source of care in their home community. The advice line provides home care measures or appropriate disposition to a higher-level care based on community-specific repositories that have been created in collaboration with local providers.

- Collaborative to Enhance Performance Improvement and Reporting Capacity - essential infrastructure for establishing learning/improvement collaboratives that will expand our quality improvement capacity through people, processes and technology so that the resources are in place to conduct, measure, report and drive quality improvement initiatives throughout the region.

The projects were selected to provide synergy among regional facilities in addressing shared challenges and goals. By working together, in a collaborative learning culture with a willingness to listen and adapt, we are confident that we have developed both the framework and means to provide the strength to achieve the shared goals and vision for RHP 2.

Summary of Categories 1-2 Projects

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Category 1: Infrastructure Development			
121805903.1.1 – Pass 1 **1.1.2** **Angleton Danbury Medical Center** Expand Existing Pediatric Primary Care Capacity **TPI#: 121805903**	This project expands the capacity of primary care to better accommodate the needs of the regional pediatric patient population, as identified by the RHP needs assessment. It will have greater access to services, allowing them to receive the right care at the right time in the right setting.	**121805903.3.1** **OD-9** Right Care, Right Setting **IT-9.3** Pediatric/Young Adult Asthma ED Visits	$1,285,356
121805903.1.2 – Pass 1 **1.1.2** **Angleton Danbury Medical Center** Expand Existing Primary Care Clinics-Primary Care Clinic Expansion TPI#: 121805903	This project expands primary care services in the community to better serve and meet the needs of the region. This will allow the right care in the right setting.	**121805903.3.2** **OD-1** Primary Care and Chronic Disease Management **IT-1.10** Diabetes Care: HbA1c Poor Control (>9.0%)	$1,209,747
121805903.1.3 – Pass 3 **1.1.2** **Angleton Danbury Medical Center** Expand Existing OB/GYN Primary Care Capacity **TPI#: 121805903**	This project expands the capacity of OB/GYN primary care services to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.	**121805903.3.4** **OD-8** Perinatal Outcome **IT-8.3** Early Elective Delivery (Medicaid Adult Core Measure/NQF #469)	$6,364,959

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
112671602.1.1 – Pass 1 **1.1.2** **Brazosport Regional Health System** Expand Existing Primary Care Capacity **TPI#: 112671602**	This project expands primary care capacity by expanding the hours to include evenings and weekends. Additionally, this project includes expanding primary care services by means of Urgent Care operating hour expansion to meet the growing need for primary care services in the area.	**112671602.3.2** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$903,299
112706003.1.1 – Pass 2 **1.7.7** **CHRISTUS-Jasper Memorial Hospital** Introduce, Expand, or Enhance Telemedicine/Telehealth **TPI#: 112706003**	This project will implement technology-assisted services to support or deliver neurological care to patients in the Jasper area to expedite treatment of acute stroke to increase survival rates. The project will provide access through telemedicine to Neuroscience services, for patients who present to the emergency department.	**112706003.3.4** **OD-6** Patient Satisfaction **IT-6.1** Percent improvement over baseline of patient satisfaction scores	$2,330,934
138296208.1.1 – Pass 1 **1.1.1** **CHRISTUS Hospital-St. Elizabeth** Establish More Primary Care Clinics **TPI#: 138296208**	This project will increase the availability of primary care services, pediatric, and obstetric services for the underserved in the Beaumont area of Jefferson County. CHRISTUS Hospital will expand access to primary care with its partner FQHC, Legacy Community Health Services, in order to establish two primary care clinics	**138296208.3.1** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$5,010,656
019053001.1.1 – Pass 1 **1.1.2** **Galveston County Health District** Expand Existing Primary Care	This project will allows the Galveston County Health District (GCHD) to contract with the Coastal Health & Wellness, a federally-qualified health center (FQHC), to increase access to primary care. Access will increase	**019053001.3.1** **OD-1** Primary Care and Chronic Disease Management **IT-1.7**	$2,180,000

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Capacity **TPI#: 019053001**	capacity to see patients both in the clinic as well as in a mobile clinic site. We propose to hire three full-time providers and adequate support staff to accomplish the project.	Controlling High Blood Pressure	
135222109.1.1 – Pass 1 **1.13.1** **Gulf Coast Center** Behavioral Health Alternative to Hospitalization: Crisis Respite Expansion to Brazoria County **TPI#: 135222109**	This project provides adult residential psychiatric crisis respite services 24 hour per day, 7 days per week at an 8 bed facility in Angleton, Texas, as an alternative to inpatient psychiatric hospitalization and as a 'step-down' for people discharged from inpatient psychiatric hospitals. The project will provide alternatives for crisis mental health workers assessing patients in Emergency Departments and law enforcement officials responding to mental health crises.	**135222109.3.1** **OD-9** Right Care, Right Setting **IT-9.2** ED Appropriate Utilization	$2,023,367
135222109.1.2 – Pass 1 **1.12.4** **Gulf Coast Center** Wellness & Recovery for Youth **TPI#: 135222109**	The project establishes a Wellness Clinic would provide a transition provider accepting of Medicaid, CHIP, and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning.	**135222109.3.2** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$2,023,367
135222109.1.3 – Pass 1 **1.13.1** **Gulf Coast Center** Behavioral Health Alternative to Hospitalization: Ambulatory Detox	This project creates an ambulatory detox program that will operate 52 weeks per year with licensed professional staff as well as Peer Support staff. Each participant participates in full course of concurrent	**135222109.3.3** **OD-9** Right Care, Right Setting **IT-9.1** Decrease in Mental Health	$2,023,367

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
TPI#: 135222109	outpatient substance abuse treatment and detox services. Target population is adults in both Galveston County and Brazoria County.	Admissions to Criminal Justice Settings Such as Jails or Prisons	
135222109.1.4 – Pass 1 **1.11.2** **Gulf Coast Center** Telemedicine Access to ED and Adult MH Routine Services **TPI#: 135222109**	This project allows for the purchase and placement of telemedicine equipment in ED's. It also places mental health crisis workers onsite to assess patients who present to the ED with psychiatric crises. The crisis worker(s) will coordinate assessments by psychiatrists via teleconference equipment as needed, to evaluate appropriateness of inpatient psychiatric admission or outpatient treatment follow-up.	**135222109.3.4** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.8** Behavioral Health /Substance Abuse 30 Day Readmission Rate	$2,261,409
135222109.1.5 – Pass 1 **1.13.1** **Gulf Coast Center** Behavioral Health Crisis Stabilization Alternatives to Hospitalization: Crisis Respite & Response-Intellectual & Developmental Disabilities (IDD) **TPI#: 135222109**	This project will provide short-term emergency respite for persons with Intellectual and Developmental Disabilities/Autism Spectrum Disorder who experience behavioral crisis that requires intervention from law enforcement, Mobile Crisis Outreach Team (MCOT), or Emergency Departments. These services would be available to people with IDD/ASD.	**135222109.3.5** **OD-9** Right Care, Right Setting **IT-9.1** Decrease in Mental Health Admissions to Criminal Justice Settings Such as Jails or Prisons	$1,547,280
284333601.1.1 – Pass 2 **1.1.2** **Liberty Dayton Regional Medical Center** Expand Existing Primary Care Capacity	This project will expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive	**135222109.3.1** **OD-9** Right Care, Right Setting **IT-9.2** ED Appropriate Utilization	$5,330,786

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
TPI#: 284333601	the right care at the right time in the right setting.		
139172412.1.1 – Pass 1 **1.1.2** **Memorial Medical Center of East Texas-Lufkin** Expand Primary Care Capacity **TPI#: 139172412**	This Project expands capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. The target population is adults age 18 and over with multiple chronic medical conditions.	**139172412.3.1** **OD-2** Potentially Preventable Admissions **IT-2.10** Flu and pneumonia Admission Rate	$2,105,321
139172412.1.2 – Pass 1 **1.2.2** **Memorial Medical Center of East Texas-Lufkin** Increase Training of Primary Care Workforce-Outreach **TPI#: 139172412**	This Project expands primary care workforce and will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. The extended primary care workforce will also be trained to operate in patient-centered medical homes.	**139172412.3.2** **OD-2** Potentially Preventable Admissions **IT-2.1** Congestive Heart Failure Admission rate (CHF)	$2,229,164
131030203.1.1 – Pass 1 **1.1.1** **Nacogdoches Memorial Hospital** Expand Primary Care Capacity **TPI#: 131030203**	This project expands the capacity of primary care by establishing a new primary care clinic to better accommodate the needs of the indigent and underserved populations of Nacogdoches County. The aim of the project is for patients to have enhanced access to	**131030203.3.1** **OD-1** Primary Care and Chronic Disease Management **IT-1.7** Controlling High Blood Pressure	$6,597,323

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	services allowing them to receive the right care at the right time in the right setting.		
131030203.1.2 – Pass 1 **1.1.1** **Nacogdoches Memorial Hospital** Expand Primary Care Capacity-Perinatal Care **TPI#: 131030203**	This project expands primary care in a maternal/child clinic by adding a certified nurse midwife (CNM) and additional support staff to increase service capacity to the indigent and underserved populations of Nacogdoches County.	**131030203.3.2** **OD-8** **Perinatal Outcomes** **IT-8.1** Timeliness of Prenatal/Postnatal Care **131030203.3.3** **IT-8.2** Percentage of Low Birth Weight Birth	$1,199,108
131030203.1.3 – Pass 1 **1.3.1** **Nacogdoches Memorial Hospital** Implement a Chronic Disease Management Registry **TPI#: 131030203**	This project implements a disease management registry in four primary care clinics in Nacogdoches County for one or more patient populations diagnosed with a selected chronic disease(s) or with Multiple Chronic Conditions (MCCs).	**131030203.3.4** **OD-1** Primary Care and Chronic Disease Management **IT-1.10** Diabetes care: HbA1c Poor Control (>9.0%)	$699,554
131030203.1.4 – Pass 3 **1.9.2** **Nacogdoches Memorial Hospital** Improve Access to Specialty Care **TPI#: 131030203**	This project will improve access to specialty care by increasing service availability with extended hours, provide a multi-specialty care clinic location, and ensure transparent, standardized referrals across the system for the Medicaid, indigent and underserved populations of Nacogdoches County.	**131030203.3.7** **OD-3** Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs) **IT-3.5** Acute Myocardial Infarction (AMI) 30 day readmission rate	$2,023,063

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
261955689.1.1 – Pass 2 **1.1.2** **Sabine County Hospital** Expand Existing Primary Care Capacity **TPI#: 261955689**	This project will expand the capacity of primary care to better accommodate the needs of the patient population and community in the county so that patients can receive the right care at the right time in the right setting.	**261955689.3.1** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Bseline of Patient Satisfaction Scores	$4,750,166
096166602.1.1 – Pass 1 **1.9.3** **Spindletop Center** Specialty Psychiatric Clinic **TPI#: 096166602**	This project increases the availability of affordable treatment for psychiatric diagnoses such as anxiety, depressive, adjustment, obsessive compulsive and post-traumatic stress disorders, Spindletop Center will open a psychiatric specialty clinic. This clinic for other diagnoses will provide hundreds of citizens with mental health care which was previously unavailable and may reduce hospital ED visits or hospitalizations.	**096166602.3.1** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$1,976,874
096166602.1.6 – Pass 3b **1.13.2** **Spindletop Center** Extended Crisis Stabilization Program **TPI#: 096166602**	This project will develop a longer-term crisis intervention and stabilization service capability to improve access to behavioral health care in the most appropriate, cost-effective setting.	**096166602.3.15** **OD-9** Right Care, Right Setting **IT-9.2** ED Appropriate Utilization	$3,087,487
096166602.1.3 – Pass 1 **1.12.4** **Spindletop Center** Enhance Service Availability to Appropriate Levels of Behavioral	The goal of this project is to expand community-based behavioral health service options for youth aged 10-17 in Jefferson, Orange, Hardin, and Chambers counties.	**096166602.3.3** **OD-9** Right Care, Right Setting **IT-9.1**	$2,154,183

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Health Care **TPI#: 096166602**		Decrease in Mental Health Admissions to Criminal Justice Settings Such as jails or Prisons	
096166602.1.7 – Pass 3b **1.12.4** **Spindletop Center** Enhance Service Availability to Appropriate Levels of Behavioral Health Care **TPI#: 096166602**	This project will provide an intervention for this targeted population by implementing a specialty inpatient detox program. The goal of this project is to avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community	**096166602.3.16** **OD-9** Right Care, Right Setting **IT-9.2** ED Appropriate Utilization	$7,498,183
096166602.1.5 – Pass 2 **1.11.3** **Spindletop Center** Introduce, Expand or Enhance Telemedicine/Telehealth **TPI#: 096166602**	The goal of this project is to support client health care, health-related education, public health and health administration by using the internet for clients to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.	**096166602.3.9** **OD-6** Patient Satisfaction **IT-6.1.1** Percent Improvement Over Baseline of Patient Satisfaction Scores. Timely Care, Appointments and Information	$3,063,312
136367307.1.1 – Pass 1 **1.12.4** **The Burke Center** Enhance Service Availability of appropriate levels of behavioral	This project will expand the capacity of primary behavioral health care to better accommodate the needs of the regional patient population and community, so that patients have enhanced access to services	**136367307.3.1** **OD-6** Patient Satisfaction **IT-6.1.1** Percent Improvement Over	$8,280,847

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
health care **TPI#: 136367307**	allowing them to receive the right care at the right time in the right setting.	Baseline of Patient Satisfaction Scores. Timely Care, Appointments and Information	
136367307.1.2 – Pass 1 **1.7.1** **The Burke Center** Introduce, Expand, or Enhance Telemedicine/Telehealth **TPI#: 136367307**	This project expands and enhances telemedicine (psychiatric) services in our region by adding additional broadband and internet capabilities; purchasing necessary equipment to allow for the expanded use of telemedicine in existing sites; and adding this capability in one or more new locations.	**136367307.3.2** **OD-6** Patient Satisfaction **IT-6.1.1** Percent Improvement Over Baseline of Patient Satisfaction Scores. Timely Care, Appts., and Information	$881,672
081844501.1.1 – Pass 1 **1.9.2** **Tri-County Services** Expanded Psychiatry Delivery Program **TPI#: 081844501**	This project will provide basic services requested and needed by these individuals in Liberty County to reduce inappropriate care. This program will admit and serve these individuals in medication services and care coordination to meet the primary treatment needs as requested. Additional medical staff would be hired to deliver these services, which also would allow for expanded hours of service as needed.	**081844501.3.1** **OD-10** Quality of Life/Functional Status **IT-10.1** Quality of Life	$874,740
136381405.1.1– Pass 1 **1.1.2** **Tyler County Hospital District** Expand Primary Care **TPI#: 136381405**	This project expands access to primary care by adding a physician/LVN to the Rural Health Clinic. It will provide primary care and chronic disease management to patients with HbA1c >9%.	**136381405.3.1** **OD-1** Primary Care and Chronic Disease Management **IT-1.10** Diabetes care: HbA1c Poor Control (>9.0%)	$973,278

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
094092602.1.1 – Pass 1 **1.1.2** **UTMB** Expand Primary Care Access In Galveston and Brazoria Counties **TPI#: 094092602**	This project increases primary care capacity for Galveston and Brazoria counties within UTMB's Community Based Clinics while focusing on controlling high blood pressure of patients.	**094092602.3.1** **OD-1** Primary Care and Chronic Disease Management **IT-1.7** Controlling High Blood Pressure	$13,667,966
094092602.1.2 – Pass 1 **1.1.2** **UTMB** Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion **TPI#: 094092602**	This project expands pediatric after hours urgent care clinic to better meet the needs of our pediatric population on Galveston Island. This includes: clinic relocation, physical expansion, exam room expansion, staffing increases and additional ancillary services.	**094092602.3.2** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores.	$1,381,324
094092602.1.3 – Pass 1 **1.1.2** **UTMB** Expansion of Alvin Primary Care Clinic to Include Adult Care **TPI#: 094092602**	This project expands primary care for both adults and children in Brazoria County. The expansion will increase existing pediatric services with the addition of adult care by expanding primary care to adult services. Project options include expanding primary care clinic space and primary care clinic staffing.	**094092602.3.3** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores **094092602.3.4** **OD-1** Primary Care and Chronic Disease Management **IT-1.1** Third Next Available Appointment	$14,646,917
094092602.1.4 – Pass 1 **1.3.1**	This project creates a patient registry that will facilitate the medical management,	**094092602.3.5**	$4,099,735

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
UTMB Transplantation Chronic Disease Management Registry **TPI#: 094092602**	evaluation and treatment of patients with end stage organ failure that may benefit from transplantation. The population served is primarily focused on patients in communities throughout Texas but also includes those in neighboring states.	**OD-3** Potentially Preventable Re-Admissions-30 Day Re-Admission Rates **IT-1.20** "Other" Outcome Improvement Target	
094092602.1.5 – Pass 1 **1.3.1** **UTMB** Implement and Utilize Disease Management Registry **TPI#: 094092602**	This project implements and utilizes chronic disease registries for diabetes, CHF, asthma, hypertension and COPD. In addition to the registries, the EHR's dash boarding tool, RADAR, will be implemented that will enable providers to view performance at a glance and target patients requiring specific interventions.	**094092602.3.6** **OD-1** Primary Care and Chronic Disease Management **IT-1.10** Diabetes Care: HbA1c Poor Control (>9.0%)	$3,240,391
094092602.1.6 – Pass 1 **1.6.2** **UTMB** Nurse Advice Line: Texas Regional Health Line (Region 2) **TPI#: 094092602**	This project implements a nurse advice call center for participating counties in Region 2. This call center will be a nurse advice line with designated phone numbers that are given to patient populations in these counties. Highly trained registered nurses will provide urgent medical advice from 4:30pm to 8am Monday thru Friday and 24/7 coverage on weekends and holidays.	**094092602.3.7** **OD-9** Right Care, Right Setting **IT-9.2** ED Appropriate Utilization	$13,073,616
094092602.1.7 – Pass 1 **1.10.2** **UTMB** Enhance Performance Improvement	This project establishes an improvement collaborative that will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement	**094092602.3.8** **OD-3** Potentially Preventable Re-Admissions –	$4,276,980

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
and Reporting Capacity **TPI#: 094092602**	from subject matter experts, from project staff coaches and from each other. The RHP2 Executive Steering Committee will assist in the selection of improvement topics/targets, monitor the progress of teams and assist in enabling required changes for sustainable improvement.	30 Day Re-Admission Rates **IT-3.1** All Cause 30 Day Readmission Rate	
094092602.1.8 – Pass 2 **1.4.1** **UTMB** Enhance Interpretation Services and Culturally Competent Care (Expand Access to Written and Oral Interpretation Services) **TPI#: 094092602**	This Project will allow UTMB Health Language Services to expand its current and future interpretation services through technology, additional personnel and training which will lead to improved access, improved quality of care and patient satisfaction for our patients and their families. The technology will allow UTMB Health to provide remote video interpreting services both for foreign languages and sign language interpreting.	**094092602.3.17** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$3,245,071
094092602.1.9 – Pass 2 **1.5.3** **UTMB** Strengthening the UTMB health information system to Reduce Health Disparities **TPI#: 094092602**	This Project will redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care using HIT to link administrative and billing databases with clinical and hospital patients' medical records, and by adding new fields including Race/Ethnicity data aligned with Census Bureau categories. Data will also be (newly) collected for Charity Care applicants to allow disparities analysis of provision of charity care. We will implement system to	**094092602.3.18** **OD-11** Addressing Health Disparities in Minority Populations **IT-11.1** Improvement in Clinical Indicator in identified disparity group	$3,859,794

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes.		
094092602.1.10 – Pass 2 **1.9.1** **UTMB** Expand High Impact Specialty Care Capicity in most Imapcted Medical Specialties: Through Training for Burn and Trauma Care **TPI#: 094092602**	This Project will provide a mechanism to close the gap for underserved populations related to burn and traumatic injuries. . By improving today's traditional health care plan for underserved populations through health care system reform, we can improve access to care through education of pre-hospital care and emergency department care providers in order to improve access to specialty care burn and trauma units which will lead to improvements in morbidity and mortality, long term outcomes, patient satisfaction and quality of life.	**094092602.3.19** **OD-4** Potentially Preventable Complications and Health Care Acquired Conditions **IT-4.1** Improvement in Risk-Adjusted Potentially Preventable Complications Rate(s).	$2,583,665
109372601.1.1 – Pass 1 **1.9.2** **UTMB** **Physician Group Practice** Expand Specialty Care Access in Galveston and Brazoria Counties **TPI#: 109372601**	This project expands both specialty and preventive services for patients in a two county area. The use of electronic medical record will allow seamless referrals and communication between primary care and specialty providers to provide better quality of care and health care outcomes in the community.	**109372601.3.1** **OD-1** Primary Care and Chronic Disease Management **IT-1.11** Diabetes care: BB Control (<140/80mm Hg)	$17,015,343

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
109372601.1.2 – Pass 1 **1.11.2** **UTMB** **Physician Group Practice** Providing Psychiatry Telemedicine Clinics to RHP 2 and the State of Texas **TPI#: 109372601**	This project refines a new model for child and/or adult psychiatry telemedicine clinics and implements (in RHP2 and the State of Texas) UTMB Health's telemedicine capability and experience, including the UTMB Health and Texas Health and Human Services Commission and Frew Advisory Committee Funded Demonstration Project. The target population includes the unserved and underserved due to lack of providers.	**109372601.3.3** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores.	$14,444,697
109372601.1.3 – Pass 2 **1.2.1** **UTMB** **Physician Group Practice** Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement **TPI#: 109372601**	This project implements and evaluate a new primary care clinic model that will train more workforce members in an "education home," (i.e., an interprofessional team-based patient-centered medical home (PCMH), in which they will acquire and demonstrate competence to function in and lead such clinics during their careers) and expand current primary care capacity in the targeted geographic area through effective implementation of the PCMH model coupled with the education home model.	**109372601.3.7** **OD-1** Primary Care and Chronic Disease Management **IT-1.6** Cholesterol Management for Patients with Cardiovascular Conditions	$3,261,953
Category 2: Program Innovation and Redesign			
121805903.2.1 – Pass 1 **Angleton Danbury Medical Center** **2.9.1**	This project provides navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	**121805903.3.3** **OD-3** Potentially Preventable	$1,360,965

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Establish/Expand a Patient Care Navigation Program **TPI#: 121805903**		Re-Admissions – 30 Day Re-Admission Rates **IT-3.1** **All cause 30 day Readmission Rate**	
094148602.2.1 – Pass 1 **Baptist Hospitals of Southeast Texas, Beaumont** **2.2.2** Expand Chronic Care Management Models **TPI#: 094148602**	This project will take a comprehensive approach to assisting patients in managing chronic disease. It is dedicated to not only teaching patients how to care for themselves after discharge, but also to establish a post-discharge planning program that prepares patients for self-management and ensures the post-discharge setting is supportive, which Baptist hopes will reduce patients' chances of hospital readmission.	**094148602.3.2** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.2** Congestive Heart Failure 30 Day Readmission Rate	$5,376,433
094148602.2.2 – Pass 1 **2.9.1** **Baptist Hospitals of Southeast Texas, Beaumont** Expand Care Transition Program **TPI#: 094148602**	This project expands the existing care transition program to develop a community-wide network and support system for Medicaid, Medicare, and uninsured patients diagnosed with heart failure. All health care entities in the area will share responsibility and tracking of these individuals. The network will share knowledge and outcomes in an effort to improve the quality of life of this population while decreasing their risk of hospitalization.	**094148602.3.2** **OD-2** Potentially Preventable Admissions **IT-2.1** Congestive Heart Failure Admission Rate	$3,893,280

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
112671602.2.1 – Pass 1 **2.2.2** **Brazosport Regional Health System** Apply Evidence-Based Care Management Model to Patients Identified as Having High-Risk Health Care Needs **TPI#: 112671602**	This project aims to expand chronic care management models for patients diagnosed with diabetes. The project involves expanding self-management programs for patients diagnosed with diabetes, measuring patient progress by monitoring the increased number of patients in the target population reached and measuring Hemoglobin A1c levels and comparing the results of the quality improvement initiative to other diabetic patients.	**112671602.3.1** **OD-1** Primary Care and Chronic Disease Management **IT-1.10** Diabetes care: HbA1c Poor Control (>9.0%)	$3,394,000
112706003.2.1 – Pass 1 **2.2.2** **CHRISTUS-Jasper Memorial Hospital** Apply Evidence-Based Care Management Model to Patients Identified as Having High-Risk Health Care Needs **TPI#: 112706003**	This project will improve the overall health of the communities by targeting individuals with chronic diseases that can be controlled through healthy living habits and early intervention. The intended outcome will be a healthier community and reduced readmissions. The project will place Community Health Workers (CHWs) within the community to work with individuals with chronic diseases with the focus of educating and teaching those individuals how to manage and live a productive, healthy life.	**112706003.3.1** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.1** All cause 30 Day Readmission Rate	$2,917,895
112706003.2.2 – Pass 1 **2.10.1** **CHRISTUS-Jasper Memorial Hospital** Implement a Palliative Care	This project will encourage providers to establish clear patient-centered treatment goals as illnesses progress and as patients move from one healthcare setting to another; doing so will ensure higher-quality	**112706003.3.2** **OD-13** Palliative Care **IT-13.3** Proportion with More Than One	$2,674,737

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Program to Address Patients with End-of-Life Decisions and Care Needs **TPI#: 112706003**	care and reduce patient and hospital costs and Medicare expenditure (*especially in the last month of life).*	Emergency Room Visit in the Last Days of Life	
112706003.2.3 – Pass 1 **2.9.2** **CHRISTUS-Jasper Memorial Hospital** "Other" Project Option: Provide Navigation Services to Targeted Patients who are at High Risk of Disconnect from Institutionalized Health Care **TPI#: 112706003**	This project will establish a program wherein a Regional Outreach Coordinator will provide support to at-risk patient populations who are likely to have trouble navigating the health care system, and who have high rates of ED/inpatient hospital use.	**112706003.3.3** **OD-6** Patient Satisfaction **IT-6.1** Percent improvement over baseline of patient satisfaction scores	$3,647,368
112706003.2.4 – Pass 2 **2.9.1** **CHRISTUS-Jasper Memorial Hospital** Establish/Expand a Patient Care Navigation Program **TPI#: 112706003**	This project will help and support patients especially in need of coordinated care to navigate through the continuum of health care services, so that these patients can receive coordinated, timely services when needed, with smooth transitions between health care settings. Specifically, the project will provide individualized assistance to oncology patients, families, and caregivers; overcome health care system barriers; and facilitate timely access to quality medical and psychosocial care, from pre-diagnosis through all phases of the cancer experience. Under this project, CHRISTUS will develop an	**112706003.3.5** **OD-6** Patient Satisfaction **IT-6.1** Percent improvement over baseline of patient satisfaction scores	$1,782,478

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	Oncology Navigation Program utilizing a collaborative team approach to care coordination to improve quality and effectiveness of cancer screening and follow-up.		
112706003.2.5 – Pass 2 **2.6.1** **CHRISTUS-Jasper Memorial Hospital** Implement Evidence-based Health Promotion Programs **TPI#: 112706003**	This project will provide pre-diabetes education to prevent/delay the onset of type 2 diabetes. The project will involve group education classes at a community-based facility to promote healthy lifestyles (including physical activity and healthy eating), to reach an identified targeted population without insurance or for which insurance does not cover pre-diabetes education. Challenges include a high volume of uninsured people with pre-diabetes, lack of insurance coverage for pre-diabetes education, lack of patient awareness, and the coordination of a physician database for referrals.	**112706003.3.6** **OD-2** Potentially Preventable Admissions **IT-2.7** PPA--Diabetes Short Term Complication Admission Rate	$2,193,820
138296208.2.1 – Pass 1 **2.2.2** **CHRISTUS Hospital-St. Elisabeth** Expanding Chronic Care Management Models (High Risk Healthcare Needs) **TPI#: 138296208**	This project will establish innovative team-based clinics in the local community to address complex chronic diseases such as congestive heart failure, diabetes, COPD, asthma and combinations of these conditions. These clinics will offer intensive care management to optimize health and healthcare utilization.	**138296208.3.2** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.2** Congestive Heart Failure 30 Day Readmission Rate	$4,259,057

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
135222109.2.1 – Pass 1 **2.15.1** **Gulf Coast Center** Integrate Primary and Behavioral Health Care Services in Brazoria/Galveston County **TPI#: 135222109**	This project co-locates outpatient physical health clinics in its adult mental health facilities. This project will allow for a nurse care manager to establish baseline and track vital health indicators gathered at regularly scheduled psychiatric visits, conduct primary screening assessments, document presence of co-occurring mental health and substance dependence, refer clients to other medical providers, and assure access to secondary and tertiary care where necessary.	**135222109.3.6** **OD-10** Quality of Life/Functional Status **IT-10.1** Quality of Life	$2,261,409
135222109.2.2 – Pass 2 **2.13.2** **Gulf Coast Center** Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting-"OTHER" **TPI#: 135222109**	This project will provide innovative services to the targeted behavioral health population using increased training of the behavioral health workforce including professionals, paraprofessionals, peer-to-peer specialists, and peer-to-peer volunteers trained in Cognitive Adaptation Training ("CAT"), Wellness Recovery Action Plan™ ("WRAP®") facilitator and patient training, and Cognitive Enhancement Therapy ("CET").	**135222109.3.7** **OD-10** Quality of Life/Functional Status **IT-10.1** Quality of Life	$1,147,251
139172412.2.1 – Pass 1 **2.12.1** **Memorial Medical Center of East Texas-Lufkin** Develop, Implement and Evaluate Standardized Clinical Protocols and Evidence-Based Care Delivery	Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.	**139172412.3.3** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.1** All cause 30 Day Readmission Rate	2,105,321

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Model to Improve Care Transitions **TPI#: 139172412**			
139172412.2.2 – Pass 1 **2.12.2** **Memorial Medical Center of East Texas-Lufkin** Implement One or More Pilot Interventions in Care Transitions Targeting One or More Patient Care Units or a Defined Patient Population. **TPI#: 139172412**	This project implements improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.	**139172412.3.4** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.5** Acute Myocardial Infarction (AMI) 30 Day Readmission Rate	1,857,637
131030203.2.1 – Pass 1 **2.6.2** **Nacogdoches Memorial Hospital** Establish Self-Management Programs for Health Promotion **TPI#: 131030203**	This project implements an evidence-based disease self-management program in Nacogdoches County for one or more patient populations diagnosed with selected chronic disease(s) or with Multiple Chronic Conditions (MCCs). The program will be led by community health workers (CHWs) in community settings and will enable patients to manage their chronic disease, promote healthy lifestyles and navigate the healthcare system for better patient compliance.	**131030203.3.5** **OD-1** Primary Care and Chronic Disease Management **IT-1.11** Diabetes Care: BB Control (<140/80mm Hg)	$639,554
131030203.2.2 – Pass 2 **2.4.1** **Nacogdoches Memorial Hospital** Redesign to Improve Patient	This project will implement improvement processes including a nurse-nurse and nurse-patient/family communication system at Memorial Hospital. Project components will	**131030203.3.6** **OD-4** Potentially Preventable Complications and Healthcare	$2,023,063

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
Experience **TPI#: 131030203**	include: organizational integration and prioritization of patient experience, data and performance measurement, implementation of processes to improve patient's experience in getting through to the clinical practice, and development of 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.	Acquired Conditions **IT-4.5** Patient Fall Rate - NQF 0141	
096166602.2.1 – Pass 1 **2.15.2** **Spindletop Center** Integrate Primary and Behavioral Health Care Services **TPI#: 096166602**	This project co-locates primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. In addition, a mobile clinic will be purchased and equipped to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics.	**096166602.3.5** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores.	$3,568,252
096166602.2.2 – Pass 1 **2.13.2** **Spindletop Center** "Other" Project Option **TPI#: 096166602**	This project aims to avert outcomes such as: potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals; avert disruptive and deleterious events; promote wellness and adherence to behavioral health treatments; and promote recovery in the community for individuals with Intellectual and	**096166602.3.6** **OD-9** Right Care, Right Setting **IT-9.4** Other Outcome Improvement Target	$731,293

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	Developmental Disabilities (IDD) or Autism Spectrum Disorders (ASD).		
096166602.2.3 – Pass 1 **2.13.2** **Spindletop Center** "Other" Project Option **TPI#: 096166602**	This project will increase training of the behavioral health workforce with the goal of averting outcomes such as: potentially avoidable inpatient admissions and disruptive and deleterious events. Also, this promotes wellness and adherence to behavioral health treatments, and to promote recovery in the community.	**096166602.3.7** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$1,353,497
096166602.2.10-Pass 3b **2.13.2** **Spindletop Center** "Other" Project Option **TPI#: 096166602**	This project will refurbish existing buildings currently owned by Spindletop Center to create 7 new apartments in Beaumont and 12 new studio apartments in Orange for behavioral health clients who are at risk of being homeless with the goal of averting outcomes such as: potentially avoidable inpatient readmissions and disruptive and deleterious events. Also, this promotes wellness and adherence to behavioral health treatments, and to promote recovery in the community.	**096166602.3.17** **OD-10** Quality of Life/Functional Status **IT-10.7** Other Outcome Improvement Target	$2,205,347
096166602.2.11– Pass 3b **2.13.2** **Spindletop Center** "Other" Project Option **TPI#: 096166602**	The goal of this project is to avert outcomes such as potentially avoidable hospital inpatient and ED admissions and to promote wellness for individuals with Intellectual and Developmental Disabilities (IDD) or Autism	**096166602.3.18** **OD-10** Quality of Life/Functional Status **IT-10.7** Other Outcome Improvement	$1,627,547

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	Spectrum Disorders (ASDs).	Target	
096166602.2.6 – Pass 2 **2.13.2** **Spindletop Center** "Other" Project Option **TPI#: 096166602**	This project will avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals and state behavioral health facilities; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community.	**096166602.3.11** **OD-9** Right Care, Right Setting **IT-9.4** Other Outcome Improvement Target	$1,420,244
096166602.2.7 – Pass 2 **2.18.2** **Spindletop Center** "Other" Project Option: Recruit, Train and Support Consumers of Mental Health Services to Provide Peer Support Services **TPI#: 096166602**	The project will use 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 peer support services. These services are supportive and not necessarily clinical in nature. With the whole health training, peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases and behavioral health symptoms.	**096166602.3.12** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$1,234,995
096166602.2.8 – Pass 2 **2.13.2** **Spindletop Center** "Other" Project Option	The goal of this project is to facilitate recovery to a historically underfunded population to avert such potentially avoidable inpatient admission and	**096166602.3.13** **OD-10** Quality of Life/Functional Status **IT-10.1**	$1,226,173

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
TPI#: 096166602	readmissions for detox or substance abuse treatment; to avert disruptive and deleterious events such as criminal justice involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the family and community.	**Quality of Life**	
096166602.2.9 – Pass 2 **2.6.4** **Spindletop Center** Implement Evidence Based Health Promotion Programs **TPI#: 096166602**	This project will promote the benefits of early childhood intervention (ECI) in improving developmental and health outcomes for infants and toddlers from birth to three years old and to improve consumers' access to healthcare resources and information using technology in community-based settings.	**096166602.3.14** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$808,424
136367307.2.1 – Pass 1 **2.18.1** **The Burke Center** Recruit, train and support consumers of mental health services to provide peer support services **TPI#: 136367307**	This project develops a program using consumers of mental health services who have made substantial progress in managing their illness and successfully recovering to provide peer support services. Peers will be certified with additional specific training geared toward whole health support and intervention.	**136367307.3.3** **OD-10** Quality of Life/Functional Status **IT-10.1** Quality of life	$1,022,037
136367307.2.2 – Pass 3b **2.15.1** **The Burke Center** Design, Implement and Evaluate Projects that Provide Integrated and Behavioral Health Care Services	This project will integrate primary care with behavioral health care services the Center provides in order to improve access to needed health services and improve overall health and wellbeing. Burke Center will partner with Angelina County/Cities Health	**136367307.3.4** **OD-6** Patient Satisfaction **IT-6.1.1** Percent Improvement Over Baseline of Patient Satisfaction	$5,255,448

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
TPI#: 136367307	District to create an integrated health home for clients with one or more comorbid chronic conditions and expand access to behavioral health.	Scores-Timely Care, Appointment and Information	
136367307.2.3 – Pass 3b **2.13.1** **The Burke Center** Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. **TPI#: 136367307**	The project will promote mental health recovery and prevent individuals from experiencing repeated hospitalizations or incarcerations. This project would create a specialized interdisciplinary team to provide mobile treatment and supports for high risk/high need individuals through a variety of supportive interventions.	**136367307.3.5** **OD-6** Patient Satisfaction **IT-6.1.1** Percent Improvement Over Baseline of Patient Satisfaction Scores-Timely Care, Appointment and Information	$4,852,781
136381405.2.1 – Pass 2 **2.4.1** **Tyler County Hospital District** Implement Processes to Measure and Improve Patient Experience **TPI#: 136381405**	This project will aim to improve inpatient experience by strengthening the communication skills of all our employees, including all departments. Nurses will be instructed regarding communicating about medication, discharge information and their patients.	**136381405.3.2** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$315,134
094092602.2.1 – Pass 1 **2.1.1** **UTMB** Implementing Patient Centered Medical Home **TPI#: 094092602**	This project enhances the Patient-Centered Medical Home model and expands it throughout primary care clinics. Restructuring the staffing model into multidisciplinary care teams that manage a panel of patients will enhance the model of primary care by improving the health of the patients in the panels, reducing system costs	**094092602.3.9** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$2,725,233

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	associated with readmissions and ED visits, and improving the patient experience through improved access to a care provider.		
094092602.2.2 – Pass 1 **2.8.8** **UTMB** Empowering the care team with systems Engineering/Lean **TPI#: 094092602**	This project improves patient access through patient centered scheduling in primary care clinics, hybrid adaptive approach in specialty clinics and streamlining work flows and more efficiently managing resources using lean and systems engineering approach.	**094092602.3.11** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores	$4,902,302
094092602.2.3 – Pass 1 **2.9.1** **UTMB** Establish/Expand a Patient Navigation Program-Community Health Program, Chronic Disease Education **TPI#: 094092602**	This project expands the Community Health Program/Chronic Disease Education program that provides care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible and uninsured patients who have chronic diseases.	**094092602.3.12** **OD-1** Primary Care and Chronic Disease Management **IT-1.7** Controlling High Blood Pressure	$2,344,031
094092602.2.4 – Pass 1 **2.12.1** **UTMB** Develop and Implement a Transitional Care Program Between Hospital, Nursing Home, and Home Health Care Home Via A Care Transition Coordinator	This project designs and implements an effective care transition program that promotes patient centered care for patients 65+ transitioning from the hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination with the goal of eliminating avoidable 30-day readmissions.	**094092602.3.13** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.1** All Cause 30 Day Readmission Rate	$1,499,186

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
TPI#: 094092602			
094092602.2.5 – Pass 1 **2.12.1** **UTMB** Implement a Care Transitions Program Care Management Registry **TPI#: 094092602**	This project implements a case management registry system with a focus on decreasing potentially preventable 30-day readmissions by 1% each year.	**094092602.3.14** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.1** All Cause 30 Day Readmission Rate	$3,813,581
094092602.2.6 – Pass 1 **2.12.2** **UTMB** Implement Care Transitions Program **TPI#: 094092602**	This project focuses on improving the transitions of care for adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of AMI, heart failure or pneumonia.	**094092602.3.15** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.5** Acute Myocardial Infarction (AMI) 30 Day Readmission Rate	$6,842,088
094092602.2.7 – Pass 1 **2.12.1** **UTMB** Implement/Expand Care Transitions Programs (STORK) **TPI#: 094092602**	This project will implement specialty obstetric episode database registry in order to integrate obstetric care across UTMB obstetrical clinic and inpatient settings; and streamline the daily tasks of obstetricians, nurses, midwives, clerks, and technologists in creating and maintaining up-to-date obstetric health information records.	**094092602.3.16** **OD-8** Timeliness of Prenatal/Postnatal Care **IT-8.9** Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia	$2,403,942

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
094092602.2.8 – Pass 2 **2.5.1** **UTMB** Redesign for Cost Containment: Develop an integrated care model with outcome-based payments **TPI#: 094092602**	This project will reduce variation in clinical practice, improve patient outcome and quality metrics and reduce cost to deliver care. This project also correlates with the regional goal of improve the quality of patient care through data collection, analysis, reporting and continuous process improvement. Post pilot, project results and outcomes will be shared within the region.	**094092602.3.20** **OD-5** Cost of Care **IT-5.1** Improved Cost Savings	$1,837,531
094092602.2.9 – Pass 2 **2.6.1** **UTMB** Engage in Population-Based Campaigns or Programs to Promote Healthy Lifestyles Using Evidence Based Methodologies including Social Media and Text Messaging in an Identified Population **TPI#: 094092602**	This project seeks to expand UTMB's social media activities to create evidence-based health promotion campaigns. Populations to be served will include specific groups, such as pregnant women in Galveston County on Medicaid (the subject of our Improvement Target) as well as broader-based populations such as overweight and obese populations in the County. We hope to set up the program to allow providers across Region 2 to take advantage of the social media platforms and content that will be created.	**094092602.3.21a** **OD-6** Patient Satisfaction **IT-6.1** Percent Improvement Over Baseline of Patient Satisfaction Scores **094092602.3.21b** **IT-8.9** Other Outcome Improvement Target- breast feeding at 6-months post delivery	$3,253,513
094092602.2.10 – Pass 2 **2.10.1** Implement a Palliative Care Program to Address Patient with End-of-Life Decisions and Care Needs **UTMB**	This project will fully develop the infrastructure to sustain a palliative care consult service for UTMB. A comprehensive palliative care team approach will better enable a holistic approach to the care of patients with advanced illness – meeting physical, psychosocial, and spiritual needs of	**094092602.3.22** **OD-13** Palliative Care **IT-13.4** Proportion Admitted to the ICU in the Last 30 Days of Life	$1,766,540

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
TPI#: 094092602	patients. We will be able to reach more patients and, in a timely way, assist care teams in all clinical services to help clarify patient goals, revise plans accordingly and provide symptom relief.		
094092602.2.11 – Pass 2 **2.11.1** **UTMB** Conduct Medication Management **TPI#: 094092602**	This project will provide for a clinical pharmacist in the Emergency Department. Addition of a clinical pharmacist to the patient care team is a systems-level patient safety intervention that serves to make it difficult for medication errors to occur and to absorb errors before harm. Positively impacting the medication regimen, understanding and adherence to the regimens will result in better management of the medical conditions. Better management of the medical condition will result in decreased costs to Emergency Departments and Hospitals throughout the region.	**094092602.3.23** **OD-3** Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates **IT-3.1** All Cause 30 Day Readmission Rate	$929,046
094092602.2.12 – Pass 2 **2.12.2** **UTMB** Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population **TPI#: 094092602**	This project will utilize the Greater Houston Health Connect Health Information Exchange (HIE) as the communication tool that underlies the process improvement for the patient experience. Emergency Medical Service (EMS) providers and UTMB emergency department (ED) staff will communicate critical patient information before a patient arrives in the ED. This will	**094092602.3.24** **OD-9** Right Care, Right Setting **IT-9.2** ED Appropriate Utilization **094092602.3.25** **OD-5** Cost of Care	$4,299,719

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
	allow EMS providers to provide better quality care in transit with this additional information, and it will also allow for streamlining the arrival process for patients in the ED.	**IT-5.1** Improved Cost Savings	
109372601.2.1 – Pass 2 **2.12.2** **UTMB** **Physician Group Practice** Implement EpicCare Link to Improve Clinical Communication Between UTMB and Referring Providers **TPI#: 109372601**	This project allows community based providers to view portions their patient's medical record via EpicCare Link. This provides better communication between primary care providers and specialty teams. The goal is to increase patient satisfaction and provide better coordinated care.	**109372601.3.4** **OD-6** Patient Satisfaction **IT 6.2** Other Outcome Improvement Target	$2,799,059
109372601.2.2 – Pass 1 **2.15.1** **UTMB** **Physician Group Practice** Expanding Integrated primary Care and Behavioral/Mental Health Care Access using Advanced Practice Clinicians **TPI#: 109372601**	This project integrates primary and behavioral health services to underserved communities in RHP 2. Services will be delivered by advanced practice clinicians and will be supported by access to a wide range of specialty care in partnership with an academic health center.	**109372601.3.5** **OD-1** Primary Care and Chronic Disease Management **IT-1.8** Depression Management: Screening and Treatment Plan for Clinical Depression **109372601.3.6** **IT-1.9** Depression Management: Depression Readmission at Twelve Months	$2,543,318

Project Title	Brief Project Description	Cat 3 Outcome Measure(s)	DY 2-5 Estimated Incentive
109372601.2.3 – Pass 2 **2.8.1** **UTMB** **Physician Group Practice** Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency. **TPI#: 109372601**	This project will improve the efficiency of hospital bed capacity and throughput by developing and validating a fully integrated data model of UTMB Health's inpatient and emergency department utilization and patient flow. Using three systems modeling methodologies we aim to optimize the efficiency of inpatient utilization improvement efforts at UTMB and to eliminate sub-optimization (waste) and unintended consequences.	**109372601.3.8** **OD-5** Cost of Care **IT-5.3** "Other" Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1).	$9,686,693

SECTION III:

Community Needs Assessment

Section III: Community Needs Assessment

Region 2 determined that a current and comprehensive community needs assessment for the entire region was essential to the development of the region. The community needs assessment serves as an important point of reference for the region and helps in understanding of common issues.

Approach: The region took a multi-pronged approach, including quantitative and qualitative information gathered at the county level and presented from the regional perspective. Data was gathered from publically available sources and was compared to state and national benchmarks.

The **quantitative community health assessment (county profiles)**[1] were prepared by The George McMillan Fleming Center for Healthcare Management at the University of Texas School of Public Health, Houston (UT-SHP) with support from the Center for the Elimination of Health Disparities (CEHD)(UTMB) and the Texas Area Health Education Center (AHEC-East)(UTMB. The data illustrate the health status of individuals and communities. Data regarding health services delivery, health resources, and information regarding socio-cultural and environmental effects on individual and community health are also presented[2].

The **qualitative community health assessment**[3] was designed and conducted by the Texas Area Health Education Center (AHEC) East program. AHEC has worked in the 16 counties of Region 2 for 20 years and has connected with partners and other information resources seeking the ideas, opinions and perspectives of residents of the 16 county service area of Region 2. The qualitative community health assessment identifies what people believe about health issues, health services, and health resources in the community.

These reports were combined into an overall **county summary report**[4] by UT-SHP and made available to all counties, providers and the public by way of our Region 2 Texas Healthcare Transformation website and through open meetings held in four locations throughout the region. These meetings were facilitated by the researchers from the UT-SHP and included a presentation of the data, discussion, and additional input.

A **Region 2 Health Partnership Summary Report**[5] that analyzed the data across the region was provided by UT-SHP. This information was presented to the Region Steering Committee and made publically available. This report synthesizes the rich data and information collected for our 16 counties, served as the basis for creating our Summary of Community Needs, and guided providers in their project preparation.

---

[1] Individual county profiles are available on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp

[2] Documentation of Sources, Description of Data and General Notes was included in every county profile. An example of this 4 page documentation is included as supplemental material.

[3] Individual county qualitative community health assessments are available on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp

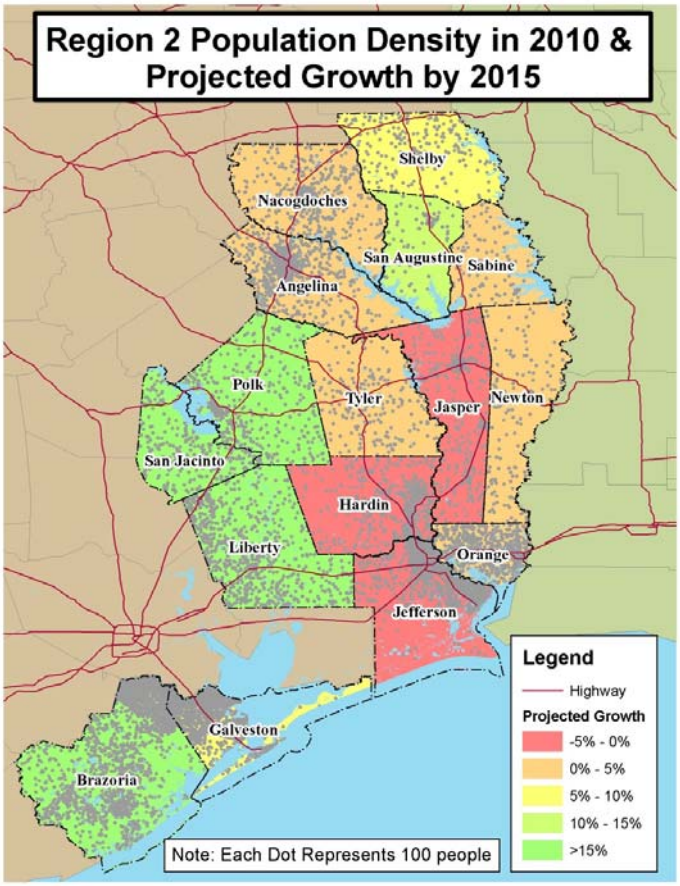
[4] Individual county summary reports are available on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp

[5] The Region 2 Health Partnership Summary Report is available on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp

Researchers from UT-SPH and the CEHD remain available to our region and have helped providers in checking that their projects address our community needs and assisted in the alignment of process, improvement, and quality measures.

Demographics:

Region 2 covers an area of 14,466.4 square miles covering 16 counties. The estimated population for 2012 is 1,458,495[6].Population density varies across the region as does our forecasted population growth.



The ethnicity[7] for Region 2 varies significantly from both Texas and the U.S.

Ethnicity	Region 2	TX	US
White	59.28%	44.12%	62.82%
Hispanic	19.51%	38.56%	16.99%
Black	16.29%	11.52%	12.25%
Asian/Pacific Islander	3.11%	4.04%	5.03%
2+ Races	1.29%	1.30%	1.98%
American Indian & Alaskan Native	0.39%	0.32%	0.73%
Other Non-Hispanic	0.12%	0.14%	0.20%

[6] Estimated June 2012 by The Neilson Company accessed through Thomson Reuters Market Expert.

[7] Ethnicity estimates are estimated 2012 from The Neilsen Company using Thomson Reuters Market Expert.

County specific ethnicity information is available in the County Profiles and in the Population Insurance Coverage & Ethnicity Estimates Summary Report provided as supplemental information.

Region 2 is older, on average, than Texas with a greater proportion of residents over the age of 45[8].

AGE DISTRIBUTION	Region Average	Texas Average	US Average
0-19	28.20%	30.40%	26.90%
20-44	32.70%	35.30%	33.60%
45-64	26.60%	24.10%	26.40%
65+	12.50%	10.40%	13.10%

The unemployment rate for three-quarters of the region is higher than the state average. For the majority of the region we have lower educational attainment than the Texas average. These disparities in education and employment contribute to lower income levels (13 of the 16 counties have a median household income less than the State average) and a greater proportion of the population living below the federal poverty line (12 of the 16 counties exceed the State average). Detailed information on age, employment, household income and educational obtainment is available in the County Profiles and in the Region 2 Health Partnership Summary Report[9]. **(CN.1)**

Other Demographic Characteristics	Range for the region	Number of counties worse than Texas average	Texas Average	US Average
Unemployment Rate (%)	5.5 - 10.9	12	7.00	**7.90**
ESL Not Proficient in English (%)	0.7 - 8.6	-	14.44	**8.60**
Did not complete HS (%)	14.1 - 28.6	7	20.00	**14.90**
With Bachelor's or higher (%)	8.6 - 26.3	14	25.80	**27.90**
Median HH Income ($)	31,729 - 64,242	13	48,622	50,046
Could Not see Doctor Due to Cost (%)	12.8-28.4	6	19.40	**14.60**
Living Below Poverty (%)	12.1 - 25.5	12	17.90	**15.30**

The economy of the region is based heavily on oil and natural gas, fuel processing, biomedical research, agriculture, and tourism. Natural resources range from the dense forest of East Texas to the sandy beaches along the coast. The region is home to two of the largest petrochemical complexes in the nation (Texas City and the Golden Triangle—Beaumont/Port Arthur/Orange) and also one of the world's largest chemical manufacturing complexes in the world (Brazoria County). There are strengths in diversified manufacturing and offshore production maintenance services. The region is home to some of the most fertile agricultural areas in the state and poultry, cattle, and timber industries help support the economies throughout East Texas[10].

[8] U.S. Census Bureau, 2010 Census summary File 1, Table P12. Note: Derived from 210 Census Summary file 1 data by the Texas state Data Center.

[9] The Region 2 Health Partnership Summary Report and the County profiles are available on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp

[10] See map of Land Cover provided in the supplemental materials for a topographical look at the region.

The region is home to four major ports that support industry, military deployment, tourism, and recreational boating. We support a large stretch of the Intercostal Waterway.
Parts of the region have large employers (ex., Dow Chemicals, Valero, Marathon Oil, Eastman Chemicals, University of Texas Medical Branch, Schlumberger Technology Corp, Chevron-Phillips) while others depend on hundreds of small businesses. State and federal government (universities and community colleges, corrections, Parks and Wildlife, Coast Guard, U.S. District Court) and local governments are also a significant employer for the region.
Incarceration has a significant role within the region. The average daily population for local jails is approximately 3,800. There are a number of state and federal prisons in Region 2, including a federal prison unit in Jefferson County (average census of 5,500) and state prison units in Angelina, Brazoria, Galveston, Jasper, Jefferson, Liberty, Polk and Tyler counties. These state correctional facilities house an estimated 25,000 prisoners.
The region is home to Texas' oldest Indian Reservation, the Alabama-Coushatta Tribe of Texas. Approximately 500 tribal members call 4,600 acres of timberland in Polk County their home.

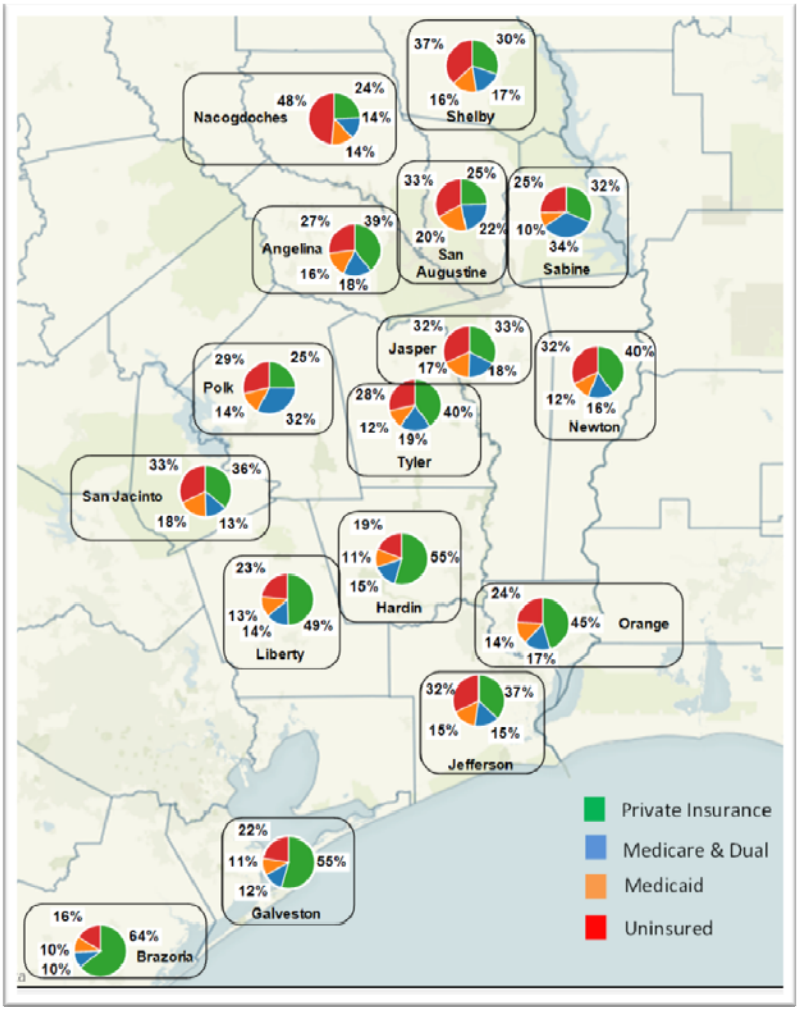
Insurance Coverage:

The insurance coverage estimates[11] for our region vary from both those in Texas and the U.S. Additionally, the insurance coverage estimates vary significantly across counties in our region. It should be noted that presentation of these numbers at the regional and county level does not adequately describe the community situation. For example, Brazoria County shows a high rate of private insurance and a lower rate of uninsured and Medicaid. However, the more affluent areas of the county who have high rates of insurance coverage and adequate access to healthcare are located predominately in the northern part of the county. Those who are uninsured and have Medicaid are located in the central and lower parts of the county where fewer physicians are located and many of these physicians do not accept Medicaid patients. **(CN.2)**

Payer Category	Region 2	Texas	U.S.
Private Insurance	47.89%	51.89%	55.37%
Medicaid	12.49%	13.29%	15.14%
Uninsured	25.19%	23.83%	15.56%
Medicare & Dual Eligible	14.42%	10.99%	13.94%

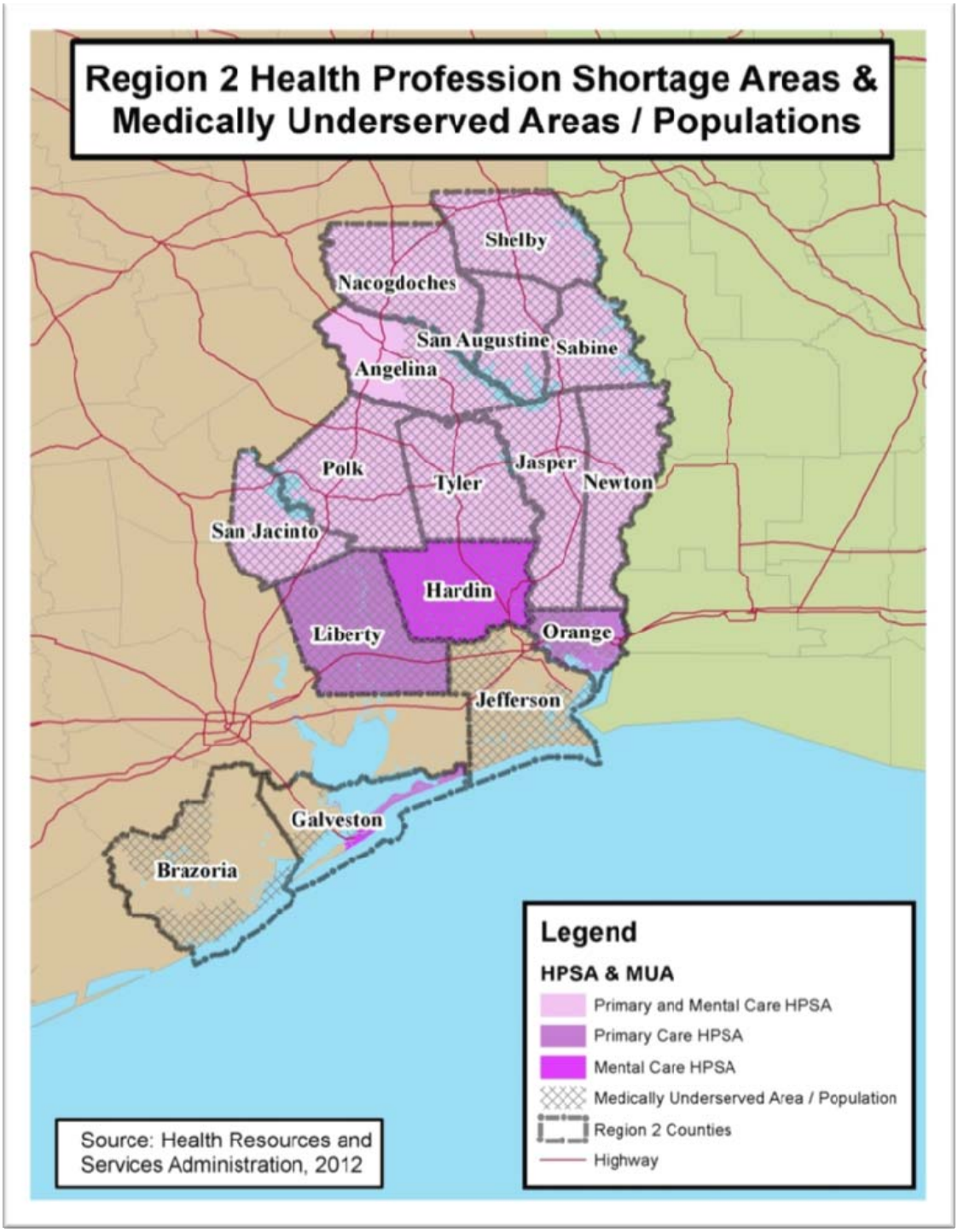
Insurance Coverage (Continued):

[11] 2012 Insurance coverage estimates come from Thomson Reuters Market Expert based on their proprietary methodology. There may be minor variations from the actual 2009 numbers for the uninsured and Medicaid populations provided in the County Profiles. The insurance coverage estimates information is provided in the supplemental materials in the Population Insurance Coverage & Ethnicity Estimates Regional Summary



<u>Current Healthcare Infrastructure:</u>

Current healthcare resources and infrastructure is inadequate to meet the needs of our region. The region is dominated by Medically Underserved Areas both in primary care and mental health and in health professional shortage areas. **(CN.3; CN.5)**


Region 2 Health Profession Shortage Areas & Medically Underserved Areas / Populations
Shelby
Nacogdoches
San Augustine
Sabine
Angelina
Polk
Tyler
Jasper
Newton
San Jacinto
Hardin
Liberty
Orange
Jefferson
Galveston
Brazoria
Legend
HPSA & MUA
Primary and Mental Care HPSA
Primary Care HPSA
Mental Care HPSA
Medically Underserved Area / Population
Region 2 Counties
Highway
Source: Health Resources and Services Administration, 2012

Both county and regional profiles illustrate that the current complement of providers in primary care and/or specialty services do not adequately serve the population. There is a particularly acute shortage in mental and behavioral health resources[12]. **(CN.3; CN.4; CN.5; CN.6; CN.8; CN.10)**

There is one Level 1 Trauma Center and three Safety-Net Hospitals to serve a region that is vulnerable to natural disaster, industrial accidents, infectious disease and potential terrorism[13]. Care for the indigent population is the responsibility of 16 different county programs. Eligibility for the programs and benefits covered by the programs varies from county-to-county.
According to The Dartmouth Atlas of Healthcare[14]the region has some of the highest cost of healthcare in the U.S. and a high 30 Day Readmission Rate. **(CN.11)**
There are four (4) separate Community Centers (MHMR) responsible the mental and behavioral health of varying portions of the region. There are five FQHCs located in the region and 20 rural health clinics. There are eight separate health districts responsible for sub-populations within the region and seven public health districts.

Key Health Challenges: Most communities in the region face similar health challenges. Detailed information on natality, health environment and behaviors, morbidity and mortality can be found in each of the county profiles[15]. Specific rates per 100,000 population and comparisons to TX and US benchmarks are documented in these profiles.
Common health challenges include obesity, diabetes, disability, hypertension, stroke and asthma and cancer. The region has some of the highest incidence for cancer in Texas and in the U.S. Many communities have high tobacco use and limited access to healthy foods. Throughout the region births to teen mothers is high as is the infant mortality rate. The rate of suicide is very high[16]. **(CN.12; CN.13; CN.14; CN.15; CN.16; CN.17; CN.18)**

BEHAVIOR				
	Range for Region	Number below Texas Average	Texas Average	US Average
Physical Inactivity (%)	25-35	15	24.5	28.0
Excessive Drinking (%)	5-18	1	16.2	14.0
Smokers (%)	18-29	7	18.5	21.0

[12] Tables for the number/rate of Primary and Specialty Care Physicians are provided as Appendix 4 in the County Profiles found on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp
[13] See Demographic section for information on industry and ports located in the region.
[14] Medicare Payments Per Enrollee by Adjustment Type & Program Component, 2008 http://www.dartmouthatlas.org/data/map.aspx?ind=188&ch=19%2c191&tf=7&loct=3&extent=-14071323.410590487%202305693.8872850095%20-7398676.589409513%206806306.112714991
[15] County Profiles found on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp
[16] Region 2 Health Partnership Summary Report is found on our Region 2 Texas Healthcare Transformation and Quality Improvement website http://www.utmb.edu/1115/CountyInformation.asp

COMMUNICABLE DISEASE MORBIDITY						
	Range for Region	Texas Average	US Average	Number below Texas average	Number in Bottom 25%	Number in Bottom 10%
AIDS Incidence Rate	2.6-13.9	9.2	11.2	2	3	2
Pertussis Rate	0.8-37.8	13.5	5.5	1	2	1
TB Rate	1.2-5.6	6.0	3.8	0	2	
Varicella Rate	1.2-92.3	17.9	6.7	3	2	1
Chlamydia Rate	131.1-553.7	467.3	409.2	2	4	
Gonorrhea Rate	13.4-205.3	124.0	99.1	3	4	2
Syphilis Rate	1.9-21.4	4.9	14.7	5	8	3

ENVIRONMENT				
	Range for Region	Number below Texas average	Texas Average	US Average
Limited Access to Healthy Foods (%)	1.6-36.3	6	11.6	10.0
Recreational Facilities Rate	0.0-9.6	11	7.2	8.0

MORBIDITY				
	Range for Region	Number below Texas average	Texas Average	US Average
Obese (%)	27.3-32.5	14	28.7	30.0
Diabetic (%)	9.3-13.4	16	9.0	10.9
Disability (%)	11.5-25.8	11	11.5	12.0
Physically Unhealthy Days	2.9-6.0	12	3.6	3.8
Mentally Unhealthy Days	1.2-6.4	8	3.3	3.5
Inadequate Social/Emotional Support	17.4-27.4	4	23.2	19.0

CANCER INCIDENCE RATES					
	Range for Region	Texas Average	Number below Texas average	Number in Bottom 25%	Number in Bottom 10%
All Cancer	425.7-554.4	451	13	4	5
Brain Cancer	6.0-10.2	6.6	6	5	5
Breast Cancer	37.1-70.9	62.1	2	1	1
Cervix Cancer	8.9-15.5	9.5	5	2	5
Digestive Cancer	63.4-104.2	83.8	12	5	3
Colon Cancer	38.9-62.3	44.2	13	5	4
Endocrine Cancer	6.6-14.1	11.5	2	4	1
Leukemia	11.0-16.9	13.3	7	6	1
Lymphoma	18.9-32.4	21.4	11	5	2
Mesothelioma	1.6-2.4	0.9	2		2
Oral Cancer	9.4-22.4	10.5	11	5	5
Prostate Cancer	117.4-221.7	141.8	13	8	3
Respiratory Cancer	68.3-106.0	68.6	15	3	5
Lung Cancer	58.9-97.8	63.8	15	5	5
Skin Cancer	13.8-27.9	14.8	12	7	4
Urinary Cancer	30.2-57.2	35.1	12	4	4

MORTALITY (rates per 100,000)						
	Range for Region	Texas Average	US Average	Number below Texas average	Number in Bottom 25%	Number in Bottom 10%
Aortic Aneurysm and Dissection	3.0-5.7	3.3	3.3	4	1	3
Cerebrovascular Disease	47.6-136.0	49.4	38.9	14	7	4
Liver Disease	10.2-18.2	11.5	9.2	5	4	1
Chronic Lower Respiratory Disease	39.4-72.5	43.3	42.3	15	5	2
Diseases of the Heart	201.5-295.2	201.0	180.1	16	8	2
Diabetes	16.9-36.6	26.0	20.9	8	3	
Hypertension	6.9-13.1	8.0	7.7	5	5	2
HIV Disease	2.2-9.5	4.1	3.0	2		3
Accidents	45.4-32.2	40.8	37.3	16	3	7
Assault	4.5-10.4	6.1	5.5	6	1	7
Intentional Self Harm	10.8-18.7	10.8	11.8	11	4	5

Participation in Federal Initiatives:

As part of our planning process, we asked stakeholders in RHP 2 to self-report any grants/funding by the U.S. Department of Health and Human Services. Below is a comprehensive list of what was provided.

The Spindletop Center:

- Pass-through grant from USDHHS to Texas Department for Assistive & Rehabilitative Services (DARS) for Early Childhood Intervention for children aged 0-2 who have developmental issues; some of this is Temporary Assistance for Needy Families (TANF) and some is Medical Assistance Program (Medicaid Title XIX)
- Pass-through grant from USDHHS to Texas Department of State Health Services (DSHS) for mental health services for children, adolescents, and adults; this includes Mental Health Block Grant, Title XX-Social Services Block Grant, TANF, and Programs for Assistance in Transition from Homelessness (PATH)
- Pass-through grant from USDHHS to South East Texas Regional Planning Commission for substance abuse programs for youth and adults; these are Block Grants for Prevention and Treatment of Substance Abuse.
- HITECH payments for EHR incentive.

Baptist Hospitals of Southeast Texas:

- Stage 1 90 day attestation period for the Medicare EHR incentive program in FFY 2013
- Behavioral Health Facelift
- Behavioral Health Admissions Renovation
- Emergency Department HIV Screening Program

Cleveland Regional Medical Center:

- Trauma Add-on to receive trauma funds

East Texas Community Health Center:

- Supplemental funding to help us toward PCMH; $35,000; year ends September 27, 2012.
- Applied for another PCMH Supplemental Funding opportunity, $60,000; we were told that the funds would be granted NLT Sep 30, 2012.
- Health Center Controlled Network (HCCN) with our state association (TACHC – TX Association of Community Health Centers) that is Transformation or Innovation funded.

The Medical Center of Southeast Texas:

- Receives federal funds on our hospital wide electronic medical records project, EHR, and after passing the attestation period.
- Participate in HRSA Grant for disaster planning.

Nacogdoches Memorial:

- Funding from the National Association of Chronic Disease Directors for the ACHIEVE program (Action Communities for Health, Innovation and Environmental Change). *This funding comes to Memorial Hospital from NACDD, but it goes to NACDD from CDC (as part of their healthy communities funding).*

The Gulf Coast Center:

- Mental Health Services Block Grant funding through its FY2012-2013 Mental Health Performance Contract with Department of State Health Services (DSHS).
- Substance Abuse Prevention and Treatment Block Grant funding through its FY2013 contracts with DSHS for Substance Abuse Treatment and Prevention Services.
  Whereas those served in these programs will be directly or indirectly impacted by the Center's DSRIP initiatives and the expanded and enhanced service opportunities proposed, and those programs will complement the Center's proposed DSRIP initiatives; none are included or duplicated in any of the Center's DSRIP proposed initiatives.
  The Center will maintain its contractual requirements for the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant funding as required.

Health Center of Southeast Texas:

- Receive funding from HRSA for our FQHC Grant.
- Indirectly, we employ 2 NHSC Loan Re-payers. They receive funds in the form of loan payments for their outstanding loans from their training to become physician assistants.

Sabine County Hospital District:

- Capital Improvement Grant funded through the Texas Department of Agriculture Rural Health Grant program
- Small Hospital Improvement Program grant funded through the Texas Department of Agriculture Rural Health Grant program.
- Participation in HRSA/NHSC loan repayment program for 2 mid-level providers.

The University of Texas Medical Branch at Galveston (UTMB) Faculty Group Practice:

- Primary and Specialty care expansion could earn EHR incentive payments.
- Ryan White funding is accessed in our HIV practice.

The University of Texas Medical Branch at Galveston (UTMB):

- Gait and Step Training to Reduce Falls in Parkinson's Disease
- Interdisciplinary Predoctoral Rehabilitation Research Training
- Physical Work Capacity After Traumatic Brain Injury
- PREPing to a Biomedical PhD
- Exercise and Quality of Life in Severely Burned Children
- NICHD Maternal Fetal Medicine Units Network
- Rehabilitation Research Career Development Program

The University of Texas Medical Branch at Galveston (UTMB): (Continued)

- Interdisciplinary Mentoring in Women's Health
- Interdisciplinary Women's Reproductive Health Fellowship (RHF)
- Texas Repository for AIDS Neuropathogenesis Research
- Galveston Global Health Consortium -Forgarty
- Understanding Mechanisms of Ethnic Disparities in Colorectal Cancer Screening
- Infectious Diseases and Inflammatory Disorders Training Program
- Psychological Well Being and Recovery Among Older Hospitalized Adults
- Underutilization of Surgical Resection in Patients with Pancreatic Cancer
- Continuity of Care and End of the Life ICU Use
- Obesity, Muscle Strength, and Disability in Older Mexican Americans and Elders from Latin America and the Caribbean
- Nutrition & Exercise to Improve Protein Metabolism & Prevent Sarcopenia in Aging
- Control of Colonic Motility in Health and Disease
- Culturally Competent Nurses in Community Health
- Longitudinal Study of Mexican American Elderly Health
- NHLBI Research Diversity Program at UTMB
- Model State-Supported Area Health Education Centers (MAHEC)
- UTMB WRHR Career Development Center of Excellence
- UTMB Claude D. Pepper Older Americans Independence Centers
- Hispanic Center of Excellence Medical Careers Diversity Program
- Student/Resident Experiences and Rotations in Community Health (SEARCH)
- UTMB Women's Health Research Scholars Program
- Residency Training in Primary Care
- Health of Older Minorities
- Maternal Fetal Medicine Units Network
- Advanced Education Nursing Traineeships
- Care of the elder hospitalized patient: the role of hospitalists
- EdTECH: Education Tools to Enhance Children's Health
- Hospital Readmission and Inpatient Medical Rehabilitation
- Assessing The Role of Nurse Practitioner in Primary Care of Older Adults

Tri-County Services:

- Title XIX – HCS, TxHmL ICF Medicaid Regular *
- Title XX – TANF **
- MH Block Grant **
- PATH **
- HOME **
- SA-Prevention **
- SA-Treatment **

  ** = includes both Federal and State Match*

  *** = Federal Pass through from Texas*

Shriners Hospital for Children, Galveston:

- UTHSC- Hypothermia Induced by Drug and Radiant or Conductive Cooling
- The Mayday Fund- Development of Systems for Evidenced Based Management of Pain, Anxiety and Itch in Children with Burn Injury
- International Association of Fire Fighters Burn Foundation-Measuring the Efficacy of Coping Techniques in Decreasing Pre-Operative Anxiety
- American Burn Association project grant -Community-Based Exercise Rehabilitation in Severely Burned Adults

Projected Major Changes in Community Needs during Waiver Period:

There are no foreseen major changes affecting our community needs assessment for the waiver period. Population is forecast to continue to grow. There are no new health care entities announced to enter the market place. Industry, employment, and tourism appear to be stable. The region would be impacted by another significant economic downturn that would raise unemployment and raise demand for Medicaid and the numbers of uninsured.

The possibility for a significant change to community needs is always present due to the region's vulnerability to hurricanes. Hurricane Katrina that impacted New Orleans in 2005 affected the region by increasing demand for services from evacuees and from changes to population that occurred by evacuees who decided to this region their permanent home.

Hurricane Ike which struck this region in September 2008 had an enormous impact on available healthcare resources to the region and to existing facilities. Demand went way up and available resources went way down. While the region has been resilient in recovery from Ike there still exists some post-storm mental health issues.

The region's aim during this waiver period is to create some major changes to the community needs by focusing on primary care and prevention service, chronic disease management, and coordination of care.

Summary of Community Needs:

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	**Access Barriers: Lack of Personal Resources** (Median Household Income: $31,729-$64,242, Unemployment Rate: 5.5-10.9, Living Below Federal Poverty Level: 12.1%-22.6%, Could Not See physician due to Cost: 12.8%-28.3%)	U.S. Census Bureau, Small Area Estimates Branch, Behavioral Risk Factor Surveillance System (BRFSS)
CN.2	**Access Barriers: Lack of Insurance** (Under 19: 13.2-20.7, Under 65: 21.2-29.9)	Small Area Health Insurance Estimates (SAHIE). U.S. Census Bureau and the Centers for Disease Control and Prevention
CN.3	**Primary Care Physician Shortage** (Physicians per 100,000: 7.0-97.2, Number of Primary Care HPSAs: 9 Number of Primary Care Partial HPSAs: 6, Preventable Hospital Admissions: 896.6-2459.1)	Texas Medical Board, US Department of Health and Human Services (HHSC), Health Resources and Services Administration (HRSA)
CN.4	**Specialty Care Physician Shortage** (Physicians per 100,000: 0.0-139.1)	Texas Medical Board, US HHSC HRSA
CN.5	**Mental/Behavioral Health Provider Shortage** (Number of Mental Health HPSAs:9, Number of Partial Mental Health HPSAs: 6, Rate of Licensed Psychologists per 100,000 pop. 8.2,	Health Resources and Services Administration (HRSA) Area Resource File (ARF), US HHSC HRSA, Health Professions Workforce Center, TX Department State Health

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
	Rate of Psychiatrists:4.2)	Services
CN.6	**Mental/Behavioral Health Facility Shortage** (Substance Abuse Facilities: 28, Detox Facilities: 5)	Substance Abuse and Mental Health Services Administration (SAMHSA)
CN.7	**Dentist Shortage** (Provider Rate per 100,000: 0.0-52.0, Number of Dentist HPSAs: 2, Number of Partial Dentist HPSAs: 9)	Texas State Board of Dental Examiners , US HHSC HRSA
CN.8	**Mid-Level Provider Shortage** (Provider Rate per 100,000: 0.0-73.4)	Texas Medical Board
CN.9	**Pharmacist Shortage** (Pharmacist Rate per 100,000: 17.4-91.2)	Texas State Board of Pharmacy
CN.10	**High ED Utilization Rates** (Rate per 100,000:17,461-78,955)	HRSA Area Resource File (Rates calculated using population data from US Census Bureau's Population Estimates Program)
CN.11	**30 Day Readmission Rates** (30 Day Readmission Rate: Medical: 16.0-18.3)	Dartmouth Atlas
CN.12	**Chronic Diseases: Diabetes** (Diabetes Prevalence: 9.3%-13.4%, Diabetes Mortality Rate per 100,000: 16.9-36.6)	National Center for Chronic Disease Prevention and Health Promotion (Calculated using BRFSS data);TX Department of State Health Services Death Statistics

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.13	**Chronic Diseases: Obesity** (Obesity Prevalence: 27.3%-32.5%, Physical Inactivity: 25%-35%)	National Center for Chronic Disease Prevention and Health Promotion (Calculated using BRFSS data)
CN.14	**Chronic Diseases: Heart & Vascular Related Diseases & Disorders** (Diseases of the Heart Mortality Rate per 100,000: 201.5-295.2, Aortic Aneurysm and Dissection Mortality Rate per 100,000: 3.0-5.7, Cerebrovascular Disease Mortality Rate per 100,000: 47.6-136.0, Hypertension Mortality Rate per 100,000: 6.9-13.1)	Texas Department of State Health Services Death Statistics
CN.15	**Chronic Diseases: Pulmonary Diseases** (Chronic Lower Respiratory Disease Mortality Rate per 100,000: 39.4-72.5)	Texas Department of State Health Services Death Statistics
CN.16	**Mental/Behavioral Health Related Mortality** (Accident Mortality Rate per 100,000: 45.4-32.2, Intentional Self Harm Mortality Rate per 100,000: 10.8-18.7)	Texas Department of State Health Services Death Statistics
CN.17	**Mental/Behavioral Health Related Morbidity** (Alcohol related admissions per 100,000: 313.7)	Texas Department of State Health Services Admissions data
CN.18	**Cancer Incidence (all)** (Incidence for all cancers range 425.7 to 554.4 (per 100,000)	Texas Cancer Registry, Cancer Incidence File

SECTION IV:

Stake Holder Engagement

Section IV: Stakeholder Engagement

RHP2 has evolved on principles of active engagement, inclusiveness, joint responsibility and transparency. During the early stages of the Texas Medicaid Transformation Waiver representatives from the University of Texas Medical Branch began reaching out to stakeholder groups throughout southeast Texas through both individual and group meetings. More than 220 contacts were made to discuss the new waiver. The focus of these early meetings was to introduce the new Texas Healthcare Transformation and Quality Improvement Program. The purpose of the new waiver was discussed and ideas about what it would mean for each stakeholder group and our communities were explored. There was open dialogue about what it would mean to become a health region and the implications this would hold for the future.
By early spring 2012 it was well established that our Regional Healthcare Partnership (RHP) would comprise 16 counties and that the University of Texas Medical Branch would serve as anchor. Efforts to connect with all stakeholder groups in these counties regarding the 1115 waiver were intensified and all stakeholders were encouraged to participate in the regional healthcare partnership and help in the development of a planning structure and process for the region.

A. RHP Participant Engagement

University of Texas Medical Branch (UTMB) formalized their role as anchoring entity (Anchor) for Region 2 and dedicated personnel and resources to focus on the transformation waiver and their responsibilities for communicating with HHSC, developing the participant network for the regional health plan, coordinating the regional health plan development process, providing opportunities for public input into the developing health plans and assuring that submission and reporting deadlines were met.

The region began to hold weekly general meetings. These meeting were held in League City which was as centrally located for our region as possible. All meetings were open to everyone's attendance and a teleconferencing option was available. Communication about the upcoming meetings was primarily handled by email with an agenda for the upcoming meeting distributed by the anchor on the Wednesday before the Friday meeting. These meetings focused on the local community needs assessment process for the regional plan and potential DSRIP projects. After several general meetings it was decided by the participating members that the region needed a steering committee that would provide leadership, set priorities, and make recommendations for the region.

A RHP2 regional steering committee (RSC) was created and members were selected by the general stakeholder group based on volunteers, existing relationships, and sensitivity to balancing the committee so that all stakeholder groups were represented and all counties had some form of representation. The RSC has 27 members[1] that include county officials (county judge, county commissioner, county government, and county indigent care program officer),

[1] See Appendix X for the RSC membership list.

representatives from the mental health authorities, county hospitals, health districts, Federally Qualified Health Centers, rural county hospitals, public hospitals, safety net hospitals, physicians, and large health systems[2]. The RSC as proved valuable in promoting dialogue among the various stakeholder groups. This dialogue promotes appreciation for the concerns and barriers faced by many of the stakeholder groups while helping to identify opportunities for collaboration and change.

The RSC meets on a bi-weekly schedule in League City and all meetings are supported by a teleconferencing option. Agendas for the meetings are sent out by the Anchor 2 days prior to the meeting[3]. Members of the RSC stay informed on all information updates as they are released from HHSC. The Anchor communicates with the RSC on an ongoing basis through phone, email and meetings. The RSC works together with the Anchor to assure that information is communicated broadly and in a timely manner. Members of the RSC are charged with communicating broadly with their stakeholder groups (i.e., across the whole region and between providers) and with their communities (includes all stakeholders group).

The Anchor has created multiple channels for communicating with the participants in our region[4]. A Texas Healthcare Transformation and Quality Improvement website[5] was created for the region and is a central means of communicating with participants and the public. The website offers an explanation of the waiver, provides updates on recent events and news, provides access to the community needs assessment information, projects considered for the health plan, and the RHP 2 Health Plan. The website provides contact information and a contact form so people can submit questions directly through the website. All general meetings held are announced on the website[6].

Technology plays an important role for Region 2's communication. Meeting support technologies, email distribution, collaborative file storage and sharing, and the website all are key to engaging participants.

RHP2 used the community needs assessment process (CNA) as an important engagement strategy. Bringing stakeholders together to focus on the needs of the community was a key step in developing a shared vision and goals for the region. Interviews were conducted with providers in each community to capture their knowledge on the gaps that existed between the

---

[2] 13 of the 16 counties have a designated member on the RSC and 3 represented by proxy. These 3 counties are rural, medically underserved counties who receive services from one of the performing providers who is a part of the RSC.

[3] Meeting agendas and sign-in sheets are available upon request.

[4] UTMB provides technology support as a community benefit to the region.

[5] http://www.utmb.edu/1115/

[6] General meetings of all participants continue to occur on a bi-weekly basis. Agendas and sign-in sheets are available upon request.

needs of the community and the available health resources. Four workshops[7] were held throughout the region for the purpose of reviewing the CNAs[8] and planning discussions on potential DSRIP Projects. The CNA identified the priority needs for the region as well as the local priorities. These priority needs crossed all stakeholder groups.

To further engage all participants in the health plan development process the RSC held a DSRIP Summit in August[9]. This was a two day meeting held at UTMB in Galveston. The Anchor hosted the meeting and provided technical support. All eligible groups were invited to present proposed DSRIP projects[10]. Twenty-two providers presented over 100 potential DSRIP projects to the RSC[11].

The RSC and Anchor worked with all providers to encourage DSRIP Project development and to broker IGT funds sharing. As providers determined their participation status and worked on the development of their DSRIP Projects, the Anchor offered a Protocol Consultation Team to assist. Information was shared broadly among all providers about the projects that were moving forward to encourage synergy and collaboration.

Going forward the Anchor will continue to provide the technical infrastructure to support communications such as the website, email distribution lists, and collaborative file storage and sharing. The Anchor will assure that all communications with HHSC are promptly communicated. Early in 2013 the RSC will hold a meeting to discuss lessons learned from developing the RHP2 Health Plan and formulate recommendations to all stakeholders on how best to further the region's development and meet the goals that the region has set. These recommendations will be shared with all of the region's stakeholders and will include approaches to leadership and engagement.

Two of the regional projects will directly promote further participant engagement. The Texas Regional Health Line will establish community-specific repositories of health resources that help create collaboration among local providers. The Collaborative to Enhance Performance Improvement and Reporting Capacity provides infrastructure for establishing learning/improvement collaborative that conduct, measure, report and drive quality improvement initiatives throughout the region.

---

[7] 7/12/12- Angelina, Nacogdoches, Sabine, San Augustine and Shelby Counties
7/19/12- Brazoria and Galveston Counties
7/25/12- Jasper, Newton, Polk, San Jacinto and Tyler Counties
7/26/12- Hardin, Jefferson, Liberty and Orange Counties

[8] See Section III for a full discussion on the CNA process, reports, and priorities.

[9] Agenda and sign-in sheets for the Summit are available upon request.

[10] The Summit preceded the release of the final planning protocol however the region had created a template for purposes of DSRIP planning which included most of the essential elements.

[11] See Addendum for list of all DSRIP projects considered which are not included in the RHP 2 Health Plan.

B. Public Engagement

The public and all stakeholder groups beyond regional health plan providers are important to the success of transformation for RHP2. UTMB started early in the process of meeting with a wide-range of people and groups to engage them in the transformation process. The RHP2 Transformation website[12] is designed to provide full and transparent information to the public on the region's development.

The RSC members were very serious in their public engagement efforts. They participated in ongoing meetings with their Board of Trustees, local medical societies, various local provider groups, area businesses, Chamber of Commerce, economic development groups, local media, faith-based organizations and employees. RSC members invited the public to attend the CNA workshop in their area. And the RSC members distributed public notices in their facilities directing people to go to the RHP2 Transformation website to read the DSRIP Projects and the RHP2 Plan as it was developed. A member of the RSC took responsibility for assuring that the Alabama-Coushatta Tribe of Texas stayed informed on RHP2 Health Plan development and had an avenue to participate if they chose[13].

Directly following the DSRIP Summit held in August the Anchor posted all projects presented on the website. Mass email distribution went out to alert people that the DSRIP Projects had been posted and encouraging comments to be submitted. Public meetings were held in September[14]and public notices of the meetings appeared in local newspaper announcing the meetings and encouraging people to attend. The meetings discussed the RHP2 Health Plan development, the DSRIP projects and provided information on how to stay informed about the region's development and participate in the process. Directions on how to access the RHP2 Transformation website and direct contact information for the Anchor was provided. All contacts coming through the website are immediately answered by the Anchor and shared with the RSC. Phone calls coming in through the centralized contact number are immediately routed for response. All incoming contacts whether by phone, contact form, email, or a relayed message[15] receive a prompt and personal response.

RHP 2 PUBLIC COMMENT PERIODS:	
10/22-10/26/12	POSTED FOR PASS 2 Comments
11/19-11/27/12	POSTED FOR PASS 2 and PASS 3 Comments
12/17-12/21/12	POSTED Proposed 12/31/12 Submission

[12] http://www.utmb.edu/1115/

[13] The Alabama-Coushatta Tribe of Texas uses the Indian Health Services. Local providers do provide emergency services and remain open to providing health services directly as needed and/or including members of the Tribe in their local initiatives.

[14] September 5, 2012 Beaumont, September 5, 2012 Nacogdoches, September 6, 2012 Galveston

See Addendum for public notices that appeared in the local newspapers.

[15] Delivered second-hand by someone who received the question/comment while participating in a community event or private discussion.

Ongoing engagement of the public remains a priority for the region. RHP2 is committed to full accountability and transparency as the region transforms. The Transformation website will remain a central vehicle for broadcasting information and allowing the public to comment. The RSC will include in their recommendations for the future of the region's development appropriate strategies for communicating with the public in an ongoing and consistent manner. The Anchor will continue to support inclusive and timely communications using a multi-channel approach.

RHP2 Regional Steering Committee

Charge: The RHP2 Regional Steering Committee (RSC) is formed as the key leadership body to guide the formation of the RHP2 Health Plan. Members of this group provide a voice for stakeholder groups throughout the region and adhere to the principles of active engagement, inclusiveness and transparency. The RSC is instrumental in setting the vision and goals for RHP2, assuring a robust community needs assessment process to guide goal setting and health plan development, and providing direct communication with the stakeholder groups they represent and their local communities.

Stakeholder Group(s)	County	Representative	Contact email
Academic Health Centers/CEO,EVP/Safety Net Hospital/Public	Galveston	Donna Sollenberger	dksoll@utmb.edu
Academic Health Center/Public Safety-Net Hospital/ Adm.	Galveston	Sandra Murdock	ssmurdoc@utmb.edu
County Commissioners	Jefferson	Bo Alfred	ealfred@co.jefferson.tx.us
County Judges	Angelina	Wes Suiter	wsuiter@angelinacounty.net
County Government	Brazoria	Cathy Sbrusch	cathys@brazoria-county.com
County Health Districts	Galveston	Lanny Brown	labrown@gchd.org
County Health Districts/Rural	Jasper-Newton	Danny Brackin	dannybrackin920@msn.com
County Health Districts/Hospitals/Adm.	Sabine	Diana Taylor	dtaylor@sabinecoutyhospital.com
County Regional Medical Center/Adm.	Shelby	Pamela Barton	pamelajeanbarton@hotmail.com
County Indigent Care Programs	Hardin	Lynda Davis	lynda.davis@co.hardin.tx.us
Critical Access Hospitals/Rural/CEO	Polk	David LeMonte	dlemonte@memorialhealth.org
Federally Qualified Health Centers	Brazoria	Mark Young	myoung@sfachc.org
Mental Health Authority	Angelina	Susan Rushing	susanr@burke-center.org
Mental Health Authority	Liberty	Cindy Sill	cindys@tricountyservices.org
Physicians/Workforce Development	Galveston	Ben Raimer, M.D.	braimer@utmb.edu
Private Non-Profit Association Representing Safety-Net Providers	Nacogdoches	Robin Moore	rmoore.etchs@tachc.org
Private Hospitals/CEO	Galveston	Stephen Jones	stephen.jones@hcahealthcare.com

Stakeholder Group(s)	County	Representative	Contact email
Private Hospitals/CEO	Jefferson	Matt Roberts	mroberts@iasishealthcare.com
Private Hospitals/Rural/CEO	Liberty	Steven Racciato	fghc1@sbcglobal.net
Public Health Districts/CEO, Hospital Adm.	Brazoria	Dave Bleakney	bleakneyd@admc.org
Public Health Districts/Planning and Programming	Brazoria	Paula Tobon-Stevens	stevensp@admc.org
Public Hospital/CEO, Adm.	Nacogdoches	Tim Hayward	hayward@nacmem.org
Rural Health Network Collaborative	San Augustine	Darlene Williams	dwilliams@memorialhealth.org
Rural Hospitals/CEO, Hospital Administration	Tyler	Sandra Wright, Ed.D.	swright@tchospitals.us
Rural Hospitals/CFO, Hospital Financing	Tyler	Richard Wallace	rwallace@tchospital.us
Safety Net Hospital/Private /Mission	Jefferson	Daniel Ford	daniel.ford@christushealth.org
Safety Net Hospital/Private /Financing	Jefferson	Gary Troutman	gary.troutman@bhset.net

SECTION V:

DSRIP Projects

SECTION V:

A. RHP Plan Development

Section V. DSRIP Projects

A. RHP Plan Development

RHP 2 values the level of engagement of our highly participatory membership. Recognizing the need for dedicated leadership to guide the development of the region, the membership selected a Regional Steering Committee (RSC) of representatives from all stakeholder groups. The RSC works closely with the Anchor in the development of the RHP 2 health plan and necessary processes to facilitate the activities of the region providers. The RSC also works closely with the membership to improve communications and promote provider information sharing and interaction.

The RSC promptly took on the task of assuring a robust community needs assessment (CNA) was performed for all communities in the region as well as for the region as a whole[1]. This CNA served as the starting point for the development of DSRIP projects by providers throughout the region.

In conjunction with the CNA activity the RSC working together with the region's membership developed a shared vision for the future.

> ***Region 2 targets a coordinated system of care that seeks to advance the health of the population, improve the patient experience and utilize resources in a more efficient, effective, and equitable manner.***

With this vision as focus and armed with the extensive insight gained from the CNA Region 2 developed four priority goals to address over the waiver period:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that include health promotion and disease prevention.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through learning collaboratives that promote best practices and the development of innovative solutions.
- Grow the health system resources for our region by expanding and enhancing training of the healthcare workforce at all levels of our future healthcare system.

Taken together these goals are the strategic direction chosen by our region as the best path forward for true transformation. These goals address the critical need to

- expand health care access and capacity for the region,

[1] See section 3 for a detailed description of our community needs assessment process, description of the region and references to the extensive community needs materials made available to all communities in the region.

- improve health through prevention services and chronic disease management, and
- promote a culture of quality and continuous learning.

With this strong set of a focused vision, strategic goals, and insight into community needs firmly in place, providers throughout the region were encouraged to develop projects that would have a significant positive impact on their community. Each and every provider was given general guidance that all projects must

- align with the vision for our region (address the triple aim),
- address targeted community needs,
- directly support the regional goals,
- assure consistency with the RHP Planning Protocol,
- promote transformation by stressing integration and synergy among providers,
- ensure that DSRIP payments do not duplicate federal initiatives funded by the U.S. Department of Health & Human Services, and,
- focus on outcomes by reflecting integration of the four categories.

The project development process was supported by the region's anchor who assured that the DSRIP Allocation Methodology, Program Funding and Mechanics Protocol, and the RHP Planning Protocol were well understood by all providers in the region. There was open discussion and dialogue about the DSRIP allocations throughout the health plan development process and there were multiple check points with the RSC to ensure adherence to Section VI of the Program Funding and Mechanics Protocol were being met. In the early stages of development providers retained flexibility in their valuation and how many projects they wanted to pursue as long as they followed the project guidelines.

RHP 2 held a 2 day DSRIP Project Summit[2] during which all providers came together and presented their proposed projects to the RSC[3]. This was an excellent opportunity to discuss projects and obtain feedback as well as to identify any project overlap or potential synergy between projects. As part of our region's ongoing commitment to engagement and transparency all projects reviewed at the summit were posted to our Region 2 Texas Healthcare Transformation website and available for review and comment[4].

Providers in the region continued to work on their projects and began to prioritize and refine projects based on the availability of IGT funding and local need. Upon release of the 430 page final Regional Healthcare Partnership Planning Protocol the anchor offered the services of protocol specialists[5] to assist regional providers in finalizing their projects. These protocol specialists assisted with milestone and measures selection and alignment as requested.

---

[2] Region 2 DSRIP Project Summit, August 28-29, 2012, Galveston, TX
[3] A complete list of projects considered by the region is available on our website.
[4] http://www.utmb.edu/1115/DSRIP.asp
[5] Faculty and researchers from the UTMB Center to Eliminate Health Disparities that undertook rapid processing of the newly released Regional Healthcare Partnership Planning Protocols. These volunteers provided a project

Moving toward the final selection of DSRIP Projects RHP 2 developed a shared framework for valuation.[6] This framework focused on four criteria to support the valuation process: population affected, severity of the health/healthcare issue, cost effectiveness, and community benefit. Use of this common framework supported providers in valuing their projects and making the final selection of projects to move forward.

Each IGT entity had autonomy over the decision of whether or not to fund eligible projects. There was continued dialogue among the providers in the region seeking to identify opportunities for project integration and synergy. Additionally the providers wanted to be sure that our entire region was involved in some way that would address the goals of the region. Providers worked with their IGT entities to select their Pass 1 projects. Projects that were chosen were then compiled and incorporated into the RHP 2 Health Plan.

Projects not included in Pass 1 remained with the performing providers for consideration in Pass 2. Pass 2 allows providers to develop and have projects funded that were not ready or chosen during Pass 1. Pass 2 projects were developed, valued and final selection made using the same process as was followed in Pass 1.

The protocol specialists who worked with the providers in the region were able to review all projects and help increase our understanding of the relationship between projects and between providers. This very detailed knowledge of the interrelationships in activities and among providers will serve to support the creation of key learning communities and quality improvement initiatives for the region[7].

RHP 2 is a Tier 3 level region which is required to have eight projects with four of those projects from Category 1 and four from Category 2. For our region's Pass 1 DSRIP we are submitting 58 projects 30 for Category 1 and 28 for Category 2. Fifteen different providers are participating in the PASS 1 DSRIP Projects.
Our region has met all eligibility criteria for proceeding to Pass 2. All of the safety-net hospitals in our region (3) are participating in DSRIP. We have exceeded the 15% percent participation from private hospitals as a Tier 3 region.
In RHP 2 there is only one hospital performing provider exempt from Category 4 reporting according to the criteria in paragraph 11.e in the Program Funding and Mechanics Protocol: Tyler County Hospital District TPI#: 136381405.

---

writing workshop and were available to work with providers throughout the region on fine-tuning their project information into the correct narratives and worksheets that addressed all of the required components.
[6] See Project Valuation narrative in Section V. B. for a full explanation of the valuation framework.
[7] Relationships between DSRIP Projects and Performing Providers, Region 2, Addendum B.

SECTION V:

B. Project Valuation

B. Project Valuation

Foundational to the *Texas Healthcare Transformation and Quality Improvement Program* is the DSRIP Pool and the development of a program of activity that develops a delivery reform and incentive plan that is based on broad collaboration of providers in the region committed to the simultaneous pursuit of the triple aim: better care for individuals (including access to care, quality of care, and health outcomes); better health for the population; and lower cost through improvement (without any harm whatsoever to individuals, families or communities)[1]. In order to determine success of these efforts the ability to measure and value outcomes is essential.

In RHP 2 extensive effort was expended to assure that all providers understood outcome measures and milestones as well as the importance of alignment between Category 1 and Category 2 process measures and improvement measures with the Category 3 outcome measures (quality improvement). Further linkage was made to the Category 4 population-focused improvement measures.

Once there was a shared understanding of the role and importance of outcome measures RHP 2 determined that we needed a shared framework to guide the valuation process. To develop this framework the region surveyed other health regions in Texas as to their approach for valuation and asked the George McMillan Fleming Center for Healthcare Management at the University of Texas School of Public Health (UT-SPH) for their recommendations on valuation criteria. The Regional Steering Committee reviewed and discussed the various approaches to valuation and the recommendations sent by UT-SPH. RHP 2 sought to adopt a RHP2 Valuation framework that

- satisfies all of the valuation provisions in the Program Funding and Mechanics Protocol,
- addresses the Triple Aim of the waiver, and,
- honors the vision and goals set forth for our regional health plan.

RHP 2 developed a unified regional approach to valuation based on four essential criteria:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are insured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

[1] Texas Healthcare Transformation and Quality Improvement Program, Demonstration Approval Period: Date of approval letter through September 30, 2016, page 39.

All RHP2 providers used this framework as the basis for determining the valuation of each of their projects. Once the overall value of the project was determined based on these criteria each provider determined the overall distribution of available DSRIP funding among their set of projects. Based on the overall valuation assigned to each individual project, each provider then assigned percent of valuation to each year's metrics, milestones, and performance outcomes.

In some cases valuations were larger than a provider's DSRIP allocation. Providers then made decisions whether or not to discount the valuation in order to include the project in the Region's plan. Some variance between similar projects may be due a valuation discount taken by a particular provider in order to add a project to the Region's plan. Any other variations between similar projects are due to differences in size of population targeted and the percent of the population that is uninsured and or Medicaid.

SECTION V:

C. Category 1: Infrastructure Development

PROJECT OPTION: 1.1.2- Expand Existing Pediatric Primary Care Capacity
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 121805903.1.1
PERFORMANCE PROVIDER/TPI: Angleton Danbury Hospital District/121805903
Expand Primary Care Capacity

- Provider: Angleton-Danbury Hospital District is a 64-bed hospital in Brazoria County serving 417.27 square mile area and servicing over 70,000 lives.
- Intervention(s): This project will expand the capacity of pediatric (18 years and younger) primary care to better accommodate the needs of the regional patient population and community.
- Need for the project: Angleton-Danbury Hospital District currently has only one pediatrician at capacity, averaging 40 patients a day and reaching retirement age.
- Target Population: The target population will be established by the number of increased visits to the outpatient clinic and a reduction in Pediatric Asthma Emergency Department visits.
- Category 1 or 2 expected patient benefits: To increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
- Category 3 outcomes: The project seeks to provide additional Pediatric services in DY4 and DY5 decreasing the Pediatric Asthma Emergency Department visits by accommodating the needs of the regional patient population and community, providing education and compliance for their chronic disease management. Offering additional pediatric primary care services in the community that is easily accessible for the pediatric population will promote improved disease management and decrease emergency room visits – as parents will seek care in the right setting.

PROJECT DESCRIPTION:
To expand the capacity of pediatric (18 years and younger) primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. The focus would be asthmatic pediatric population residing in the following zip codes: 77511, 77512, 77577, 77515, 77531, 77534, 77541, 77566, 77578, 77583, and 77486.

Category Project Area:
1.1 Expand Primary Care Capacity- Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

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

Challenges:

Some anticipated challenges are as follows: 1) Patient compliance- This is a huge concern so we are proposing to tie the navigation program and services to ensure that there is follow through and compliance with disease management strategies and 2) Patient education – this can be overcome by providing education in basic lay terms as well as having a bilingual caregiver in the clinic. We also have a high Medicaid/self pay population in the community. Expanding access to primary care in the community can help better serve this population as many primary care providers are no longer taking Medicaid patients.

The 5-year expected outcome(s):

Over the 5 year demonstration period it is expected that with the expansion of Pediatric Primary Care Services in the community we will reduce asthma related emergency room visits by at the end of the demonstration period. We will also see a significant increase in our pediatric patient population. By DY 5 we anticipate seeing a 30% increase in our baseline numbers established in DY 3 to 9,360 visits. With more access to primary care services, we also anticipate a reduction of pediatric related asthma ED visits by 20% by the end of DY5.

Relationship to Regional goals:

Our regional goal is to improve the health of our region by expanding and coordinating access to patient-centered primary care services that include health promotion and disease prevention.

STARTING POINT/BASELINE:

We have recruited an additional pediatrician to the community and he will start seeing patients on October 1, 2012. The office plans for expansion should be completed by mid-November 2012 and additional staff will be hired and trained. Baselines are being established. The current pediatrician is at capacity, and is averaging approximately 40 patients a day in the outpatient clinic.

RATIONALE:

RELATION BETWEEN PROJECT CHOICES AND COMMUNITY NEEDS

ADHD will recruit an additional pediatrician in partnership with an existing practice. In accordance with our Physician Development Plan, we have a critical, demonstrated need for additional primary care providers, particularly pediatricians. We currently only have one Angleton-based Pediatric Physician and he is quickly approaching retirement. We utilized several assessment tools to develop this Plan, including GMENAC (Graduate Medical Education Needs Assessment Council), external & internal surveys, Community Health Assessments as well as other statistical reports. Beginning in November the physical office space will be expanded to allow for additional patient exam rooms as the current clinic is at capacity. The physician, Dr. Edward Chang, has completed the credentialing process and will begin to see patients in mid October. Additional staff will be added to meet the demands of the growing patient population. Hours of operation will evaluated as they currently include evening and weekend availability.

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in

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

With the additional pediatrician ADHD will be able to provide age appropriate healthcare access to an increasing number of pediatrics in the right setting. Care would be provided in the most appropriate setting in a timely fashion. As many children leave the confines of the hospital district to receive primary care services, an additional pediatrician would allow for easier access, convenience, and more appropriate disease management and follow up care.

Unique Community Need Identification numbers:

CN.3: Primary Care Physician Shortage

CN.15: Chronic Diseases: Pulmonary Diseases

Expansion or enhancement:

We do not receive any DHHS funding

RELATED CATEGORY 3 OUTCOME MEASURE(S):

In accordance with our Physician Development Plan, we have a critical, demonstrated need for additional primary care providers, particularly pediatricians. We currently only have one Angleton-based Pediatric Physician and he is quickly approaching retirement. We utilized several assessment tools to develop this Plan, including GMENAC (Graduate Medical Education Needs Assessment Council), external & internal surveys, Community Health Assessments as well as other statistical reports. There are a limited number of providers that accept new patients and not many that accept Medicaid.

Due to numerous environmental factors, individuals with Asthma related conditions are apt to experience an exacerbation of their condition. The American Lung Association (2006 State of Air Report) reports that Brazoria County received an ozone grade of “F” for air quality and the biggest population at risk is Pediatric Asthma patients. Asthma is a serious environmental health threat, but it can be controlled by taking medication, education, and seeing a primary care physician.

With the additional pediatrician, ADHD anticipates more appropriate disease management strategies as well as care being delivered and offered in the most appropriate setting. With Asthma being a prevalent disease in the community – we anticipate with proper management, care, and education there will be a reduction in Pediatric Asthma Emergency Department Visits (IT-9.3).

If these patients are not properly managed by their PCP or pulmonary specialist, an exacerbation can result in extreme reactions – resulting in visits to ED, urgent care, or requiring costly inpatient admissions.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding primary care capacity and emphasis on pediatrics, access to services, and receiving the right care at the right time in the right settingties to these Category 1 and 2 projects in our RHP: 136381405.1.1, 121805903.1.1, 094092602.1.1, 094092602.1.3, 094092602.2.2, 136367307.1.1, 284333601.1.1, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; -; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The addition of the pediatric primary care practitioner will expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. 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. 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.

The expansion of the pediatric clinic will fill the need for pediatric primary care services in community. Additional primary care services will allow individuals to receive services in a timely manner in the most appropriate setting. The project will promote education and chronic disease management so that individuals will be less likely utilizes more expensive healthcare option such as the ED, urgent care, or inpatient admissions.

Brazoria County is the 5th fastest growing and is among the largest counties in Texas. The current Angleton based pediatrician is a sole practitioner in the community and is near retirement age. His practice is at capacity and is among the few pediatric Medicaid providers. Southern Brazoria County has a Medicaid population of 26,303 and an uninsured population of 43,471.By adding an additional pediatrician to the community, individuals will be able to stay close to home while alleviating some of the demands on our current pediatrician.

The Community Needs Assessment clearly supports the needs for this project. Access Barriers (lack of personal resources and lack of insurance), primary care physician shortage, and high chronic disease are proven factors within the community. Because of the demonstrated need of primary care, high Medicaid population, and explosive growth in the community – it was evident that this addition would add value to the community.

Providing the targeted population with proactive care early on in their chronic condition, this will result in savings if the condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring and treatment, ADHD anticipates a reduction in Pediatric Asthma Emergency Department Visits.

Currently, Angleton Danbury Hospital District is not receiving any additional federal funding to support this project.

121805903.1.1	1.1.2	1.1.2 A, B,C	EXPAND EXISTING PEDIATRIC PRIMARY CARE CAPACITY
Angleton Danbury Hospital District			TPI -121805903
Related Category 3 Outcome Measure(s):	*121805903.3.1*	IT-9.3	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)
Milestone 1 (P-5) Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric: P 5.1.Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Milestone 1 Estimated Incentive Payment: $314,352	**Milestone 2** P-4. Milestone: Expand the hours of a primary care clinic, including evening and/or weekend hours Metric: P-4.1.Increased number of hours at primary care clinic over baseline a. Data Source: Clinic documentation b. Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients. Milestone 2 Estimated Incentive Payment: $205,765 **Milestone 3** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period b. Data Source: Registry, EHR,	**Milestone 4** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1: I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: Increase baseline numbers by 15% from DY 3 to 8,280 visits Data Source: Performing Provider document Milestone 4 Estimated Incentive Payment: $343,939	**Milestone 5** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1: I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: Increase baseline numbers by 30% from DY 3 to 9,360 visits Data Source: Performing Provider document Milestone 5 Estimated Incentive Payment: $284,123

121805903.1.1	1.1.2	1.1.2 A, B,C	EXPAND EXISTING PEDIATRIC PRIMARY CARE CAPACITY	
Angleton Danbury Hospital District				**TPI -121805903**
Related Category 3 Outcome Measure(s):	*121805903.3.1*	IT-9.3	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)**
	claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Baseline numbers: 7,200 visits Milestone 3 Estimated Incentive Payment: $137,176			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $314,352	Year 3 Estimated Milestone Bundle Amount: $342,942		Year 4 Estimated Milestone Bundle Amount: $343,939	Year 5 Estimated Milestone Bundle Amount: $284,123
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,285,355				

PROJECT OPTION: 1.1.2 - Expand existing Primary Care Clinics – PRIMARY CARE CLINIC Expansion

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 121805903.1.2

PERFORMANCE PROVIDER/TPI: Angleton Danbury Hospital District/121805903

- Provider: Angleton-Danbury Hospital District is a 64-bed hospital in Brazoria County serving 417.27 square mile area and service area of over 70,000 covered.

- Intervention(s): This project will expand the capacity of primary care services in the community, chronic disease management, education, and services that can be provided in the most appropriate setting in a timely manner.

- Need for the project: Angleton-Danbury Hospital District currently has few primary care physicians, who are at capacity and no longer accepting Medicare and or Medicaid patients. We currently have 8 primary care physicians in which only 1 family practitioner is accepting new and Medicaid patients along with 1 Internal Medicine physician who is accepting Medicaid.

- Target Population: The target population will be established by the number of increased visits to the outpatient clinic and a reduction in unnecessary emergency department visits. Over the past 12 months the clinic has seen over 1,500 patients that have resulted in 1,787 visits. These patients have a higher acuity with many comorbidities as evidenced in our community needs assessment.

- Category 1 or 2 expected patient benefits: To increase primary care clinic volume of visits and evidence of improved access for patients seeking services. DY 4 will show a 15% Medicaid/Indigent/uninsured case load and DY 5 will reflect a 20% Medicaid/Indigent/uninsured case load. With the increase availability of primary care we anticipate seeing fewer individuals with poor A1c control in the targeted population.

- Category 3 outcomes: The project seeks to provide additional Primary Care services in DY4 and DY5 by improving education and chronic disease management in the community. Improved access to primary care will result in early diagnosis and intervention decreasing unnecessary hospitalization and other associated complications.

PROJECT DESCRIPTION:

ADHD will expand the Primary Care Clinic to help relieve the over burdened healthcare system and lack of primary care within the community. This primary care clinic will service the following zip codes: 77511, 77512, 77577, 77515, 77531, 77534, 77541, 77566, 77578, 77583, and 77486.

Category Project Area

1.1.2 Expand Primary Care Capacity

Project Goal(s):

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

Challenges:

Some challenges identified in this program are as follows: 1) securing a competent/skilled workforce. Aggressive recruiting and training of the workforce will be essential in overcoming this challenge. We will also look to secure a mid-level practitioner to the clinic. 2) Patient compliance- This is a huge concern so are proposing to tie the navigation program and services to ensure that there is follow though and compliance with disease management strategies. 3) Patient education – this can be overcome by providing education in basic lay terms as well as having a bilingual caregiver in the clinic.

The 5-year expected outcome(s):

By the end of the waiver period we anticipate improved chronic disease management in the targeted diabetic population as evidenced by more appropriate A1c levels using IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure) We will accomplish this by offering more aggressive education and monitoring to ensure compliance of the diabetic disease management process to patients. We will also have skilled workforce to manage the disease and increased number of available primary care appointment times. Current baseline visits are at 1,787 and by DY 5 we anticipate an increase to 3,306 visits which is an 85% increase from baseline.

Relationship to Regional Goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

A business plan, architectural / construction documents, construction, recruiting plan, and staffing plan have been developed and completed to ensure the success of this project in DY 1. Baseline data was established through DY 2 as 1,787 visits which was pulled from the office EHR. The initial information collected for DY 1 reflects patients of higher complexity with numerous complications and co morbidities requiring extensive care management. The clinic services individuals in Southern Brazoria County - a region in which there is a demonstrated need for primary care services (CNA). 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. We feel the combination of adding these services on a mobile wellness bus will provide and assist with the growing healthcare needs in the region as demonstrated in the CNA.

A primary care clinic in the community would provide a more cost effective means for care in the region – the right care in the right setting. The primary care clinic will have a significant impact on the ED visits and alleviate the congestion in the waiting and treatment areas. After the establishment of the clinic in DY 3, the positive impact (decrease in ED visits) will be seen in DY 4 and DY5. Resulting in an increase of patient visits by 85% over baseline.

RATIONALE:

Relation between Project Choices and Community Needs:

Our project option for the Expansion of Primary Care Capacity is: 1.1.2 Expand existing primary care capacity. There are 3 essential core components to this project: 1.1.2a Expand Primary Care Clinic Space, 1.1.2b Expand Primary Care Clinic Hours, and 1.1.2c Expand Primary Care Clinic Staffing. 1.1.2a was completed in DY1, 1.1.2b will be reviewed and additional hours will be implemented in DY 3, and 1.1.2c will be addressed with the hiring of a midlevel practitioner and support staff in DY2.

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

It is well known the national supply of primary care does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER care. RHPs are in real need of expanding primary care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

We are following the required project option for this program: 1.1.2
In DY 1 the Health Focus Clinic opened for operation. This allowed for more primary care services in the region.
In DY 1 space was reconfigured and office spaces along with treatment areas were customized to meet the needs of the new clinic operations. A Board Certified Internal Medicine Physician was recruited as well as support staff. This clinic has expanded the capacity of primary care to better accommodate the needs of the regional patient population and community. Patients have increased access to services allowing them to receive the right care in the right setting. The clinic accepts Medicare/Medicaid (among the few in the community) along with serving the indigent and uninsured population. Numerous things were accomplished in DY1 to make the clinic functional and operational.
In DY2 we gathered baseline information of 1,787 visits and will expand clinic staffing to include a mid-level practitioner and additional support staff (P-5). DY3 we will expand the hours of the primary care clinic, to include more appointment availability (P-4). The data source for this information will be clinic documentation. The metric used will be the increased number of hours at primary care clinic over baseline (P-4.1). Our improvement metric for DY 3 will be to increase primary care clinic volume of visits and offer improved access for patients seeking service (I-12). The metric used for this improvement target would be the documentation of increased number of visits. The data source for this metric would be the EHR (I-12.1). DY 4 and DY 5 we will continue to increase the primary care clinic volume of visits and demonstrate evidence of improved access for patients seeking services (I-12). The metric will be the documentation of increased number of visits (I-12.1) which by DY5 would be an increase of patient visits by 85%, expanded hours, and additional providers to impact the health status of our community. This clinic will also tie directly as a referral source for our patient navigation project.

Unique Community Need Identification numbers:

CN.1 Access barriers: lack of personal resources
CN.2 Access barriers: lack of insurance
CN.3 Primary Care shortage
CN.8 Mid-level Provider Shortage
CN.10 High ED Utilization Rates
CN.12 Chronic Disease: Diabetes
CN.13 Chronic Disease: Obesity

Expansion or enhancement:

The expansion of the existing primary care is a new initiative by the hospital district and we currently do not receive any State or Federal funding for this project.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Outcome Domain 1 – Primary Care and Chronic Disease Management was selected in conjunction with the chosen Category 1.1.2 Project of expanding existing primary care services because 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.

We will utilize Improvement target [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) - NQF 0059

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: Diabetes is prevalent and costly with severe complications and can be controlled

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.

With the high incidence of diabetes in the community (according to the CNA), uncontrolled diabetes can be managed by taking appropriate pro-active steps to avoid conditions that can lead to expensive care in the ED and inpatient settings. With the help of the increased access to primary care services to the targeted population who are at high risk, we will be able to provide adequate preventative care services – leading to the right care in the right setting. The baseline population for this measure will be gathered though the electronic medical record.

We will continue to monitor and expand the target group end of the waiver period. The overall goal is to decrease the number of individuals with poor A1c control in the targeted population while increasing the primary clinic volume.

A primary care clinic in the community would provide a more cost effective means for care in the region – the right care in the right setting.

An additional primary care clinic will have a significant impact on chronic disease management and alleviate unnecessary congestion in the ED waiting and treatment areas. After the establishment of the clinic, a positive impact should be seen in the disease management of our targeted population.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding primary care and emphasis on receivng care in the right setting ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, , 284333601.1.1, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; -; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning

collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The expansion of primary care services would add much value to the community – especially to the targeted diabetic population. The project will help bridge the primary care gap in the community so that there is increased access and availability for the right care in the right setting.

Brazoria County is the 5th fastest growing county in Texas and is among the largest counties in Texas. We will serve both the Medicaid and uninsured population through various outreach strategies while targeting high risk individuals. The community needs assessment supports the demand for this project. Access barriers (lack of personal resources and lack of insurance), Primary Care Physician Shortage, and High Chronic disease are proven factors within the community. According to the Community Needs Assessment, we have a high identified diabetic population and many that may currently be undiagnosed and unmanaged.

Providing the targeted population with proactive care early on in their disease process will result in savings if the patient condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring, and screening, ADHD anticipates a reduction in our Diabetic related complications.

Currently Angleton Danbury Hospital District is not receiving any additional federal funding to support chronic disease management.

121805903.1.2	1.1.1	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CLINICS – PRIMARY CARE CLINIC EXPANSION***
Angleton Danbury Hospital District			***121805903***
Related Category 3 Outcome Measure(s):	*121805903.3.2*	3.IT-1.10	IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)-

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015-9/30/2016)**
Milestone 1 (P-5) Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Hired bilingual medical assistant for clinic operations. P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Milestone 1 Estimated Incentive Payment: $147,930 Milestone 2: I-12: Increase primary care clinic volume of visits and evidence of	**Milestone 3**: I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Increase visits by 32% based on DY 2 numbers to 2,359 visits b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Milestone 3 Estimated Incentive Payment: $322,769	**Milestone 4** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services <u>Metric 1</u>: I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: Increase visits by 77% based on DY 2 numbers to 3,163 visits Data Source: Performing Provider document Milestone 4 Estimated Incentive Payment: $323,707	**Milestone 4** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services <u>Metric 1</u>: I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: Increase visits by 85% based on DY 2 numbers to 3,306 visits Data Source: Performing Provider document Milestone 5 Estimated Incentive Payment: $267,410

121805903.1.2	1.1.1	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CLINICS – PRIMARY CARE CLINIC EXPANSION***
Angleton Danbury Hospital District			***121805903***
Related Category 3 Outcome Measure(s):	*121805903.3.2*	3.IT-1.10	IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)-

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015-9/30/2016)**
improved access for patients seeking services. Metric I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period: 1,787 visits (baseline) b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Milestone 2 Estimated Incentive Payment: $147,931			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $295,861	Year 3 Estimated Milestone Bundle Amount: $322,769	Year 4 Estimated Milestone Bundle Amount: $323,707	Year 5 Estimated Milestone Bundle Amount: $267,410
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,209,746			

PROJECT OPTION: 1.1.2 Expand Existing OB/GYN Primary Care
UNIQUE RHP PROJECT IDENTIFICATION NUMBER 121805903.1.3-Pass 3
PERFORMING PROVIDER NAME/TPI: Angleton Danbury Hospital District / 121805903

Title of project 1.1.2 Expand existing OB/GYN primary care capacity
Provider: Angleton-Danbury Hospital District is a 64-bed hospital in Brazoria County serving 417.27 square mile area and a primary service area of over 70,000 lives.
Intervention(s): This project will expand the capacity of primary care services – particularly obstetrics and gynecological services - in the community, prenatal care management, and education that can be provided in the most appropriate setting in a timely manner.
Need for the project: Angleton-Danbury Hospital District currently has 2 OB/GYNs who are at or beyond capacity. Their patient population is 75% Medicaid, indigent, and self-pay. Much of the region is medically underserved.
Target Population: The target population will increase and have improved access as evidenced by a 15% increase in outpatient clinic visits in DY 4 and 30% increase in DY 5. Improved access to OB/GYN services will also help in the reduction of early elective deliveries and increase early breast cancer screening. Southern Brazoria County has a significant number of Medicaid and uninsured. Medicaid enrollees total 26,303 and the uninsured population is 43,471. One additional OB/GYN and an additional midwife will help to alleviate the current burden on the system and provide proper care and education on various healthcare needs. Currently 75% of the payor mix in the labor and delivery unit is Medicaid, Indigent, and Self Pay.
Category 1 expected patient benefits: To increase primary care clinic volume of visits and evidence of improved access for patients seeking services. With the increase availability of primary care we anticipate improved prenatal care and education. The target population will increase and have improved access as evidenced by a 15% increase in outpatient clinic visits in DY 4 and 40% increase in DY 5 totaling 12,460 visits.
Category 3 outcomes: The project seeks to provide additional Primary Care services in DY4 and DY5 decreasing the number of early elective deliveries, therefore promoting improved health for both the mother and baby. Decrease in early elective deliveries will result in fewer complications resulting in healthier infants and lower healthcare costs. Southern Brazoria County has a significant number of Medicaid and uninsured. Medicaid enrollees total 26,303 and the uninsured population is 43,471. Baseline deliveries >=37 and <39 weeks is 121 in DY 2. The goal will be to see a 10% reduction in elective deliveries by DY5 from the baseline numbers established in DY 2.
By DY 5 we also anticipate completing 140 mammograms to Medicaid, indigent, and uninsured individuals within the community. Studies have shown that low social economic/low income status are important predictors associated with low rates of regular mammography screening and delayed diagnosis and treatment of breast cancer resulting in poor outcomes.

Category Project Area:
1.1.2 Expand Primary Care Capacity- Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Project Description:

To expand the capacity of OB/GYN primary care services to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. The focus would be on the residents residing in the following zip codes: 77515, 77541, 77534, 77583, 77531, and 77541. Brazoria county's Medicaid Enrollee numbers are 26,303 and uninsured 43,471 individuals.

Project goal(s):

Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Projects plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care. The project focus will impact the high number of Medicaid, uninsured, and indigent within the community. Southern Brazoria County has a significant number of Medicaid and uninsured. Medicaid enrollees total 26,303 and the uninsured population is 43,471.

Anticipated challenges:

Some anticipated challenges are as follows: 1) Physician Recruiting – it has been challenging to recruit experienced OB/GYN and midwife to fill the need in the community. This can be overcome by initiating relationships with recruiting firms that will aggressively look for physicians to join a busy practice. 2) Patient compliance with prenatal care – this can be overcome by providing education in basic lay terms as well as having a bilingual caregiver in the clinic. Having an additional OB/GYN and midwife on staff will also promote improved access for scheduling. OB/GYNs can also provide community education on the importance of prenatal care and wellness to promote health and wellness for the patient and baby. We have a high Medicaid/self pay population in the community. Expanding access to primary care in the community can help better serve this population as many primary care providers are no longer taking Medicaid patients.

The 5-year expected outcome(s):

Over the 5 year demonstration period it is expected that with the expansion of OB/GYN Primary Care Services in the community we will reduce the number of early elective deliveries by at the end of the demonstration period. OD: 8 IT – 8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone measure) We will also expect to see a significant increase in our OB/GYN patient population. With the significantly high Medicaid population in the community, we anticipate seeing a 30% increase in patient visits by DY5 and a 10% reduction in our early elective deliveries by DY 5. By DY 5 we also anticipate completing 140 mammograms to Medicaid, indigent, and uninsured individuals within the community. Studies have shown that low social economic/low income status are important predictors associated with low rates of regular mammography screening and delayed diagnosis and treatment of breast cancer

resulting in poor outcomes (OD 12 Primary Care and Primary Prevention – IT-12.1 Breast Cancer Screening (HEDIS 2012).

Regional goals

Our regional goal is to improve the health of our region by expanding and coordinating access to patient-centered primary care services that include health promotion and disease prevention.

Starting Point/Baseline:

According to the CNA the region is medically underserved. OB/GYN primary care falls under that category. GMNEC data statistics support the need for 5 additional OB/GYNs in our service area. We currently only have 2 male OB/GYNs. An aggressive physician recruitment plan was approved and recruitment efforts are under way. The additional OB/GYN will be recruited to an existing practice where the baseline of patient visits for DY2 was 8,900.

Almost 75% of the payor mix in the labor and delivery unit is Medicaid and Self Pay.

Rationale

Relation between Project Choices and Community Needs:

1.1.2 Expand existing primary care capacity

Required core project components:

a) Expand primary care clinic space – We plan to expand current space to accommodate additional practitioners. The new space will be approximately a total of 5,000 sq/ft.

b) Expand primary care clinic hours- This will be evaluated and revised with the additional case load to provide further access. Additional appointment times will be added.

c) Expand primary care clinic staffing- we plan to hire an OB/GYN in DY 2 and midwife in DY 4 along with additional support staff in DY 2 – 4.

To meet these requirements we plan to implement the following process and improvement milestones:

Year 2:

Milestone P-5: Train/hire additional OB/GYN provider and staff. P 5.1.Documentation of increased number of providers and staff and/or clinic sites. Metric: staffing charts a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation b. Rationale: Additional staff members and providers will be necessary to increase capacity to deliver care. The baseline in DY2 is 8,900 visits.

Year 3

P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours as justified by the growing case load. Metric: P-4.1.Increased number of hours at primary care clinic over baseline a. Data Source: Clinic documentation b. Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients.

I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing

Provider to increase capacity to provide care. DY 3 volume will increase by 15% from DY 2 to 10,235.
Year 4 and 5
I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1: I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: DY 4 will show an increase case load to 10,235 visits – 15% increase from DY3 established baseline measures. Data Source: Performing Provider document

ADHD will recruit an additional OB/GYN and a midwife in partnership with an existing practice. In accordance with our Physician Development Plan, we have a critical, demonstrated need for additional primary care providers. We currently only have two Angleton-based male OB/GYNs. We utilized several assessment tools to develop this Plan, including GMENAC (Graduate Medical Education Needs Assessment Council), external & internal surveys, Community Health Assessments as well as other statistical reports.

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. With the additional OB/GYN and midwife ADHD will be able to provide appropriate healthcare access to an increasing number of ladies and expectant mothers in the right setting. Prenatal care would be provided in the most appropriate setting in a timely fashion. As many ladies leave the confines of the hospital district to receive primary care services, an additional OB/GYN and midwife would allow for easier access, convenience, and more appropriate disease management and follow up care.

Unique Community Need Identification numbers:
CN.1: Access Barriers: Lack of Personal Resources,
CN.2: Access Barriers: Lack of Insurance
CN.3: Primary Care Physician Shortage
CN.8: Mid-Level Provider Shortage
CN 10: High ED Utilization
CN 18: Cancer Incidence

Expansion or enhancement

This project will enhance our primary care program. We do not receive any DHHS funding.

Related Category 3 Outcome Measures:

IT-8.3: Early Elective Delivery (Medicaid Core Measure/NQF #469)
Improvement Target: Reduction in Early Elective Deliveries
Data Source: EHR

Studies have shown that babies born two to three weeks before their due date have a higher risk of health problems. Studies have also shown that a baby's brain at 35 weeks weighs only two-thirds of what it will weight at 39 to 40 weeks. Elective deliveries can also lead to higher healthcare cost due to being medically riskier.

With an additional OB/GYN and midwife, ADHD anticipates more appropriate and timely prenatal care management as well as care being delivered and offered in the most appropriate setting. With elective deliveries before 39 weeks being a prevalent risk to newborns nationwide – we anticipate with prenatal care management and education there will be a reduction in Early Elective Deliveries (IT-8.3).

Relationship to other Projects:

This project's focus on primary care services, and emphasis on pediatric, and obstetric services ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 121805903.1.3, 284333601.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; -; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared

learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The addition of the OB/GYN and midwife primary care practitioners will expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. 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. By enhancing access points, available appointment times, patient awareness of available services and overall OB/GYN 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.

The expansion of the OB/GYN clinic will fill the need for obstetrical services in community. Additional primary care services will allow individuals to receive services in a timely manner in the most appropriate setting. The project will promote education and prenatal care management so that individuals will be less likely utilizes more expensive healthcare option such as the ED, urgent care, or inpatient admissions.

Texas has the highest percentage of uninsured in the nation at 23.8%. Brazoria County is the 5th fastest growing and is among the largest counties in Texas. Brazoria County Medicaid population is 26,303 with the uninsured population just over 43,000. The current Angleton based OB/GYNs are at and beyond capacity. Both practices are at capacity and are among the few Medicaid providers. By adding an additional OB/GYN to the community, individuals will be able to stay close to home while alleviating some of the demands on the current OB/GYNs. The Community Needs Assessment clearly supports the needs for this project. Access Barriers (lack

of personal resources and lack of insurance), and primary care physician shortage. Because of the demonstrated need of primary care, high Medicaid population, and explosive growth in the community – it was evident that this addition would add value to the community.

Providing the targeted population with proactive care early on in their pregnancy will result in savings if the condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring and treatment, ADHD anticipates a reduction in Early Elective Deliveries (IT.8.3). Education will also help to increase the number of Breast Cancer Screenings in the county especially among the Hispanic population which has a high incidence rate of breast cancer (IT-12.1).

Currently, Angleton Danbury Hospital District is not receiving any additional federal funding to support this project.

121805903.1.3	1.1.2	1.1.2 A, B,C	EXPAND EXISTING PRIMARY CARE CAPACITY – OB/GYN
Angleton Danbury Hospital District			121805903
Related Category 3 Outcome Measure(s):	121805903.3.4	3.IT-8.3	IT-8.Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone Measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015-9/30/2016)
Milestone 1 (P-5) Milestone: Recruit an additional OB/GYN to join existing practice 1.1.2c) Expand primary care clinic staffing- we plan to hire an OB/GYN in DY 2 and midwife in DY 4 along with additional support staff in DY 2 – 4. Metric P 5.1.Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation Signed practice support agreement b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Baseline Volume: 8900 visits Milestone 1 Estimated Incentive Payment: $1,877,927	**Milestone 2** 1.1.2 Expand existing primary care capacity Required core project components: a) Expand primary care clinic space – We plan to expand current space to accommodate additional practitioners. The new space will be approximately a total of 5,000 sq/ft. Milestone 2 Estimated Incentive Payment: $518,824 **Milestone 3** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period will be at 10,235 visits from DY 2 – 15% increase b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the	**Milestone 4** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 : I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: Increase case load to 11,570 visits – 30 % increase from DY2 Data Source: Performing Provider document Milestone 4 Estimated Incentive Payment: $802,822 **Milestone 5** (P-5) Milestone: Recruit a midwife to join existing practice 1.1.2c) Expand primary care clinic staffing- we plan to hire a midwife in DY 4 along with additional support staff Metric P 5.1.Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described	**Milestone 6** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1: I-12.1: Documentation of increased number of visits. Demonstrate improvement over period reporting time Goal: Increase case load to 12,460 visits – 40% increase from DY 2 Data Source: Performing Provider document Milestone 5 Estimated Incentive Payment: $1,151,977

121805903.1.3	1.1.2	1.1.2 A, B,C	EXPAND EXISTING PRIMARY CARE CAPACITY – OB/GYN	
Angleton Danbury Hospital District				121805903
Related Category 3 Outcome Measure(s):	121805903.3.4	3.IT-8.3	IT-8.Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (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)	
	ability for the Performing Provider to increase capacity to provide care. Milestone 3 Estimated Incentive Payment: $1,210,587	by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation Signed practice support agreement b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Milestone 5 Estimated Incentive Payment: $802,822		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,877,927	Year 3 Estimated Milestone Bundle Amount: $1,729,412	Year 4 Estimated Milestone Bundle Amount: $1,605,643	Year 5 Estimated Milestone Bundle Amount: $1,151,977	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $6,364,959				

PROJECT OPTION: 1.1.2 -Expand Existing primary care capacity

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 112671602.1.1
PERFORMING PROVIDER/TPI: Brazosport Regional Health System – Lake Jackson Family Medicine Center (LJFMC) / Brazosport Regional Health System – Urgent Care Center
TPI: 112671602

- Provider: Brazosport Regional Health System (BRHS) – Lake Jackson Family Medicine Center (LJFMC) is a division of BRHS that provides primary care to patients of all ages in Southern Brazoria County. LJFMC is a primary care clinic, currently housing two full time physicians in Lake Jackson, Texas. BRHS Urgent Care Center (UCC) is an Urgent Care facility that provides healthcare services on a walk-in basis for patients in Southern Brazoria County. It is staffed with two full time Nurse Practitioners, alleviating some of the primary care needs of the population. LJFMC and BHRS UCC exist to serve a population of approximately 80,000 within the BRHS primary service area.
- Interventions: The project will use LJFMC as a base for expanding primary care capacity by expanding the hours to include evenings and weekends. The project will also expand primary care capacity by means of BRHS UCC operating hour expansion to assist LJFMC in meeting the growing need for primary care services in the area.
- Need for the project: We are currently experiencing a severe shortage of primary care providers in the BRHS service area. Brazoria County has 44.2 primary care providers per 100,000 residents, falling far below the Texas and U.S. averages of 69.5 and 91.0 physicians per 100,000 residents, respectively.
- Target Population: The target population is patients in the BRHS LJFMC service area who do not have a primary care provider and/or patients in the service area who have experienced difficulty in primary care access. Approximately 25% of our patients are either Medicaid or self-pay patients without insurance, so we expect they will benefit from the extended clinic hours and increased access to medical care. LJFMC is one of the few primary care practices in the area that accepts new Medicaid patients.
- Category 2 expected patient benefits: The project seeks to increase access to primary care, through LJFMC and the BRHS UCC, by increasing the operating hours and therefore increasing the number of available primary care visits. The expected increase in the number of available primary care appointments is approximately 10,250 for LJFMC by DY 5, and the expected increase in the number of available primary care appointments is approximately 13,200 for Urgent Care by DY 5.
- Category 3 outcomes: IT-6.1 The project seeks to increase patient satisfaction by increasing access to primary care in LJFMC and BRHS UCC.

PROJECT DESCRIPTION:

The project proposes using Brazosport Regional Health System's (BRHS) Lake Jackson Family Medicine Center (LJFMC) as a base for expanding primary care capacity by expanding the hours to include evenings and weekends. LJFMC is staffed and managed by Brazosport Regional Physician Services (BRPS), a division of Brazosport Regional Health System. Another goal of the project includes expanding primary care services by means of Urgent Care operating hour expansion to assist LJFMC, and thus BRHS, in meeting the growing need for primary care services in the area.

Project goal(s):

By expanding the hours of the primary care clinic into weekend and evening hours, and adding an additional provider and support staff, the goal is to make the clinic more accessible to the public and increase the number of patients that can be seen. Additionally, by expanding the hours of the Brazosport Regional Urgent Care Center, possibly adding a provider and/or adding diagnostic equipment capabilities, the goal is to make Urgent Care more accessible to the public and increase the number of patients seen.

Anticipated challenges:

Anticipated challenges to achieving the goals of the project include:

- Finding providers and support staff who are willing to work evening and weekend hours.
    - Response: Offering an incentive to those who agree to fill these hours. We also have additional providers and employees within the system who will be called upon to fill the additional hours. Reach out to EmCare (the company that staffs our Emergency Department physicians and mid-level providers) to arrange a possible temporary provider staffing arrangement.
- Recruiting an additional provider for LJFMC.
    - Response: Efforts will be focused on recruiting a physician who desires to work in a salaried position at LJFMC. However, if we are unable to find the right physician, we will recruit a mid-level provider.

- Recruiting an additional provider for Brazosport Regional Urgent Care Center
    - Response: Efforts will be focused on recruiting a mid-level provider with Urgent Care or Emergency Department experience who will be willing to be employed by BRPS.

The 5-year expected outcome(s):

The improvement target for this project is to increase patient satisfaction by increasing access to primary care, through LJFMC and Brazosport Regional Urgent Care Center, and increase the number of primary care visits. By the end of the 5th year, we expect to have added an additional provider and approximately 17 hours a week to LJFMC clinic hours, thereby increasing the number of patients that can be seen by 30%; and at Brazosport Regional Urgent Care Center increasing clinic hours by approximately 30 hours a week and increasing the

number of possible patient visits by 30%. The type of patient visit will vary and an average of 3 possible patient visits per hour per provider was used to estimate the expected outcome.

Regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

LJFMC is currently open five days a week from 8:00 a.m. to 5:00 p.m., has two full-time physicians, and schedules approximately four patients per hour for each physician. Urgent Care is currently open seven days a week from 9:00 a.m. until 6:00 p.m., with extended hours on Wednesday night until 8:00 p.m., has 2 Nurse Practitioners who rotate the daily shifts, and see approximately 3-4 patients per hour per provider. Patient satisfaction information is currently not being collected for the primary care clinic patients, so no baseline patient satisfaction score is currently available.

RATIONALE:

Relation between Project Choices and Community Needs

As shown in the Region 2 Community Health Needs Assessment, Brazoria County has 44.2 primary care physicians per 100,000 residents, falling far below the Texas average of 69.5 physicians per 100,000 residents, and less than half of the US average of 91.0 physicians per 100,000 residents. At the LJFMC, it currently takes about a month for a well patient to be seen and, although we feel it is part of our mission in the community to accept all sick patients, whether or not we have seen them in the past, the schedule is extremely tight and new patients who are sick often have to wait 3 or more days to be seen. We also have a high percentage of working adults in the area who would like to be able to go to the physician at a time that is more convenient to their work schedule. In the Brazosport area, which is our primary service area, we have had three primary care physicians close their practices within a two month period, one due to relocation to a more urban area, and the others due to retirement. This leaves us at an even more severe shortage as the remaining physicians were not able to absorb these patients. The current lack of primary care providers in the area has led to decreased patient satisfaction of patients, in part due to the lack of available appointment times outside of the traditional working day. A project that expands on primary care must measure its success by monitoring both the increased number of patient visits as well as patient satisfaction with the expanded capability.

At the same time, we are expanding our chronic care model to better serve patients with Diabetes. In the long run, better management of chronic conditions should reduce the number of visits required to remain healthy, but in the short run, we expect these patients to see the physician more often in order to gain valuable information and education.

Project Option 1.1.2 Core Components

The Project Option 1.1.2 core project components are described as following:

- A. Expand primary care clinic space:
    - The current space in LJFMC is large enough for an expansion of clinic hour, providers, staff members, and increased patient capacity.
    - The current space in Brazosport Regional Urgent Care Center is sufficient but may be reconfigured in the future to accommodate additional treatment space.
- B. Expand primary care clinic hours:
    - In Years 3 and 4 the primary goal is to make primary care services more accessible to the population by expanding the hours of LJFMC outside of normal working hours. The additional hours will be gradually increased throughout the term of the project. In years 3 and 4 we plan to expand the hours of the Urgent Care Center in order to increase the capacity.
- C. Expand primary care clinic staffing:
    - With the expansion of clinic hours we will also expand on the clinic staff. The recruiting activities have already begun to try and add a provider and the necessary additional staff.

In Years 2 and 3 the primary goal is to make primary care services more accessible to the population by expanding the hours of LJFMC outside of normal working hours. The additional hours will be gradually increased throughout the term of the project. In year 4 we plan to expand the hours of the Urgent Care Center and add one or more additional midlevel providers to LJFMC, possibly to the Urgent Care Center, in order to increase the capacity.

Unique Community Need Identification numbers:

CN.3: Primary Care Physician Shortage

CN.8: Mid-Level Provider Shortage

Expansion or enhancement:

The LJFMC opened in 2011, striving to meet the needs of the community with traditional office hours. We have found that many patients request appointments outside of the traditional workday. There are currently no providers in the area who offer scheduled office visits after 5:00 on weekdays or on Saturdays. Urgent Care has also experienced an increased number of visits for primary care health needs, attributable in part to the lack of primary care providers/clinics in the community. This project serves to meet community requests for expanded hours, as well as the increasing need for additional primary care services.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD-6: Patient Satisfaction

IT-6.1: Percent improvement over baseline of patient satisfaction scores

1) Are [patients] getting timely care, appointments and information

Process Milestone P-2: Establish baseline rates

At this time, LJFMC is not formally collecting satisfaction information from patients. We will begin collecting this information in Year 2 of the project and continue collecting it as the hours are scaled up.

Satisfaction will continue to be measured throughout the project, expecting to see increasing satisfaction as additional non-traditional hours and capacity become available.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding primary care and emphasis on urgent care and expanded hours ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 284333601.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning

collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The project was valued based on the additional hours and number of patients that can be seen in those hours. Similar to the current schedule, and accounting for holidays and slower periods, we estimated three patients per additional clinic operating hour. The project outcome measure on patient satisfaction is an appropriate measure because the current lack of available appointment times in the clinic has caused difficulties for potential patients seeking care. Because the demand is high for primary care in the community, volume increases in both LJFMC and the Urgent Care Center can be reasonably expected. As such, monitoring only the volume, provider, and patient visit increases will not generate an overall picture of the project effectiveness. The demand is very evident in the community and patient satisfaction regarding the entire primary care experience, specifically appointment availability, along with the additional milestones will generate valid feedback on the entire primary care expansion project.

112671602.1.1	1.1.2	1.1.2.B	EXPAND PRIMARY CARE CAPACITY
Brazosport Regional Health System			112671602
Related Category 3 Outcome Measure(s):	112697602.3.2	IT – 6.1	Percent Improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 **P-5**: Train/hire additional Primary Care Provider and staff and/or increase the number of Primary Care Clinics for existing providers. **Metric** **P-5.1**: Adding additional provider/staff. **Baseline**: 2 physicians at LJFMC in 2012 seeing 5,800 visits. 2 mid-level providers at Brazosport Regional Urgent Care Center in 2012, 9,200 visits. **Goal**: Hire 1 mid-level provider for LJFMC. The additional provider is expected to increase the capacity of available patient appointments by approximately 3000. **Data Source**: BRPS Contract agreement **Rationale**: Increased number of Primary Care Providers will allow increased patient access. The current space in LJFMC is large enough for an expansion of clinic	**Milestone 2** **P-4:** Expand the hours of the primary care clinic, including evening and/or weekend hours. **Metric** **P-4.1:** Increased number of hours at primary care clinic over baseline. **Baseline:** As of year 3, LJFMC will be open from 8:00 a.m. to 5:00 p.m. five days a week. The hours of Brazosport Regional Urgent Care Center are 9:00 a.m. to 6:00 p.m., 7 days per week, with extended hours on Wednesdays until 8:00 p.m. In DY 3, the approximate number of patient appointments annually at LJFMC is 8,800 and the approximate number of patient appointments annually at Urgent Care is 9,000. **Goal:** Expand the hours of LJFMC from 40 operating hours per week to 55 hours per week. Expand the hours of Brazosport Regional Urgent Care Center from 65 hours per week to 112 hours per week. The approximate number of projected patient appointments annually at LJFMC will be 8,800, and the	**Milestone 3** **P-4:** Expand the hours of the primary care clinic, including evening and/or weekend hours. **Metric** **P-4.1:** Increased number of hours at primary care clinic over baseline. **Baseline:** As of year 4, LJFMC will be open 55 hours per week. Brazosport Regional Urgent Care Center will be open 112 hours per week. In DY 4, the approximate number of patient appointments annually at LJFMC is 8,800, and the approximate number of patient appointments annually at Urgent Care is 11,000. **Goal:** Expand the hours of LJFMC from 55 operating hours per week to 63hours per week. The hours at Urgent Care will not be expanded beyond 112 hours per week. The approximate number of projected patient appointments annually at LJFMC will be 9,320, and the approximate number of projected patient appointments annually at Urgent Care will be 12,000.	**Milestone 5** **Improvement Milestone I-15:** Increase access to primary care capacity. **Improvement Metric I-15.2:** Increased number of primary care visits. **Goal:** By expanding the hours of the LJFMC to 63 hours per week, and the hours of Brazosport Regional Urgent Care Center to 112 hours per week, the goal is to make the clinic more accessible to the public and increase the number of potential patient visits at LJFMC by 10% above the number of patients seen in Year 4, representing approximately 10,250 patient visits. The Brazosport Regional Urgent Care Center will also increase hours of operation in order to make primary care more accessible to the community and increase the number of potential patient visits by 10% above the number of patient visits in DY 4, representing approximately 13,200 patient visits. **Data Source:** LJFMC Documentation

112671602.1.1	1.1.2	1.1.2.B	EXPAND PRIMARY CARE CAPACITY	
Brazosport Regional Health System				112671602
Related Category 3 Outcome Measure(s):	112697602.3.2	IT – 6.1	Percent Improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
hour, providers, staff members, and increased patient capacity. The current space in Brazosport Regional Urgent Care Center is sufficient but may be reconfigured in the future to accommodate additional treatment space. **Milestone 1 Estimated Incentive Payment: $200,967**	approximate number of projected patient appointments annually at Urgent Care will be 11,000. The number of providers at LJFMC remains the same, and therefore the number of possible appointments remains the same, but extending the clinic hours will increase appointment availability. **Data Source:** LJFMC Documentation, EMR, Urgent Care Center Documentation **Milestone 2 Estimated Incentive Payment: $186,548**		**Data Source:** LJFMC Documentation, EMR, Urgent Care Center Documentation **Milestone 3 Estimated Incentive Payment: $124,941** **Milestone 4** **Improvement Milestone I-15:** Increase access to primary care capacity. **Improvement Metric I-15.2:** Increased number of primary care visits. **Goal:** By expanding the hours of the LJFMC and adding an additional provider, the goal is to make the clinic more accessible to the public and increase the number of potential patient visits by at least 50% from DY 2 to DY 4, representing approximately 9,320 patient appointments in DY 4. Similarly, the goal is to make Brazosport Regional Urgent Care Center more accessible to the public and increase the number of potential patient visits by approximately 30% from DY 2 to DY	and/or EMR, Urgent Care Center Documentation **Milestone 5 Estimated Incentive Payment: $265,902**

112671602.1.1	1.1.2	1.1.2.B	EXPAND PRIMARY CARE CAPACITY	
Brazosport Regional Health System				112671602
Related Category 3 Outcome Measure(s):	112697602.3.2	IT – 6.1	**Percent Improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			4, representing approximately 12,000 patient visits. **Data Source:** LJFMC Documentation and/or EMR, Urgent Care Center Documentation **Milestone Estimated Incentive Payment: $124,941**	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 200,967	Year 3 Estimated Milestone Bundle Amount: $ 186,548		Year 4 Estimated Milestone Bundle Amount: $ 249,882	Year 5 Estimated Milestone Bundle Amount: $ 265,902
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 903,299				

PROJECT OPTION 1.7.7: Introduce, Expand or Enhance Telemedicine/Telehealth

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: **112706003.1.1-Pass 2**
PERFORMING PROVIDER NAME/TPI: CHRISTUS Jasper Memorial Hospital/112706003

Title of Project: *Telemedicine For Neurological Care*

Category Project Area:
Provider: Located 65 miles north of Beaumont, **CHRISTUS Jasper CHRISTUS Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. We provide services to residents of Jasper County as well as surrounding counties of Newton, Sabine, and Tyler. The populations total approximately 60,000 individuals. This project is not being performed under the collaborative option.

Interventions: Jasper will implement technology-assisted services (telemedicine) to support or deliver neurological care to patients in the Jasper area, to expedite treatment of acute stroke to increase survival rates. The implementation includes the purchase of necessary equipment and the contractual alliance with specialists.
Need for the Project: Jasper's catchment area lacks adequate specialists to provide neurological care to patients, requiring either delays or costly transfers. Recruitment efforts are often in vain, as specialists prefer to practice in other areas. As a result, the Jasper catchment area lacks adequate providers of neurological care. Approximately 31% of the community population is sedentary and nearly 25% are smokers. 23% of the population earns below the federal poverty level. Jefferson County and Jasper County residents have a higher rate of physical inactivity, obesity, adult smoking, hypertension, and poor physical health days than the statewide average, each of which increases a patient's risk of being high-risk. In addition, Jefferson County and Jasper County have a higher rate of mortality from aortic aneurysm, diseases of the heart, COPD, cerebrovascular conditions, chronic liver disease, and hypertension than the statewide average. These conditions can lead to acute episodes requiring the need for specialty intervention. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas.
Target Population: The target population for this project is residents of the Jasper catchment area who present with neurological symptoms. It is estimated that 7% of Jasper's catchment area patients have been diagnosed with neurological problems, of which 39% are Medicaid or uninsured.
Category 1 or 2 Expected Benefit: Improving the availability of neurological consultations to facilities without this service will allow more timely provision of care, reduce unnecessary transfers, and improve clinical outcomes. A qualified neurological evaluation will allow acute stroke patients access to life saving treatments when such services are most vital. Under this project CHRISTUS expects to have 955 patient consultations in DY3, 1050 patient consultations in DY 4, and 1102 patient consultations in DY5.

Category 3 Outcome: IT. 6.1 Patient satisfaction. With telemedicine consultation capabilities to consult with neurologist in St. Luke in Houston, physicians will be able to admit patients to CHRISTUS Jasper Memorial with treatment plan mapped with neurologist input. CHRISTUS Jasper does not have neurologist on medical staff, if patient needs this level of care and consultation at this time must be transferred. This would increase patient satisfaction with the care provided closer to home, saving time for definitive treatment, and saving monies with unnecessary transfers to another facility.

Project Description:

This project will implement technology-assisted services to support or deliver neurological care to patients in the Jasper area to expedite treatment of acute stroke to increase survival rates. The project will provide access through telemedicine to NeuroScience services, to provide management of strokes in the acute care setting for patients who present to the emergency department. Challenges will include infrastructure development, monitoring of education of providers and staff, and retaining specialists to provide the service.

Telemedicine is a method of health care service delivery used to facilitate access to health care and medical consultations by a physician to other health care providers in underserved areas for purposes of patient diagnosis or treatment that requires advanced telecommunications technologies. Telemedicine involves a remote site provider with the patient, and a hub site provider providing consultation regarding the treatment of the patient. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Project goal(s):

To provide high quality, reliable, and timely neurological consultative services to the hospitals in the Jasper community via telemedicine. The availability of telemedicine services will allow participating providers to provide more comprehensive specialty coverage to the patients and populations they serve at a cost substantially less than what would otherwise be required.

Anticipated challenges:

1. Funding for equipment that is needed.
2. Training of staff in the facilities where the equipment would be located.
3. Support of data collection to document the outcomes provided by the program.
4. Credential providers.

Challenges:

Improving the availability of neurological consultations to facilities without this service will allow more timely provision of care, reduce unnecessary transfers, and improve clinical outcomes. A qualified neurological evaluation will allow acute stroke patients access to life saving treatments such as "clot busting" drugs that are currently not provided in facilities without neurological services. There is also the capability for "long distance" education via the telemedicine equipment provided.

The 5-year expected outcome(s):

Connecting with the correct agency and/or specialist for appropriate evaluation of a patient that requires a visual exam or a review of local records/films/etc. is a very time consuming process that delays patient care and ties up exam rooms and costly resources in the Emergency

Departments. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g. face-to-face consultations or examinations between provider and patients) that states can choose to cover under Medicaid. By implementing this program CHRISTUS expects to see an improvement in patient outcomes, patient satisfaction and improvements in the cost of providing care for this patient population.

Regional goals

- A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Starting Point/Baseline:

CHRISTUS will purchase equipment for telemedicine services and contract with St. Luke's NeuroScience Center and Baylor College of Medicine for physician support to provide physician availability in the specialty for consultation by and through the telemedicine equipment for patients presenting at CHRISTUS Jasper Memorial Hospital with neurologic symptoms. Currently CHRISTUS Jasper Memorial is a general medical/surgical hospital with medical imaging and laboratory services, and an inpatient rehabilitation unit. Patients presenting in the ED with neurological problems lose valuable time when they need to be transferred to another facility for diagnosis. Telemedicine will provide real time diagnosis and save valuable response time.

Rationale

One of the greatest challenges facing the U.S. healthcare system is to provide quality care to the large segment of the population with limited access to specialty physicians due to factors such as lack of providers, geographic limitations, or socioeconomic conditions. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers.

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

- Improved access to specialists
- Increased patient satisfaction with care
- Improved clinical outcomes
- Reduction in emergency room utilization
- Cost Savings

In Texas, and in our rural area, communities are struggling to care for an increasing number of underserved, disadvantaged, and at-risk populations. In most communities, especially in rural areas, care is not organized to promote prevention and early intervention, coordinate services, or monitor access to and quality of care. Moreover, public and private funding to subsidize care remains inadequate, despite growing community needs associated with increases in the uninsured and aging populations. Consequently, many people are left to seek care in emergency rooms, often as a last resort, in an unmanaged and episodic manner. The costs of such care are borne by care-giving institutions, local governments, and, ultimately, taxpayers, many of whom are already burdened with the costs of meeting health-related costs of their own.

Given the various benefits observed through the provision of health care via telemedicine, there is a tremendous amount of momentum toward increasing access to care through the use of health information technologies, thereby creating an exciting and central role for innovation and implementation of new and advanced platforms for service delivery. Two such platforms include the use of wireless and telemonitoring technologies. It is our belief that healthcare delivery is about to make a significant leap forward. The development and installation of highspeed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients without bringing them into a hospital or a specialty care center. This real/near-time monitoring and interacting could enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectations of our healthcare system.

This project will improve survival rates of patients presenting with acute strokes; it will decrease mortality rates by improving management times of medications and transfer to a higher level of care facility. This will allow timely, cost effective coverage in more rural areas. It will allow for standardization of neurological treatment in keeping with evidence-based best practices. It will prevent unnecessary transfers, create an avenue for long distance education, and improve patient outcomes.

Relation between Project Choices and Community Needs:

CHRISTUS Jasper Memorial is in a rural setting with limited resources, a population with limited health literacy, and is 65 miles from the nearest hospital with capabilities to treat stroke and other neurological problems.

Unique Community Need Identification numbers:

CN.1
CN.5
CN.6

Expansion or enhancement:

This project will allow CHRISTUS to significantly enhance our telemedicine services. We currently have some technology but the cost to increase broadband width and purchase additional equipment necessary to expand telemedicine has proved prohibitive within our current funding streams.

Related Category 3 Outcome Measures:

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

Relationship to other Projects:

This project's focus on using technology to assist in delivering nerological care and emphasis on stroke patients ties to the following Category 1 and 2 projects in our RHP: 096166602.1.5, 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the expansion and enhancement of telemedicine services in our region for psychiatric, behavioral, and neurological support. The following Category 1 projects in our RHP are related: 136367307.1.2- Introduce, Expand, or Enhance Telemedicine/Telehealth; 112706003.1.1- Introduce, Expand, or Enhance Telemedicine/Telehealth; and 096166602.1.5- Introduce, Expand or Enhance Telemedicine/Telehealth

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The valuation of each CHRISTUS project use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the

project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The telemedicine project will enable emergency room physicians to consult neurologist at St. Luke's in Houston real time with a computer work station in the room with the patient to increase the quality of care in a timely fashion, resulting in timely interventions to patients presenting with neurologic symptoms. The telemedicine program offers access to neurologist round the clock and helps expedite transfers to a higher level of care for the treatment of these patients. With this program we will provide continuity of care in a cost-effective manner with the ability to consult the neurologist for care plan and treatment. The increase in patient access, and the cost effectiveness of this project justify its valuation under the methodology described above.

112706003.1.1	1.7.7	1.7.7.X	TELEMEDICINE FOR NEUROLOGICAL CARE	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	**112706003.3.4**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*P-1*]: Conduct needs assessment to validate specialty is needed. Metric 1 [P-1.1]: Needs Assessment completion Baseline/Goal: Complete assessment. Data Source: Needs assessment. Estimated Milestone 1 Payment Amount: $301,090.50 **Milestone 2** Process P-X: Establish baseline for measures. This milestone will be a comprehensive assessment of all the baseline data that will be necessary to measure the future success of the project. Metric: Submission of baseline assessment documentation Goal: To establish baseline for future years. Data Source: Provider documentation of baseline study Estimated Milestone 2 Payment Amount: $301,090.50	**Milestone 3** [P-3]: Implement telemedicine program for selected specialty (neurology). Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements, etc. Baseline/Goal: Submission of implementation documentation. Data Source: Program materials. Estimated Milestone 3 Payment Amount: $205,635.66 **Milestone 4** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Estimated Milestone 4 Payment Amount: $205,635.66		**Milestone 6** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Estimated Milestone 6 Payment Amount: $306,761.50 **Milestone 7** I-12.1: Increase number of telemedicine visits for neurological services Metric 1 I-12.1: Number of telemedicine visits Baseline: 10% over baseline rate Data Source: HER 10% over baseline is 1050. Estimated Milestone 7 Payment Amount: $306,761.50	**Milestone 8** I-12.1: Increase number of telemedicine visits for neurological services Metric 1 I-12.1: Number of telemedicine visits Baseline: 15% over baseline rate Data Source: HER 15% over baseline is 1102. Estimated Milestone 8 Payment Amount: $249,161.50 **Milestone 9** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Estimated Milestone 9 Payment Amount: $249,161.50

112706003.1.1	1.7.7	1.7.7.X	TELEMEDICINE FOR NEUROLOGICAL CARE	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	**112706003.3.4**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5 I-12.1: Increase number of telemedicine visits for neurological services Metric 1 I-12.1: Number of telemedicine visits Baseline: 5% over baseline rate Data Source: HER Estimated Milestone 5 Payment Amount: $205,635.66			
Year 2 Estimated Milestone Bundle Amount: $602,181	Year 3 Estimated Milestone Bundle Amount: $616,907		Year 4 Estimated Milestone Bundle Amount: $613,523	Year 5 Estimated Milestone Bundle Amount: $498,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,330,934				

PROJECT OPTION: 1.1.1-Expand Access to Primary Care for the Underserved in Jefferson County

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 138296208.1.1

PERFORMING PROVIDER/TPI: CHRISTUS Hospital – St. Elizabeth/TPI: 138296208

Provider: Located 65 miles north of Beaumont, CHRISTUS Jasper Memorial Hospital is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. CHRISTUS Hospital-St. Elizabeth, a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatric. CHRISTUS Hospital-St. Mary, a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. This is not a project being performed under the collaborative option.

Interventions: CHRISTUS will increase the availability of primary care services, pediatric, and obstetric services for the underserved in the Beaumont area of Jefferson County by increasing access through the addition of two primary care clinics. The clinics will provide primary care to adults, women, and children, and will also provide psychiatry/therapy services one day per week, and extended urgent care hours as needed.

Need for the Project: Beaumont has a great need for increased access to primary and preventative care: the mortality rate in Jefferson County is 18.6% higher than the statewide average; the current obesity rate in Jefferson County is 6.3% higher than the statewide average; the diabetes rate in Jefferson County population is double the statewide average; and the Texas Department of State Health Services has noted that there is a lack of primary care in the region. Patients currently 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

Target Population: The target population for this project is residents of the CHRISTUS Beaumont catchment area who require increased access to primary care, which we estimate to be approximately 120,000 patients using the best data currently available to us.

Category 1 or 2 Expected Benefit: 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. Additionally, the project will increase access for underserved patients to pediatric, obstetric services, urgent care, and psychiatry/therapy services, decrease patients' inefficient reliance on the ED for such services. Roughly 99% of the patients touched by this project will be either Medicaid or indigent. Through this project, CHRISTUS expects to see approximately an additional 12,500 patients in DY3—with approximately 2,600 Medicaid patients and 9,600 indigent patients. In DY4 CHRISTUS expects to see approximately 15,000 patients—with approximately 3,200 Medicaid patients and 12,000 indigent patients. In DY5 CHRISTUS expects to see approximately 20,000 patients—with approximately 4,200 Medicaid patients and 15,600 indigent patients.

CHRISTUS will accomplish this by adding primary care clinics as indicated in the milestones below.

Category 3 Outcome: CHRISTUS expects to increase access to primary care by establishing at additional primary care clinics. The associated Category 3 outcome chosen by CHRISTUS is patient satisfaction. We feel this is an appropriate measure because primary care is often a patient's main interaction with healthcare. By increasing the level of primary care available in the community, patients will have higher overall satisfaction with their care.

PROJECT DESCRIPTION:

To increase the availability of primary care services, pediatric, and obstetric services for the underserved in the Beaumont area of Jefferson County, CHRISTUS Hospital – St. Elizabeth will expand access to primary care with its partner FQHC, Legacy Community Health Services, in order to establish two primary care clinics serving patients in the following Beaumont zip codes: 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77720, 77725, 77726, 77708, and 77709. The clinics will be located in areas with high rates of Medicare and Medicaid participation. The project will lease existing medical office space at strategic locations, hire additional family practice physicians, and collaborate with existing OB practices. The clinics will provide primary care to adults, women, and children, and will also provide psychiatry/therapy services one day per week, and extended urgent care hours by the end of DY 2.

Category Project Area

Category 1: Expand Primary Care Capacity;

Project Option 1.1.1: Establish more primary care clinics

Project goal(s):

Our goal is to expand the capacity of primary care to better accommodate the needs of the Region 2 patient population and community, as identified by the Region 2 RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Specifically, by establishing two new clinics, our goal is to increase access for underserved patients to pediatric, obstetric services, urgent care, and psychiatry/therapy services, decrease patients' inefficient reliance on the ED for such services, and increase patient satisfaction.

Anticipated challenges:

Challenges include: identifying available space and need; recruiting and retaining qualified staff for the clinics; implementing information technology and necessary equipment to the clinics; creating awareness of the available services in the community. CHRISTUS plans to overcome these challenges by assigning a team of CHRISTUS employees to coordinate the implementation of the clinics. The team will be responsible for developing recruitment strategies and compensation packages to attract new physicians to the clinics, identify space for the primary care clinics and work with information technology vendors to plan for and procure the information technology needed for the new primary care clinics.

The 5-year expected outcome(s):

2 new primary care clinics will be will be established in the Jefferson County service area within the next 4 years.

Regional goals:

- A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

STARTING POINT/BASELINE:

CHRISTUS Hospital – St. Elizabeth, partnering with Legacy Community Health Services, has already identified three potential clinical spaces to rent; if negotiations for those are unsuccessful, Legacy will pursue other opportunities. Beaumont has a great need for increased access to primary and preventative care: the mortality rate in Jefferson County is 18.6% higher than the statewide average; the current obesity rate in Jefferson County is 6.3% higher than the statewide average; the diabetes rate in Jefferson County population is double the statewide average; and the Texas Department of State Health Services has noted that there is a lack of primary care in the region.

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, appropriate utilization and reduced cost of services. For DY2-DY3, process milestone P-1 was chosen because it most accurately reflects the primary goal of the project in each of these two years, and will be necessary to facilitate the achievement of the desired improvement outcomes in years D4-D5. For years DY4-DY5, improvement measure I-12 was selected because we believe increases to primary care clinic volume of visits is the best evidence to support whether the project has been successful at improving access for patients seeking services.

Relation between Project Choices and Community Needs:

In Region 2, more than 50% of the region is designated as Health Professional Shortage Areas in Primary Care and/or Mental Health. The region has a severe shortage of primary care providers with a ratio of PCP's to 100,000 population of 54.6 (TX=69.5; US=91.0). The region is also short mental health professionals (psychiatrist, psychologist) and other specialty doctors (specialty physician ratios). Further, due in part to a lack of access to primary care services, Region 2 patients are forced to inefficiently rely on the ED for primary care and behavioral health services. Consequently, Region 2 has a very high ED utilization rate and has some of the highest health care costs in the U.S.

One month after Hurricane Ike struck the area in 2008, Beaumont's only FQHC closed its doors. Additionally, with the implementation of Managed Care in Jefferson County, many providers have opted out of participating in Medicaid. Thus, the addition of two primary care clinics in Medicaid-heavy areas will have a substantial impact on the availability of primary care services to low-income and uninsured community members.

Unique Community Need Identification numbers:

CN.3 Primary Care Physician Shortage
CN.4 Specialty Care Physician Shortage
CN.8 Mid-Level Provider Shortage
CN.10 High ED Utilization Rates

Expansion or enhancement:

This project significantly expands the existing healthcare delivery system by adding two new FQHC satellite clinics that will be able to provide a comprehensive array of primary care, dental and behavior health care, along with supportive services such as case management and transportation assistance to patients in the Jefferson County community.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD-6: Patient Satisfaction; IT-6.1: Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. This outcome measure was selected for DY4-DY5 because CHRISTUS considers enhanced patient satisfaction/experience to be one of its highest priorities, especially with regard to timely access to needed services. This outcome measure provides 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. For DY2-DY3, process milestones P-1 through P-3 were chosen due to the current lack of a survey instrument and other resources needed to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3, we will establish baseline numbers for patient satisfaction.

RELATIONSHIP TO OTHER PROJECTS:

This project is part of CHRISTUS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Other DSRIP projects will enhance these efforts by addressing community health needs through the continuum of care. *Promoting Community Health – Community Health Workers*, will target individuals with chronic diseases and help get them established with a medical home at a primary care clinic. *Regional Outreach Coordination & Patient Care Navigation* will provide support to at-risk patient populations needing to navigate their way through the health care system when the clinic does not meet all of their needs. *Patient Care Navigation* may help them to utilize one of the *CHRISTUS Disease Management Clinics* available to FQHC patients. For those patients with more progressed illness, the *CHRISTUS SETX Comprehensive Palliative Care Program* will provide clear patient treatment goals and ensure high quality care. This project's focus on primary care services, pediatric, and obstetric services and emphasis on the underserved in the Beaumont area of Jefferson County ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 121805903.1.3, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared

learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This particular project directly addresses the aims of the Waiver, in that it is transformational, patient-centered, and will result in a reduced systemic cost of providing care. The project addresses community needs because so many residents in Jefferson County and the rest of the service area are at risk due to the lack of a medical home and appropriate, timely and effective primary preventive care. They are at high-risk for hospitalization when their condition deteriorates due to a lack of self-management. This project will require a hefty investment in infrastructure, staffing, training, community education, and creative solutions; however, the return on investment will make this project high value to the community and the Region. Additional Federal Funds are not expected at this time.

138296208 1.1	1.1.1 Establish more primary care clinics	N/A	ESTABLISH MORE PRIMARY CARE CLINICS IN JEFFERSON COUNTY	
CHRISTUS Hospital – St. Elizabeth				138296208
Related Category 3 Outcome Measure(s):	138296208.3.1	IT-6.1	Improving Patient Satisfaction	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Establish additional/expand existing/relocate primary care clinics Metric 1: P-1.1 Number of additional clinics or expanded hours or space Baseline/Goal: Establish one additional clinic in the Jefferson County community. Data Source: Documentation of detailed expansion plans and new primary care schedule or other Performing Provider document or other plans as designated by Performing Provider Milestone 1 Estimated Incentive Payment: $647,624.07 Milestone 2: P-X Establish a baseline for primary care clinic volume in order to measure improvement over self Metric: Documentation of baseline number of patient visits. Baseline/Goal: Establish baseline number of patient visits.	**Milestone 3**: P-1 Establish additional/expand existing/relocate primary care clinics Metric 3: P-1.1 Number of additional clinics or expanded hours or space Baseline/Goal: Establish a second additional clinic in the Jefferson County community. Data Source: Documentation of detailed expansion plans and new primary care schedule or other Performing Provider document or other plans as designated by Performing Provider Milestone 3 Estimated Incentive Payment: $1,324,731 **Milestone 3**: Establish additional/expand existing/relocate primary care clinics		**Milestone 4**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 4: I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: To serve at least 12,000 Medicaid and indigent patients in DY4. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 3 Estimated Incentive Payment: $1,322,677	**Milestone 5**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 5: I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: To serve at least 15,000 Medicaid and indigent patients in DY5 Data Source: Registry, EHR, claims or other Performing Provider source Milestone 4 Estimated Incentive Payment: $1,068,000

138296208 1.1	1.1.1 Establish more primary care clinics	N/A	ESTABLISH MORE PRIMARY CARE CLINICS IN JEFFERSON COUNTY	
CHRISTUS Hospital – St. Elizabeth				138296208
Related Category 3 Outcome Measure(s):	**138296208.3.1**	**IT-6.1**	**Improving Patient Satisfaction**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Internal documents and data systems measuring the number patient visits Milestone 2 Estimated Incentive Payment: $647,624.07				
Year 2 Estimated Milestone Bundle Amount:: $1,295,248	Year 3 Estimated Milestone Bundle Amount: $1,324,731		Year 4 Estimated Milestone Bundle Amount: $1,322,677	Year 5 Estimated Milestone Bundle Amount: $1,068,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $5,010,656				

PROJECT OPTION: 1.1.2 Expand Primary Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 019053001.1.1

PERFORMING PROVIDER/TPI: Galveston County Health District/Coastal Health & Wellness /0190530-01

Title of Project: Expanding Primary Care for Galveston County Residents at Coastal Health & Wellness

- Provider - Coastal Health & Wellness (CHW) is the designated Federally Qualified Health Center (FQHC) and is required to provides primary care, counseling, and dental services for Galveston County residents. The services provided by CHW are funded through a federal grant and county ad velorum tax funding along with patient fees. Coastal Health & Wellness now employs 112 staff, including 9 primary care providers. CHW has provided discounted health services to over 15,800 Galveston County's uninsured or under-insured residents with approximately 48,800 clinic visits in 2012.

- Intervention – This project will add primary care staff to enhance the capacity of Coastal Health & Wellness to provide care to an estimated 2500 additional Galveston County citizens. This project gives our patients the ability to access approximately 9600-10,000 more appointments, or visits and better utilize care to overcome the lack of personal resources and lack of insurance, primary care physician shortage, high ED utilization rates and high 30 day readmission rates.

- Need for the Project – Coastal Health & Wellness provides primary care at discounted rates for those meeting financial guidelines at 200% of the Federal Poverty Level or below. Galveston County citizens are adversely affected by a high rate of poverty, lack of community resources, low ratio of primary health care providers to population, lack of community resources including few mental health and substance abuse facilities/providers, low rates of childhood immunizations, and higher incidences of diabetes, hypertension, cancer and transportation barriers. The need for the primary care services of CHW will only increase as the number of Medicaid patients increases with the implementation of the Affordable Care Act.

- Target Population – CHW provides discounted primary care services to Galveston County citizens that are living at 200% of the Federal Poverty level or below. This population of 75,480 persons are concentrated in 8 census tracts Current Coastal Health & Wellness funding levels allow for services to be provided to 15,800 persons in the target population or approximately 48,800 clinic visits. The Galveston County Service area has an uninsured rate that is significantly worse than the U.S. average for children 0-18 years (15%) and 16.8% of citizens report not being able to see a doctor because of cost concerns, this is higher than the U.S. rate. The rate of preventable

hospital stays is higher than the Texas rate, indicating a lack of access to primary care. Many of these citizens will be added to the Medicaid roles as the Affordable Care Act unfolds allowing them to access primary health care that they may not have been able to afford previously. Category 1 expected benefits – An additional three providers and their support staff, would conservatively increase the number of encounters by approximately 800-900 visits per month or 9600-10,800 visits annually. Capacity for new individual patients could also increase by 30% or more to 17,500 annually and expand primary care services to the FQHC-designated target population beyond what current funding allows.

- Category 3 outcome measures - IT 3.7 - with disease management provided by the 3 additional primary care providers and support staff, Coastal Health & Wellness will be able to reduce the number of patients with uncontrolled hypertension by 2.5% each year.

PROJECT DESCRIPTION:

Galveston County Health District (GCHD) will contract with the Coastal Health & Wellness (formerly the 4C's Clinic), its federally-qualified health center (FQHC), to increase access to primary care. Access will be increased by increasing capacity to see patients both in the clinic as well as in a mobile clinic site. We propose to hire three full-time providers and adequate support staff to accomplish the project. The target population for this project includes any Galveston county resident, but specifically those that are below 200% of federal poverty and are un- or underinsured.

Goal:

"Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time, in the right setting." Coastal Health & Wellness (CHW) has adopted a priority in the GCHD Strategic Health Plan to increase access to care, and does so by building capacity through high productivity and efficiencies. As an FQHC, the clinic collects data regarding unduplicated patients and number of visits on an annual basis. This data is compared with health centers across the nation. CHW has high productivity among health centers. CHW medical providers strive to see 3 patients per provider per hour of scheduled clinic time. This goal is financially incentivized. For 2012, the cumulative average through the end of June is 2.8 patient visits/provider/hour. All appointment slots are filled each month. Same Day appointments are added to provider schedules to counteract the effect of patients that do not keep appointments. Evening clinics (open to 8 pm at one location twice a week and the other location twice a week) as well as a Saturday clinic at one location provide opportunities for patients to walk-in without an appointment. These hours have been maintained to provide an alternative to visits to a local emergency department. Both sites, Texas City and Galveston, have physical space to add providers. The Texas City site is new and was designed to provide

more than enough exam and treatment rooms to expand the number of medical providers. There are 28 exam rooms and 3 treatment rooms in Texas City. The Galveston site will be renovated during this project and will also expand available space to increase access. By hiring three new medical providers (a mix of physician and mid-levels) it is anticipated that approximately 800-900 new office visits will be available for patients on a monthly basis. CHW has been in existence since 1970 and has been a Joint Commission accredited clinic since 2000. The clinic also plans to implement a mobile clinic which will travel to the most remote locations of Galveston County, the Bolivar peninsula and the Bayshore area. Both areas experience a lack of convenient health care. A citizen's group from Bolivar has requested that GCHD provide health care service in the area. GCHD has committed to the purchase of a mobile clinic. The expanded provider staff will man this outreach as well as provide care in the two clinic sites.

Anticipated Challenges:

Challenges include recruitment challenges in Texas which has shortages of physicians (especially primary care physicians) and in Galveston County, which is a designated Health Professional Shortage Area. Coastal Health & Wellness has been able to attract healthcare professionals because of competitive salaries and incentives, good benefits and because the clinic has the advantage of being deemed for Federal Tort Claims Act liability coverage. CHW is an eligible site for providing loan repayment arrangements for potential medical providers.

The 5-year expected outcomes:

The Improvement Target is IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018), a standalone measure. The goal is to improve the measure by 5% over baseline by the end of the 5 year project. The numerator is the number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator is: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The Data Source is the electronic medical record.

By the end of year five, it is anticipated that a baseline for hypertension will have been established, and approximately 800-900 new visits per month will be added to the current capacity, thus providing access to new individuals as well as more frequent access to patients. The average numbers of patients with controlled hypertension will be at least 5% greater than the baseline measurement in year 3. Medical access provides diagnosis, expert consultation, patient education and access to prescription medications. Coastal Health & Wellness is able to provide medications at a discounted price as a clinic benefit due to 340B drug pricing and clinic support for a formulary of primary care medications for patients eligible for discounted service. In this way, hypertension will be managed for a target population that is either currently undiagnosed or uncontrolled.

Regional Goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

We will recruit and retain three additional Primary Care Providers and the additional support staff needed. There are currently 9 FTE budgeted medical providers at Coastal Health & Wellness. For 2011, medical providers had 34,200 clinic visits for 13,576 patients. An additional three providers would conservatively increase the number of encounters by approximately 800-900 visits per month or 9600-10,800 visits annually. Capacity for new individual patients could also increase by 30% or more to 17,500 annually.

RATIONALE:

The RHP2 Community Needs Assessment identified access barriers: lack of personal resources and lack of insurance, primary care physician shortage, high ED utilization rates and high 30 day readmission rates as community needs. Some highlights of the Galveston County Community Needs Assessment are below:

- Lack of Personal Resources – 13% of, a significant portion of Galveston County residents, lives below the FPL and has an unemployment rate of 6.9%.
- Lack of Insurance - 21.8% of the Galveston County adult population is uninsured with only 9.5% with Medicaid. 15% of children in Galveston County lack insurance
- Primary Care Physician Shortage - Galveston County has 55.6 Primary Care Physicians per 100,000 population, Texas has 69.5 per 100,000
- High ED utilization Rates – Rate per 100,000: 17,461-78,955

In our current system, more often than not, patients receive services in urgent 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. By adding additional providers to the staff of Coastal Health & Wellness the capacity to provide more Galveston County citizens with access to primary care is enhanced. This project gives our patients the ability to access more appointments and better utilize the care that we provide. We propose to hire and train additional providers to an existing clinic with well established infrastructure.

We also propose to bring the same high quality services to areas of extreme provider shortage via a mobile project. The rationale for the mobile clinic is that it will allow us to reach communities of Bolivar Peninsula and San Leon/Bacliff. Both communities are isolated by lack of public transportation and high rates of poverty (including residents of a peninsula only reached by ferry). This project will allow CHW to connect primary care to these communities and will take the services to the patients, which will help keep them healthy proactively.

These activities will provide efficient, low cost, high-quality access to primary care in an organization with sufficient infrastructure and experience to be successful.

Unique Community Need Identification Numbers: Project to address the following needs of Galveston County residents as identified by the RHP - 2 Community Needs Assessment.

CN 1- Access Barriers: Lack of Personal Resources
CN 2 - Access Barriers: Lack of Insurance
CN 3 - Primary Care Physician Shortage
CN 10 – High ED utilization Rates

Expansion or enhancement:

Coastal Health & Wellness will recruit, retain and train 3 additional primary care providers and the necessary support staff. This project is an expansion of an existing and successful delivery system. Coastal Health & Wellness is an FQHC that receives funds annually to support the project. Additional funds were awarded to the project in 2010 to expand capacity and the Saturday walk-in clinic was added. This has now become a core part of the project. CHW has demonstrated the ability to meet all federal requirements as a section 330 community health center and is deemed for Federal Tort Claims Act, which provides liability coverage for the project. This DSRIP project will allow Coastal Health & Wellness to further expand its primary care services beyond what has already been committed by hiring the additional staff and instituting the mobile clinic.

RELATED CATEGORY 3 OUTCOME MEASURES

The outcome domain is OD-1, Primary Care and Disease Management.

The Improvement Target is IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018), a standalone measure. The goal is to improve the measure by 5% over baseline by the end of the 5 year project. The numerator is the number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator is: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The Data Source is the electronic medical record.

The starting point/base line for the IT is to be developed during year 2 using the new electronic health record. Past performance on this indicator has been approximated by chart audit for the clinic population and was 43% controlled for 2011 by audit of 70 records. We believe that a more accurate baseline will be set using the whole population in the electronic medical record. The milestone for DY2 is to establish a baseline rate. The metric is equal to the metric for the IT. The numerator is the number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator is: patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The data source is the electronic medical record of Coastal Health & Wellness.

The process milestones for DY2 and DY3 are:

P-2, Establish baseline rates. (DY2). The metric will be determined as above with the numerator and denominator defined above. The Data source is Coastal health & Wellness Electronic Medical Record. The goal is to establish an accurate baseline based on data from the entire project population. The rationale is: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke

mortality and a 14 to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

P-4 Conduct Plan Do Study Act (PDSA) cycles (DY3) to improve data collection and intervention activities. Metric: the committee assigned to this improvement project will propose and develop at least three interventions during DY3 designed to impact the outcome goal by lowering BP in the target population. These interventions will be tested and if effective, adopted for the whole population. The data source will be the minutes and written PDSA cycle notes of the responsible committee. The goal is to lower the BP of the target population by 2.5% per year. The rationale is as above.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on increasing access to primary care and emphasis on mobile clinics and expanding the number of providers ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 284333601.1.1, 261955689.1.1, 136367307.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will

establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The addition of the proposed primary care providers and staff will expand the capacity of Coastal Health & Wellness to better accommodate the needs of the regional patient population and community, as identified by the RHP-2 needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. 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. 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 with reduced cost of services.

The expansion of the primary care clinic staffing will fill the need for primary care services in our community. Additional primary care services will allow individuals to receive services in a timely manner in the most appropriate setting. The project will promote education and chronic disease management so that individuals will be less likely to utilize more expensive healthcare option such as the ED, urgent care, or inpatient admissions.

Galveston County is growing at 1.5% per year and is still one of the larger counties in Texas. Coastal Health & Wellness is the primary care home for the uninsured and underinsured of Galveston County. This practice is at capacity and is among the few Medicaid providers in the County. By adding an additional 3 Primary Care providers and support staff to the community, individuals will be able to stay close to home while alleviating some of the demands on our hospital ER's. The Community Needs Assessment clearly supports the needs for this project. Access Barriers (lack of personal resources and lack of insurance), primary care physician shortage, and high chronic disease are proven factors within the community. Because of the demonstrated need of primary care, high Medicaid population, and explosive growth in the community – it was evident that this addition would add value to the community.

Providing the targeted population with proactive care early on in their chronic condition, this will result in savings if the condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring and treatment, Coastal Health & Wellness anticipates a reduction in hypertensive Emergency visits.

Currently, Coastal Health & Wellness is not receiving any additional federal funding to support this project.

019053001.1.1	1.1.2	CORE COMPONENT – C) EXPAND CLINIC STAFFING	EXPAND PRIMARY CARE CAPACITY AT COASTAL HEALTH &WELLNESS
Galveston County Health District/Coastal Health & Wellness			019053001
Related Category 3 Outcome Measure(s):	**019053001.3.1**	**IT-1.7**	**Controlling High Blood Pressure**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 - [*P-5*] - *Advertise and hire additional clinic staff:* *1 Primary Care Provider* *2 Medical Assistants* *1 Quality Data Specialist* *1 Patients Services Specialist* Metric 1 [P-5.1]: Documentation of number of providers and staff hired Baseline: 9 Providers , 13 Medical Assistants, 10 Patient Services Specialists, and 0 Quality Data Specialist currently (2012) Goal: 12 Primary Care Providers 13 Medical Assistants, 11 Patient Services Specialists, and 1 Quality Data Specialist Data Source: CHW Personnel Records Milestone 1 Estimated Incentive Payment *(maximum amount): $380,000*	**Milestone 2** [P-5]: Advertise and hire 2 Additional Primary Care Providers 1 Additional Medical Assistant Metric 1 [P-5.1]: Documentation of number of providers and staff hired Baseline: 9 Providers and 13 Medical Assistants currently (2012) Goal: 12 Primary Care Providers 13 Medical Assistants, 11 Patient Services Specialists, and 1 Quality Data Specialist Data Source: CHW Personnel Records Milestone 2 Estimated Incentive Payment: $455,000 **Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [P-I-12.1]: Documentation of increased number of visits. Baseline: TBD in Year 3	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [P-I-12.1]: Documentation of increased number of visits. Baseline: TBD in Year 3 Goal: 800 patients/month Data Source: EHR Milestone 4 Estimated Incentive Payment: $550,000 **Milestone 5** P-3 Implement a mobile health clinic program Metric: P-3.1 Baseline: no current mobile clinic Goal: 8 hours/week of mobile clinic Data Source: New primary care schedule or other performing provider documents Milestone 4 Estimated Incentive Payment: $50,000	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [[P-I-12.1]: Documentation of increased number of visits. Baseline: TBD in Year 3 Goal: 900 patients/month Data Source: EHR Milestone 5 Estimated Incentive Payment: $550,000 **Milestone 7** P-3 Implement a mobile health clinic program Metric: P-3.1 Average an additional 8 hours/week of expanded access expanded from baseline. Baseline: no current mobile clinic Goal: 8 hours/week of mobile clinic Data Source: New primary care schedule or other performing provider documents

019053001.1.1	1.1.2	CORE COMPONENT – C) EXPAND CLINIC STAFFING	EXPAND PRIMARY CARE CAPACITY AT COASTAL HEALTH &WELLNESS
Galveston County Health District/Coastal Health & Wellness			**019053001**
Related Category 3 Outcome Measure(s):	**019053001.3.1**	**IT-1.7**	**Controlling High Blood Pressure**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Goal: 200 patients/month Data Source: EHR Milestone 3 Estimated Incentive $145,000		Milestone 7 Estimated Incentive Payment: $50,000
Year 2 Estimated Milestone Bundle Amount:: $380,000	Year 3 Estimated Milestone Bundle Amount: $600,000	Year 4 Estimated Milestone Bundle Amount: $600,000	Year 5 Estimated Milestone Bundle Amount: $600,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,180,000			

PROJECT OPTION: 1.13.1 Development of behavioral health crisis stabilization services as alternatives to hospitalization

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 135222109.1.1

PERFORMING PROVIDER/TPI: Gulf Coast Center/135222109

Title of project

Behavioral Health Alternative to Hospitalization: Crisis Respite expansion to Brazoria County

Summary: Behavioral Health Alternative to Hospitalization – Crisis Respite expansion to Brazoria County

Provider: The Gulf Coast Center (GCC) is the mental health authority and substance abuse recovery provider through the Texas Department of State Health Services (DSHS) for Galveston and Brazoria Counties. The Center is one of 39 community mental health centers in the State of Texas through the auspices of the Texas Department of State Health Services. Serving Galveston and Brazoria Counties, the Gulf Coast Center provides a complete array of services to those with mental health, recovery and intellectual and developmental disability needs. The Gulf Coast Center adult services are currently charged with serving 1759 adults, although currently serving more than 2400 adults. Service sites include four adult mental health clinics (two in Galveston County and two in Brazoria County). This project focuses on the Center's mental health adult population age 18 and older. Galveston County covers 873 square miles and is divided into three distinct geographic areas: the mainland, Galveston Island, and Port Bolivar. As one of the largest counties in Texas, Brazoria County covers 1386 square miles. As of 2010, the U.S. Census Bureau estimated a population of 313,166 in Brazoria County, of which 72.2% were adults age 18 and older.

Intervention: Expanding Crisis Respite service to Brazoria County. Service expansion to prevent unnecessary inpatient psychiatric hospitalization, reduces demand on local Emergency Departments, and provide alternative to criminal justice system involvement.

Need for project: There is currently no intermediate respite service resource available in Brazoria County for adults with mental illness.

Target population: The target population includes Brazoria County residents in need of crisis intervention/stabilization services so as to minimize visits to local emergency departments and other higher levels of care. Increased utilization of available crisis respite beds will help to aid in the reduction of emergency department visits and/or subsequent hospitalizations. The goal of the project is to serve/assist 30% - 50% of crisis intervention related referrals over the course of DY3-5 with Crisis Respite alternative to hospitalization. Approximately 50% of our patients are either Medicaid eligible or low income uninsured.

Category 1 or 2 expected patient benefits: Our goal is to reduce preventable emergency department visits for targeted behavioral health/substance abuse conditions by serving/assisting 25% in DY4 and 40% in DY5 of individuals with the Crisis Respite services. Educate target population to contact appropriate GCC behavioral health outpatient clinic for emergent psychiatric needs to include Crisis Respite services for resolution of crisis situation in lieu of the utilization of emergency department services when clinically appropriate; during GCC business hours and after business hours.

Category 3 Outcomes: Our goal is reduce preventable emergency department visits for targeted behavioral health/substance abuse conditions by serving/assisting 30%-50% of individuals over the course of DY3-5 with the Crisis Respite alternative to hospitalization.

PROJECT DESCRIPTION:

Provide adult residential psychiatric crisis respite services 24 hour per day, 7 days per week at 8 bed facility in Angleton, Texas, as an alternative to inpatient psychiatric hospitalization and as a 'step-down' for people discharged from inpatient psychiatric hospitals. The project will provide 24 hr. supervision up to 7 days to insure clients are connected with mental health services and are compliant with taking psychiatric medication. The project will provide alternatives for crisis mental health workers assessing patients in Emergency Departments and law enforcement officials responding to mental health crises.

Project goal(s):

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.[1]

The goal is to expand Crisis Respite services to Brazoria County (8 beds at GCC Angleton facility) to prevent unnecessary inpatient psychiatric hospitalization, reduce demand on local Emergency Departments, and provide alternative to criminal justice system involvement.

Anticipated challenges:

A 10-bed crisis respite facility is located in Galveston County; however, it frequently has no vacancies and is over an hour's drive from Angleton. The only options currently available for Brazoria County law enforcement officials responding to a mental health crisis are to 1) drive the person to Texas City if there is a vacancy at the crisis respite facility, 2) transport to a psychiatric inpatient hospital in Houston, or 3) transport to at State Mental Health Facility. All three options remove the officer from the county for a minimum of two hours. If the person can benefit from up to 7 days of residential crisis respite and stabilize on their medications in the community then a psychiatric inpatient hospitalization will be avoided and the inpatient bed will be available for someone with a serious psychiatric crisis. On-call physician coverage is

[1] **Behavioral Health NEWS BRIEF Vol. 7 Issue 3 -** May 25, 2012 , http://www.dshs.state.tx.us/sa/_BHNB/

required 24/7, thus the challenge of securing a physician willing to commit to ongoing on-call coverage. Additionally, as nursing services and supports are not routinely available on-site, the Center's existing nursing staff will be need to be available throughout the business day to address medical related issues on an 'as needed' basis.

The 5-year expected outcome(s):

There is currently no intermediate respite service resource available in Brazoria County for adults with mental illness. This project provides a less restrictive environment for those requiring stabilization due to a behavioral health concern. Without this alternative, adults with mental illness are at risk of hospitalization and criminal justice involvement. This voluntary, short-term respite program affords individuals in need the opportunity for crisis resolution and 24/7 supervision, facilitating stabilization prior to integration into the community; thus reducing the recidivism rates within the criminal justice and inpatient mental health system.

Regional goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention

STARTING POINT/BASELINE:

During the recovery period following the devastation of Hurricane Ike in 2008, the Gulf Coast Center received a stimulus grant to open and operate an 8 bed crisis respite facility in Brazoria County. When that grant ended in 2011, the facility was closed. As part of the 1115 Waiver planning process, we have met with Brazoria County personnel and elected official who request that Gulf Coast Center re-open the Crisis Respite facility in Brazoria County so mental health sheriff deputies will have a local alternative for some people in a mental health crisis

RATIONALE:

Relation between Project Choices and Community Needs

The Behavioral Health Alternative to Hospitalization: Crisis Respite expansion project will help to develop and implement crisis stabilization/respite services to address the identified lack of alternative resources in the current community crisis system related to adult mental health services.

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 (e.g. for example, a community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs). Discussions are underway both internally and with community stakeholders to help develop the best system to address identified need.

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. Staff will be identified to research service availability in the service community and target those needs.

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) Data collection will determine where the greatest need is, considering types and volume of services most needed.

d. Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. Identified staff will explore alternative models and feasibility.

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. It is anticipated that this intervention will improve access to, and the quality of, behavioral health crisis stabilization by removing identified barriers such as transportation and admission delays. Most significantly, with the addition of the new services, it will divert admission from the more expensive psychiatric hospital beds to the local and more appropriate level of care. It will also offer improved and enhanced coordination of services within the continuum of care for admitted clients. It is expected that this intervention will occur early enough to prevent further deterioration, thus reducing the cost for stabilization which would be involved in a hospital psychiatric stay. It will also improve the coordination of care processes among substance abuse services, mental health services, law enforcement, including the mental health deputies, hospital emergency departments and homeless/housing programs. Regular, consistent review and assessments will be accomplished to determine the quality of services and possible improvement opportunities.

The Crisis Respite Expansion program will implement the following Process Measures: 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 services providers; P-4: Hire and train staff to implement identified crisis stabilization services; P-5: Develop administration of operational protocols and clinical guidelines for crisis services P-6: Evaluate and continuously improve crisis services; P-9: 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. GCC will participate in meetings with other community health centers participating in the

waiver through our regional collaborative ETBHN to discuss similar projects. The Improvement Measure will be I-12: Utilization of appropriate crisis alternatives with the goal to reduce preventable inpatient admission, number of people cycling through multiple systems (criminal justice, emergency departments and inpatient psychiatric system).

The Region is limited in mental health, behavioral health, and substance abuse resources (CN.5, CN.6).[2] Rates of psychologists and psychiatrists are well below both the State and U.S. averages. There are only an estimated 122 psychologists and 75 psychiatrists for the entire Region. The rate of psychologists in RHP2 is 8.7 per 100,000 and the rate for psychiatrists is 5.3 per 100,000. Additionally, there are just 28 substance abuse facilities and 5 detox facilities for the 16 county Region (CN.6). The Community Needs Assessment identifies no voluntary respite service facilities in Brazoria County and Galveston County. The lack of respite resources results in increased use of inpatient psychiatric beds and high risk for criminal justice involvement.

Unique Community Need Identification numbers:

CN.5. Mental/Behavioral Health Provider Shortage Health Resources Services Administration (HRSA), Area Resource File (ARF), US HHSC, Health Professions Workforce Center, TX Department of State Health Services.

CN.6.Mental/Behavioral Health Facility Shortage (Substance Abuse Facilities: 28, Detox Facilities: 5) Substance Abuse and Mental Health Services Administration (SAMHSA).

Expansion or enhancement:

The expansion of Crisis Respite services to Brazoria County will provide a much needed, short-term resource for individuals experiencing a mental health crisis but not requiring a higher level of care such as inpatient psychiatric services. Respite services can be utilized in lieu of Emergency Department visits. The Gulf Coast Center does not currently receive state or federal funding for this project.

RELATED CATEGORY 3 OUTCOME MEASURE(S)

The Outcome Domain 9 – Right Care, Right Setting supports the project as evidenced in IT-9.2

Rationale: There is currently no intermediate respite service resource available in Brazoria County for adults with mental illness. This project provides a less restrictive environment for those requiring stabilization due to a behavioral health concern. Without this alternative, adults with mental illness are at risk of hospitalization and criminal justice involvement. This voluntary, short-term respite program affords individuals in need the opportunity for crisis resolution and 24/7 supervision, facilitating stabilization prior to integration into the community; thus reducing admissions to the inpatient mental health system.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on providing adult residential psychiatric crisis respite and emphasis on Brazoria Counties ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5,

[2] Psychologists, psychiatrists, substance abuse facilities, and detox facilities data from Substance Abuse and Mental Health Services Administration.

096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDER'S PROJECTS IN THE RHP:

This project focuses on the development of behavioral health crisis stabilization services along with these other Category 1 projects in our RHP: 135222109.1.1 - Behavioral health alternative to hospitalization: crisis respite expansion to Brazoria County; 135222109.1.3 - Behavioral health alternative to hospitalization: ambulatory detox; 135222109.1.5-Behavioral health crisis stabilization alternatives to hospitalization: crisis respite & response-intellectual & developmental disabilities.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Population Affected: Assuming an average length of stay of seven days at the eight bed facility, there is a capacity of approximately 400 admissions per year; of which almost all will be primarily uninsured or on Medicaid.

> Score: Total of 3 points for moderately-sized population affected (2) and the number of uninsured/Medicaid population to be served (1).

Severity: Per the June 2012 Qualitative Community Health Assessment for Brazoria County, almost 50% of responders stated that the increase to the number of places for mental health services was very important (highest ranking). The re-start of the proposed project (originally put into operating with a short term grant following Hurricane Ike) was specifically requested by Brazoria County elected officials and healthcare leaders. Currently there are no intermediate mental health respite resources available in Brazoria County for adults with mental illness.

> Score: Total of 5 points for strong support on Community Needs Assessment (2) and the significant impact on population to be served by providing option not currently available and minimizing wait time for crisis respite for both the individual and family (3).

Cost-Effectiveness: Cost of an inpatient bed day at regional psychiatric hospital (GCC Contract) is approximately $470/bed day. Approximate cost of the proposed crisis respite bed day is projected to be $122/bed day or 74% less than the regional psychiatric hospital.

Score: Total of 5 points for very low cost per person; especially in comparison to regional psychiatric inpatient stay.

Community Benefit: The proposed project will improve access to services sooner when needed, improve overall quality of the service received by the consumer and family, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing a cost effective alternative, and will work in collaboration with other community resources including but not limited to the County Mental Health Deputies, local community hospitals, and NAMI Gulf Coast.

Score: Total of 4 points for its improvement of access (1), improvement of quality (1), improves costs (1), and collaboration (1).

135222109.1.1	1.13.1	**1.13.1 A-E**	**BEHAVIORAL HEALTH ALTERNATIVE TO HOSPITALIZATION: CRISIS RESPITE EXPANSION TO BRAZORIA COUNTY**
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.1	IT-9.2	**OD- 9 Right Care, Right Setting IT-9.2 ED appropriate utilization(Standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-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 services providers. Metric 1 P-1.1 Number meetings and participants Baseline/Goal: For past 2 years, no crisis respite (or comparable services) available in Brazoria County. Establish stakeholder group for quality improvement Data Source: Attendance Lists Milestone 1 Estimated Incentive Payment (maximum amount): $179,198 **Milestone 2** P-4: Hire and train staff to implement identified crisis stabilization services Metric 1 P-4.1 Number of staff hired and trained Baseline/Goal: No Crisis Respite services available in Brazoria County; hire staff for Crisis Respite expansion project	**Milestone 4** P-6: Evaluate and continuously improve crisis services Metric 1 P-6.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline/Goal: Assess and improve processes Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 4 Estimated Incentive Payment: $ 314,850 **Milestone 5 P-9** Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance).	**Milestone 6** I-12: Utilization of appropriate crisis alternatives Metric 1 I-12.1: 25% Goal: Reduce Emergency Department visits of 25% of crisis respite consumers for target conditions: o Behavioral Health/Substance Abuse Data Source: Claims, encounter, and clinical record data Milestone 6 Estimated Incentive Payment: $ 526,275	**Milestone 7** I-12: Utilization of appropriate crisis alternatives Metric 1 I-12.1: 40% Goal: : Reduce Emergency Department visits of 40% of crisis respite consumers for target conditions: o Behavioral Health/Substance Abuse Data Source: Claims, encounter, and clinical record data Milestone 7 Estimated Incentive Payment: $ 434,749

135222109.1.1	1.13.1	**1.13.1 A-E**	**BEHAVIORAL HEALTH ALTERNATIVE TO HOSPITALIZATION: CRISIS RESPITE EXPANSION TO BRAZORIA COUNTY**
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.1	IT-9.2	**OD- 9 Right Care, Right Setting 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)**
Data Source: Certifications of training completion Milestone 2 Estimated Incentive Payment (maximum amount): $179,198 **Milestone 3** P-5: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 P-5.1 Completion of policies and procedures Baseline/Goal: Revise previously utilized guidelines Data Source: Internal policy and procedures documents and operations manual Milestone 3 Estimated Incentive Payment (maximum amount): $179,197	Metric: P-9.1 Participate in semi-annual face-to-face meetings or seminars organized in the RHP Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 5 Estimated Incentive Payment (maximum amount): $ 209,900		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 537,593	Year 3 Estimated Milestone Bundle Amount: $ 524,750	Year 4 Estimated Milestone Bundle Amount: $ 526,275	Year 5 Estimated Milestone Bundle Amount: $ 434,749
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $ 2,023,367			

PROJECT OPTION: 1.12.4 Enhance Service Availability (i.e. hours, locations, transportation, mobile clinics) of Appropriate Levels of Behavioral Health Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: **135222109.1.2**
PERFORMING PROVIDER NAME/TPI: Gulf Coast Center/135222109

Title of project: Wellness & Recovery for Youth

Provider: The Gulf Coast Center is one of thirty-nine community mental health centers in Texas serving individuals with intellectual and developmental disabilities (IDD), mental illness, HIV and substance abuse recovery services. Serving Galveston and Brazoria Counties, the Gulf Coast Center is currently charged with serving 198 youth. Specific to this project, staff employed by the Gulf Coast Center will serve youth between the age of 3 to 17 residing in Galveston and Northern Brazoria Counties.
Intervention: Establish a Wellness Clinic that in DY3 at least 40 youth will be served; the overall scope of the project, however, will benefit many more youth who will then be able to access psychiatric services as the youth who are ready for transition to a less restrictive level of care transfer to the Wellness Clinic. It is anticipated that a total combined number of 325 youth will participate in the Wellness Clinic and/or have address to psychiatric services due to youth transitioning to the Wellness Clinic. A Wellness approach to service delivery within one location will expand access to psychiatric medication services while promoting physical health as well as psychological health. Collaborative intervention will prevent the development of serious psychiatric and medical problems in youth directly addressing needs such as nutrition, fitness, self-care, self-esteem, and sleep hygiene thereby treating the whole child and more successfully meeting treatment needs in one location rather than expecting families with limited resources to travel to multiple providers.
Need for the Project: Gulf Coast Center's current youth population served contains individuals ready for transition to a less restrictive level of care for which a wellness approach would accommodate in terms of psychiatric needs and enhance care in terms other unmet needs. Many youth are unable to transition out of our existing services because of the lack of providers accepting Medicaid, CHIP and/or their complexity of a psychiatric history. Establishment of the Wellness Clinic would provide a transition provider accepting of Medicaid, CHIP, and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning. For youth not currently served within our agency who will be new patients, psychiatric resources are limited within the local area. Further, the Wellness approach collaborating psychiatric and psychological providers with medical providers for youth is not known to be available in this immediate area.
Target Population: The target population is our patients currently served who are ready for transition to a less restrictive level of care and new patients residing within Galveston and Northern Brazoria Counties. Approximately 85% of our patients are either Medicaid or CHIP eligible.
Category 1 Expected Patient Benefits: The project seeks to achieve 40% of people reporting satisfaction with access to care in DY4 and 60% in DY5.

Category 3 Outcomes: Our goal is to demonstrate improvement over our baseline of patient satisfaction scores - 40% DY4 to 60% DY5.

PROJECT DESCRIPTION:

Gulf Coast Center's current youth population served contains individuals ready for transition to a less restrictive level of care for which a wellness approach would accommodate in terms of psychiatric needs and enhance care in terms other unmet needs. Many youth are unable to transition out of our existing services because of the lack of providers accepting Medicaid, CHIP and/or their complexity of a psychiatric history. Establishment of the Wellness Clinic would provide a transition provider accepting of Medicaid, CHIP, and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning.

Project goal(s):

Enhance service availability for psychiatric mental health services that will also promote physical and psychological health to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Specifically, develop a Wellness approach to service delivery within one location that would expand access to psychiatric medication services while promoting physical health as well as psychological health. This approach would prevent the development of serious psychiatric and medical problems in youth directly addressing needs such as nutrition, fitness, self-care, self-esteem, and sleep hygiene while treatment is enhanced through continuity amongst providers collaboratively working together. Incorporation of subspecialist child and adolescent psychiatric care will facilitate identification of medical disorders that may impact psychiatric disorders and vice versa. One main location for a child's routine health care will allow families to experience less travel to and from appointments, less conflict around scheduling of appointments at different locations and less cost around time off of work and for gas associated with health care of their child due to this collaborative approach.

Anticipated challenges:

The need to enhance service availability to appropriate levels of behavioral health care for youth comes directly from the lack of board certified child and adolescent psychiatrists in our local area accepting Medicaid, CHIP and accepting clients with the level of treatment need the population we serve currently experiences. One challenge anticipated is securing medical physicians to deliver services at affordable costs, especially when considering sustainability. A response to consider for this type of challenge includes utilizing revenue generated from therapy services to assist with covering medical practitioner costs, as well as, utilizing a Physician's Assistant and/or Residency Program (both at a lower cost to the operation) with required oversight from board certified medical physicians. Another example of a challenge for Wellness & Recovery for Youth is management of no shows for appointments. Response to this challenge is to consider utilizing an open access model opposed to scheduled appointments. The lack of continuity between psychiatric, psychological and physical health results in a lack of possible progress of improved level of functioning for the youth and family. A wellness approach to healthcare addressing psychiatric and physical needs will promote progress beyond what disciplines working in silos with minimal consultation usually obtain. Priority must be given by each member of the multidisciplinary team to efforts required to maintain continuity for each youth and family served in order to achieve the Wellness approach

described. Continuity is fostered through multidisciplinary team meetings and through the constant of the identified case manager to liaison and relay information amongst all team members.

The 5-year expected outcome(s):

Over the 5 year project, Wellness & Recovery for Youth will demonstrate improved overall level of functioning of youth served, who actively participated in services. Over this 5 year period, Gulf Coast Center will have had the opportunity to transfer a significant portion of our current client population ready for transition to a less restrictive level of care to Wellness & Recovery for Youth. Instead of having youth remain in our current services who are ready for transition to a less restrictive service, but unable to do so due to the lack of providers accepting Medicaid, CHIP and/or their past complex psychiatric history, they will transfer to Wellness & Recovery for Youth. This shift of patients to the Wellness & Recovery for Youth will allow our original clinic to admit new patients whose lower level of functioning requires provision of care through Gulf Coast Center. Essentially, Gulf Coast Center will meet the needs of the community by serving more youth whose mental health is not stable and require core mental health services while Wellness & Recovery for Youth provides a new approach to meeting needs possibly not addressed for currently served youth in the past (i.e. nutrition, fitness, physical health) assisting them in maintaining their mental health stability while enhancing their overall level of functioning. An assessment tool will be identified to measure functioning levels of youth served throughout the period necessary to measure progress/lack of progress. And a task force will be identified, developed and maintained throughout the duration of the project for feedback; input and guidance regarding community need and project development.

Regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management

STARTING POINT/BASELINE:

Currently, there are 54 youth admitted to the Galveston County Child & Adolescent Gulf Coast Center "After-Care Services". After-Care Services indicates within our system that having completed treatment (i.e. therapy, skills training) the youth's mental health status is stable enough that he or she can receive medication and case management services only to maintain his or her therapeutic level of functioning. Essentially, youth assigned to After-Care Services are ready for transition to a less restrictive level of care. Many are unable to transition out of our existing services because of the lack of providers accepting Medicaid, CHIP and/or their complex psychiatric history. Establishment of the Wellness & Recovery Clinic would provide a transition provider accepting Medicaid, CHIP and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning. A starting point would be for Gulf Coast Center's Galveston County Child & Adolescent Treatment Team to assess the 54 youth within the After-Care Services to determine which individuals at the given time meet the transition criterion to transfer to Wellness & Recovery for Youth. The project would grow from there accessing referrals from Gulf Coast Center as well as the community.

RATIONALE:

Relation between Project Choices and Community Needs

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. For psychiatric emergencies, this impact can be costly for our emergency rooms, law enforcement and detention facilities. In the end, this impact results in more costly, less coordinated care and a lack of appropriate follow-up care for which youth and families do not benefit. Mental Illness left untreated progresses in severity greatly impacting the individual, the family and our already overburdened systems. Youth and families may experience barriers in accessing primary and psychiatric 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.

Mental Health Association estimated for the general population of Texas in 2003, that there were 151,464 youth in the state who had a significant impairment due to mental illness, however, only 39,598 (26%) actually received any mental health treatment. For Galveston County specifically, the same report identified 1,688 youth diagnosed with a mental illness and only 181 (11%) received services. Those who are in treatment depend on mental health services to help them function in school, their family, and among peers and within society as a whole. Youth who do not receive essential treatment (i.e. psychological services and medication therapy) find themselves expelled from school, interfacing with law enforcement, entering emergency rooms for costly care, running away or even contemplating suicide. Department of State and Health Services (DSHS) reported the number of deaths within the state of Texas classified as self-inflected through intentional harm for 2009 was a count of 27 for youth age 5 to 14 and 411 for those 15 to 24 years of age. The Galveston County 2011-2012 Community Plan identifies “Juvenile Issues” to be the priority as the greatest need of all listed needs within the plan. The plan reported that during 2010, Galveston County Juvenile Justice Department received 254 referrals on youth for felony offenses and 443 misdemeanor referrals that same year. To put this data in perspective for the state of Texas, the Galveston County Community Plan reported that the total number of referrals to juvenile probation departments statewide during 2008 (latest year available) was 99,276 per TJPC. The Wellness and Recovery for Youth project supports the Galveston Community Plan by meeting two primary mental health suggestions indicated in the plan: more collaboration between mental illness service providers, schools and law enforcement and more individual, group and family mental health outpatient services for youth. Wellness and Recovery for Youth will expand access to psychiatric care for youth. Specifically, development of a Wellness approach that will expand access to psychiatric medication services while promoting physical health as well as psychological health. This approach will prevent the development of serious psychiatric and medical problems in youth directly addressing needs such as nutrition, fitness, self-care, self-esteem, and sleep hygiene. Incorporation of subspecialist child and adolescent psychiatric care

will facilitate identification of medical disorders that may impact psychiatric disorders and vice versa.

American Academy of Child and Adolescent Psychology (March 2011) reported 16-33% of youth are obese. Weight gain due to diet and lack of exercise is reportedly responsible for over 300,000 deaths each year. The annual cost to society is estimated at $100 billion. Obesity in children and adolescents is commonly rooted in non-physical causes with significant physical consequences possible. Given the complexity of the needs of the child within this example, it is clear that a physical health provider alone will not meet all of the child's needs nor will a mental health provider alone meet all of the child's health care needs. A Wellness approach to healthcare with a multi-disciplinary team has a better chance of meeting the needs of this child. Obesity is associated with emotional problems manifested in physical discomfort and often medical illness. A youth suffering due to obesity along with possibly other medical and/or mental health disorders is simply one example of how access to medical, psychiatric and psychological care in one location can work to treat the whole child.

Unique Community Need Identification numbers:

CN.5 Mental/Behavioral Health Provider Shortage

CN.13 Chronic Diseases: Obesity

Expansion or enhancement:

Wellness & Recovery for Youth would be an expansion project for Gulf Coast Center operating outside of our contract with Department of State Health Services (DSHS) to provide Resiliency & Disease Management (core services) provided by the Galveston County Child & Adolescent Mental Health Team. Service provision within the Wellness & Recovery for Youth clinic would include similar services like therapy and psychiatric medication services, however, there would be services not provided within our regular operation such as nutrition, and fitness coaching.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Outcome Domain-6 Patient Satisfaction fits with the chosen Category 1 project "Wellness & Recovery for Youth" because the Improvement Target 6.1 Percent Improvement over Baseline of Patient Satisfaction Scores directly measures satisfaction with access to expanded primary care capacity. Upon admission to Wellness & Recovery for Youth, a survey will be provided to establish a baseline of satisfaction with initial access of services. Additional data will be collected for each year of the project following the establishment of the baseline.

Patient Satisfaction Outcome Domain is directly linked to the Regional Goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention. 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 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.

The Wellness and Recovery for Youth project model is built around providing a coordinated, patient-centered approach to healthcare that will expand access to psychiatric services while promoting physical health as well as psychological health from a multi-disciplinary treatment team serving the family within one location. It is our belief that patient satisfaction will directly correlate with patient attendance. Patients satisfied and engaged in treatment will know who their providers are and what services are available to them, work with providers to reduce barriers around transportation, and decrease their need for emergent and urgent care visits that are costly.

RELATIONSHIP TO OTHER PROJECTS :

This project's focus on establishing a wellness clinic and emphasis on the behavioral and phsyical health of youth ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

The Gulf Coast Center will be the Performing Provider; but will, as it does now, collaborate and link with available community resources and participating private providers as available. This project focuses on the establishment of a wellness clinic that would provide a transition provider accepting of Medicaid/CHIP and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning. There are no other related Category 1 similar projects in our RHP.

This project focuses on the establishment of a wellness clinic that would provide a transition provider accepting of Medicaid/CHIP and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning. There are no other related Category 1 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

Population Affected: The proposed project is directed towards children with Medicaid or CHIP, who have no place to transition to because of the lack of providers other than the Gulf Coast

Center who will take Medicaid or CHIP, and/or their complex psychiatric history. Participation in the proposed project would be available to those served by the Gulf Coast Center, as well as community referrals.

Severity: Per the June 2012 Qualitative Community Health Assessment for Brazoria County, almost 50% of responders stated that the increase to the number of places for mental health services was very important (highest ranking). Per the June 2012 Qualitative Community Health Assessment for Galveston County, one of the more commonly stated challenges to health was the lack of access to affordable / available health resources including behavioral health. Currently there are no available resources for children in services who are in need of a less restrictive level of care and promotion of physical health, to transition to. *Cost-Effectiveness*: Over the four year period, the proposed project is estimated to cost approximately $1.2 million, and serve over 325; for an estimated average cost of $3,690/youth served during the four year project – considered extremely cost efficient for the population served, and the services and supports proposed to be provided. *Community Benefit*: The proposed project will improve access to youth to transition to less restrictive level of care services as soon as clinically appropriate, improve overall quality of services received and expand the services provided, is innovative and transformative to the services currently available for youth in Galveston and Brazoria counties diagnosed with a behavioral health issue, will work in collaboration with community medical resources, and will improve costs long term by transitioning youth who are ready to transition to more appropriate care thus allowing youth whose lower level of functioning requires the more intensive care of the Gulf Coast Center an opportunity into services – who otherwise cannot access needed Gulf Coast Center due to the lack of capacity or openings in Gulf Coast Center services.

135222109.1.2	1.12.4	1.12.4	Enhance Service Availability: Wellness & Recovery for Youth	
Gulf Coast Center				135222109
Related Category 3 Outcome Measure(s):	P1-Project Planning P2-Establish baseline rates 135222109.3.2	6.IT.-6.1	OD-6 Patient Satisfaction	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-4] Hire and train staff to operate and manage projects selected. Metric 1 [P-4.1]: Number of staff secured and trained. Baseline/Goal: For Fiscal Year 2012, Gulf Coast Center had 1 Board Certified Child Psychiatrist providing psychiatric medication services within Galveston County at 16 hours per week. Goal is to expand with at least 1 more Child Psychiatrist and a Physician's Assistant plus additional disciplines to create a multi-disciplinary team. Data Source: Project records; Training curricula Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 537,593	**Milestone 2** [P-7]: Evaluate and continuously improve services. Metric 1 [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Baseline/Goal: Families will report the Wellness and Recovery for Youth decreases their child's health care schedule conflicts, amount of time to take off work for their child's health care appointments, and associated transportation costs while providing improved services. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment: $ 524,750	**Milestone 4** [I-14] Improved Consumer Satisfaction with Access Metric 1 [I-14.1]: 40 % of people reporting satisfaction with access to care. a. Numerator: The number of individuals receiving services through expanded access sites that have expressed satisfaction with services. b. Denominator: The number of individuals receiving services through expanded access sites. Goal: Significant number of patients and their families will report improved access to psychiatric services and satisfaction with the wellness approach to treatment. Data Source: CG-CAHPS3	**Milestone 5** [[I-14] Improved Consumer Satisfaction with Access a. Metric 1 [I-14.1]: 60% of people reporting satisfaction with access to care. Numerator: The number of individuals receiving services through expanded access sites that have expressed satisfaction with services. b. Denominator: The number of individuals receiving services through expanded access sites. Goal: Increased number of patients and their families from Year 4 will report improved access to psychiatric services and satisfaction with the wellness approach to treatment. Data Source: CG-CAHPS3

135222109.1.2	1.12.4	1.12.4	Enhance Service Availability: Wellness & Recovery for Youth	
Gulf Coast Center				135222109
Related Category 3 Outcome Measure(s):	P1-Project Planning P2-Establish baseline rates 135222109.3.2	6.IT.-6.1	OD-6 Patient Satisfaction	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 4 Estimated Incentive Payment: $ 526,275	Milestone 5 Estimated Incentive Payment: $ 434,749
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $537,593	Year 3 Estimated Milestone Bundle Amount: $ 524,750		Year 4 Estimated Milestone Bundle Amount: $ 526,275	Year 5 Estimated Milestone Bundle Amount: $ 434,749
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $2,023,367				

PROJECT OPTION: 1.13.1 Development of health crisis stabilization services as alternatives to hospitalization
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 135222109.1.3
PERFORMING PROVIDER NAME/TPI: Gulf Coast Center/135222109
Title of project: Behavioral Health Alternative to Hospitalization: Ambulatory Detox

Provider: The Gulf Coast Center (GCC) is the mental health authority and substance abuse recovery provider through the Texas Department of State Health Services (DSHS) for Galveston and Brazoria Counties. The Center is one of 39 community mental health centers in the State of Texas through the auspices of the Texas Department of State Health Services. Serving Galveston and Brazoria Counties, the Gulf Coast Center provides a complete array of services to those with mental health, recovery and intellectual and developmental disability needs. GCC is currently a provider of outpatient substance abuse counseling and treatment. In FY 2012 1,492 individuals were seen in the Gulf Coast Center Recovery Program. Gulf Coast Recovery serves adult men and women with a documented diagnosis of substance use or addiction.
Intervention: The goal of this project is multi-faceted: 1) provide alternative to hospitalization and/or arrest, 2) provide rapid access to outpatient substance abuse detox treatment for people who have been admitted to inpatient psychiatric hospital; 3) facilitate quick discharge from inpatient psychiatric hospitalization and smooth transition to detox treatment if person has co-occurring mental illness and substance abuse issues.
Need for project: Currently inpatient psychiatric beds are being used for individuals who may present with symptoms of mental illness, but in fact, their substance abuse is the mitigating factor, whether or not they have a co-occurring psychiatric diagnosis. Also, emergency departments are recipients of the target population based on symptoms related to substance use and detox physical impact. Only two residential detox beds are available for a three county area (including the two counties in this project- Brazoria County and Galveston County), which may lead to more demand for the Ambulatory Detox Project than the project can address.
Target population: GCC Recovery serves adult men and women residents of Brazoria and Galveston Counties with a documented diagnosis of substance use or addiction of which 76% are involved with the legal system, 44% are unemployed and 45% who work typically have minimum wage employment with no benefit – significantly, no medical coverage. 21% of Center clients reported poor physical health or physical problems.
Category 1 expected patient benefits: This intervention will occur early enough in the abuse cycle to prevent further deterioration for those with a co-occurring psychiatric and substance abuse disorders, thus reducing the risk and cost for inpatient detoxification and stabilization. It will improve coordination of care among substance abuse services, mental health services, law enforcement, including mental health deputies, hospital EDs and homeless/housing programs.
Category 3 Outcomes: There were 635 individuals admitted in 2012 to GCC's Psychiatric Unit or County Jail for Brazoria County and Galveston County with a need for detoxification. Project will result in a 25% reduction in those admissions by starting enrollment into the project in the latter part of DY2 and admitting 160 participants to the Ambulatory Detox Program in years 3 and 4 and 200 in year 5. The ongoing engagement of stakeholders will foster rapid change and utilization of Ambulatory Detox as an alternative to incarceration or hospitalization.

PROJECT DESCRIPTION:

The Ambulatory Detox project will operate 52 weeks per year with licensed professional staff as well as Peer Support staff. Staffing will include a physician, RN program coordinator, RN monitor of detox effects, Licensed Chemical Dependency Counselor, and Peer Support staff to provide comprehensive treatment and education related to the person's addiction and recovery. Each participant participates in full course of concurrent outpatient substance abuse treatment and detox services. Target population is adults in Galveston County and Brazoria County.

Project goal(s):

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.[1]

The goal is to provide Ambulatory Detox supports as an alternative to hospitalization and/or incarceration. Approximately 75% of the people admitted to the Gulf Coast Center's inpatient psychiatric beds have co-occurring substance abuse issues. The goal of this project is multi-faceted: 1) provide alternative to hospitalization and/or arrest, 2) provide rapid access to outpatient substance abuse detox treatment for people who have been admitted to inpatient psychiatric hospital; 3) facilitate quick discharge from inpatient psychiatric hospitalization and smooth transition to detox treatment if person has co-occurring mental illness and substance abuse issues.

Anticipated challenges:

Currently inpatient psychiatric beds are being used for individuals who may present with symptoms of mental illness, but in fact, their substance abuse is the mitigating factor, whether or not they have a co-occurring psychiatric diagnosis. Also, emergency departments are recipients of the target population based on symptoms related to substance use and detox physical impact. Only two residential detox beds are available for a three county area (including the two counties in this project- Brazoria County and Galveston County), which may lead to more demand for the Ambulatory Detox Project than the project can address. Another challenge is related to potential "drop-out" rates as people transition between detox and outpatient services which we hope will improve since clients will be co-enrolled in outpatient

[1] **Behavioral Health NEWS BRIEF Vol. 7 Issue 3 -** May 25, 2012 , http://www.dshs.state.tx.us/sa/_BHNB/

treatment services. There are no local residential detox slots for female clients currently have to travel to Houston to receive services.

The 5-year expected outcome(s):

The initial expected outcome is to develop a consumer-centered ambulatory detox program that results in a decrease in the number of mental health admissions and readmissions to criminal justice settings such as jails or prisons, by assuring that the right care in the right setting is provided initially. Additional outcomes will be to decrease the misuse of emergency departments and psychiatric inpatient units, and redirect those with substance abuse as the mitigating factor to more appropriate services.

Regional goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention

STARTING POINT/BASELINE:

The Gulf Coast Center is currently a provider of outpatient substance abuse counseling and treatment. In FY 2012 1,492 individuals were seen in the Gulf Coast Center Recovery Program. Gulf Coast Recovery serves adult men and women with a documented diagnosis of substance use or addiction of which 76% are involved with the legal system, 44% are unemployed and 45% who work typically have minimum wage employment with no benefit – significantly, no medical coverage. 21% of Center clients reported poor physical health or physical problems. And the vast majority report poor socio-economic. Adding the Ambulatory Detox will address this significant need in the area due to the limited residential detox treatment available. By implementing the medical component required for ambulatory detox, the Gulf Coast Center will be able to expand substance abuse treatment and facilitate recovery at a crucial time in the abuse cycle.

RATIONALE:

Relation between Project Choices and Community Needs

The Behavioral Health Alternative to Hospitalization: Ambulatory Detox project will help to develop and implement crisis stabilization services to address the identified gaps in the current community crisis system related to substance abuse. The project option is 1.13.1. The project components are in five parts, four of which have already been completed. They are as follows:

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 (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs). *The component has already been fulfilled*

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. *The component has already been fulfilled*

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) *The component has already been fulfilled*

d. Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. *The component has already been fulfilled*

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. It is anticipated that this intervention will improve access to, and the quality of, behavioral health crisis stabilization by removing identified barriers such as transportation and admission delays. Most significantly, with the addition of the new ambulatory detox services, it will divert admission from the more expensive psychiatric hospital beds to the local and more appropriate level of care. It will also offer improved and enhanced coordination of services within the continuum of care for admitted clients. It is expected that this intervention will occur early enough to prevent further deterioration for those with a co-occurring psychiatric and substance abuse disorders, thus reducing the cost for detoxification and stabilization which would be involved in a hospital psychiatric stay. It will also improve the coordination of care processes among substance abuse services, mental health services, law enforcement, including the mental health deputies, hospital emergency departments and homeless/housing programs.

The Ambulatory Detox program will implement the following Process Measures: 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 services providers; P-4: Hire and train staff to implement identified crisis stabilization services; P-6: Evaluate and continuously improve crisis services; P-9: 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. GCC will participate in meetings with other community health centers participating in the waiver through our regional

collaborative ETBHN to discuss similar projects. The Improvement Measure will be I-12: Utilization of appropriate crisis alternatives with the goal to reduce preventable inpatient admission, number of people cycling through multiple systems (criminal justice, emergency departments and inpatient psychiatric system).

The Region is limited in mental health, behavioral health, and substance abuse resources (CN.5, CN.6).[2] Rates of psychologists and psychiatrists are well below both the State and U.S. averages. There are only an estimated 122 psychologists and 75 psychiatrists for the entire Region. The rate of psychologists in RHP2 is 8.7 per 100,000 and the rate for psychiatrists is 5.3 per 100,000. Additionally, there are just 28 substance abuse facilities and 5 detox facilities for the 16 county Region (CN.6). The Community Needs Assessment identifies limited or no detox facilities in Brazoria County and Galveston County. This deficit results in increased use of inpatient psychiatric beds and high risk for criminal justice involvement.

Unique Community Need Identification numbers:

CN.6.Mental/Behavioral Health Facility Shortage (Substance Abuse Facilities: 28, Detox Facilities: 5) Substance Abuse and Mental Health Services Administration (SAMHSA)

Expansion or enhancement:

This project is a new initiative for the Gulf Coast Center and for the two county areas that the Center serves: Brazoria County and Galveston County; and is not currently available. The Gulf Coast Center does not currently receive state or federal funding for this project.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD- 9 Right Care, Right Setting

The chosen process milestones are P-1 Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan; P-2 Establish baseline rates which will with review of jail and hospital reports; P-3 Develop and test data systems by implementing computer software or programming; P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities and provide means for quick response to needed changes; and P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

The project chose IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons *(Standalone measure)* with the following:

a Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to psychiatric hospital unit or criminal justice setting (e.g. jail, prison, etc.) within the measurement period.

b Denominator: The number of individuals receiving project intervention(s)

c Data Sources: Claims/ encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records.

d Rationale/Evidence: Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies

[2] Psychologists, psychiatrists, substance abuse facilities, and detox facilities data from Substance Abuse and Mental Health Services Administration.

of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. 635 individuals admitted in 2012 to Psychiatric Unit or County Jail who presented with a need for detoxification. Project will result in a 25% reduction in those admissions by admitting 159 participants to the Ambulatory Detox Program.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on creating an ambulatory detox program and emphasis on Galveston and Brazoria Counties ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

The Gulf Coast Center will be the Performing Provider; but will, as it does now, collaborate and link with available community resources and participating private providers as available.

This project focuses on the development of behavioral health crisis stabilization services along with these other Category 1 projects in our RHP: 135222109.1.1 - Behavioral health alternative to hospitalization: crisis respite expansion to Brazoria County; 135222109.1.3 - Behavioral health alternative to hospitalization: ambulatory detox; 135222109.1.5-Behavioral health crisis stabilization alternatives to hospitalization: crisis respite & response-intellectual & developmental disabilities.

PLAN FOR LEARNING COLLABORATIVE;

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

Population Affected: Per Region 2's Health Partnership power point presentation with governmental data, it was reported that in Galveston County 17.8% of the population reported excessive drinking; which exceeds both the State and US percentages. In both the Galveston and Brazoria counties Qualitative Community Health Assessments, a large percentage indicated that alcohol and drug abuse treatment services were not available. The proposed project will be available for both Galveston and Brazoria counties to help address this identified need; and almost all will be either uninsured or on Medicaid. *Severity*: In both the Galveston and Brazoria counties Qualitative Community Health Assessments, a large percentage indicated that alcohol and drug abuse treatment services were not available. Currently, there are only two

residential detox beds available for a three county area (including the two counties in this project- Brazoria and Galveston County); and there are no Brazoria or Galveston County local residential detox slots for female clients; they currently have to travel to Houston to receive services separating them from their family support. Additionally, impacting behavioral health services and availability of limited psychiatric inpatient beds, is the fact that 75% of those admitted to the local mental health inpatient unit have a co-occurring disorder; with the substance abuse being the mitigating factor. *Cost-Effectiveness*: Cost of an inpatient bed day at regional psychiatric hospital (GCC Contract) is approximately $470/bed day. The proposed project is expected to cost approximately $255,000 per year; and serve around 350 persons a year for an estimated four year total cost of $1 million serving 1,400, or $730 per person served. Compared to an average length of stay of seven days - the inpatient stay cost would be around $3,290 as compared to $730. *Community Benefit*: The proposed project will improve access to the right services sooner, improve overall quality of the service, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing a cost effective alternative, is a new and transformative initiative for behavioral health services by creating an immediately available alternative for someone presenting with a co-occurring disorder when the substance abuse issue is the mitigating factor and identifying that issue up front; and will work in collaboration with other community resources including but not limited to the Mental Health Deputies, local law enforcement, local community hospitals, and NAMI Gulf Coast.

135222109.1.3	1.13.1	1.13.1.E	BEHAVIORAL HEALTH ALTERNATIVE TO HOSPITALIZATION: AMBULATORY DETOX	
Gulf Coast Center				135222109
Related Category 3 Outcome Measure(s):	**135222109.3.3**	**IT-9.1**	**OD- 9 Right Care, Right Setting IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Standalone measure)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: 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. Metric 1 P-1.1 Number meetings (4) and participants Baseline/Goal: we had no ambulatory detox options in 2012; Establish stakeholder group for quality improvement Data Source: Attendance Lists Milestone 1 Estimated Incentive Payment (maximum amount): $179,198 **Milestone 2** P-4: Hire and train staff to implement identified crisis stabilization services Metric 1 P-4.1 Number of staff hired and trained Baseline/Goal: we had no ambulatory detox options in 2012; hire staff for ambulatory detox project Data Source: Certifications of training	**Milestone 4** P-6: Evaluate and continuously improve crisis services Metric 1 P-6.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline/Goal: Assess and improve processes Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 4 Estimated Incentive Payment: $ 314,850 **Milestone 5 P-9** Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance).		**Milestone 6** I-12: Utilization of appropriate crisis alternatives Metric 1 I-12.1: 160 diverted to Ambulatory Detox Numerator: Total clients in Ambulatory Detox Project Denominator: Total clients in all Recovery Services Goal: Reduce preventable inpatient admission, number of people cycling through multiple systems (criminal justice, emergency departments and inpatient psychiatric system) Data Source: Claims, encounter, and clinical record data Milestone 6 Estimated Incentive Payment: $ 526,275	**Milestone 7** I-12: Utilization of appropriate crisis alternatives Metric 1 I-12.1: 200 diverted to Ambulatory Detox Numerator: Total clients in Ambulatory Detox Project Denominator: Total clients in all Recovery Services Goal: Reduce preventable inpatient admission, number of people cycling through multiple systems (criminal justice, emergency departments and inpatient psychiatric system) Data Source: Claims, encounter, and clinical record data Milestone 7 Estimated Incentive Payment: $ 434,749

135222109.1.3	1.13.1	1.13.1.E	BEHAVIORAL HEALTH ALTERNATIVE TO HOSPITALIZATION: AMBULATORY DETOX	
Gulf Coast Center				135222109
Related Category 3 Outcome Measure(s):	**135222109.3.3**	**IT-9.1**	**OD- 9 Right Care, Right Setting IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (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)**
completion Milestone 2 Estimated Incentive Payment (maximum amount): $179,198 **Milestone 3** P-5: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 P-5.1 Completion of policies and procedures Baseline/Goal: we had no ambulatory detox options in 2012 To establish operations guidelines Data Source: Internal policy and procedures documents and operations manual Milestone 3 Estimated Incentive Payment (maximum amount): $179,197	Metric: P-9.1 Participate in semi-annual face-to-face meetings or seminars organized in the RHP Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 5 Estimated Incentive Payment (maximum amount): $ 209,900			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $537,593	Year 3 Estimated Milestone Bundle Amount: $ 524,750		Year 4 Estimated Milestone Bundle Amount: $ 526,275	Year 5 Estimated Milestone Bundle Amount: $ 434,749
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,023,367				

PROJECT OPTION: 1.11.2 Implement technology-assisted services (telehealth, telemonitoring, telementoring or telemedicine) to support, coordinate, or deliver behavioral health services
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 135222109.1.4
PERFORMING PROVIDER NAME/TPI: Gulf Coast Center/135222109
Title of project: Telemedicine Access to ED and Adult MH routine services

Provider: The Gulf Coast Center (GCC) is the mental health authority and substance abuse recovery provider through the Texas Department of State Health Services (DSHS) for Galveston and Brazoria Counties. The Gulf Coast Center provides a complete array of services to those with mental health, recovery and intellectual and developmental disability needs. The Gulf Coast Center adult services are currently charged with serving 1759 adults, although currently serving more than 2400 adults. Galveston County covers 873 square miles and Brazoria County covers 1386 square miles.
Intervention: The project will implement telemedicine into the ED for individuals presenting with emergent psychiatric complaints and into the local community mental health Intake offices to provide improved access for psychiatric discharge follow-ups, post ED consult follow-ups, and routine access assessments.
Need for project: The primary focus of ED physicians is traditionally on health care issues. They do not necessarily involve themselves in behavioral health issues. This results in frequent referrals for hospitalization due to psychiatric conditions that could otherwise be amelirated by immediate psychiatric care. Making psychiatrists readily available in the local EDs via telemedicine would enhance the treatment options for those experiencing a behavioral health crisis and avoid unnecessary psychiatric admissions. Providing a telemedicine psychiatrist will enhance the treatment options for those experiencing a behavioral health crisis and avoid unnecessary psychiatric admissions. Psychiatrist availability for routine access in the local mental health Intake department is very limited and results in less than optimum appointment wait times for more complex cases and continuity of care. The limited availability of psychiatrist time also results in lengthy waits for initial psychiatric evaluations and increased potential for hospital admits and readmissions.
Target population: The target population of the project is persons in need of Psychiatric consultations to determine the appropriate level of care and to prevent unnecessary admits and readmissions into inpatient facilities. Approximately 50% of persons seen are either Medicaid eligible or low income uninsured individuals and have limited access to behavioral health care. We expect they will benefit from improved access to psychiatric consults to avoid unnecessary hospital admissions.
Category 1 expected patient benefits: The project seeks to achieve a 25% level of satisfaction with the telemedicine psychiatric consultation services in DY3 and to improve to 50% and then 75% in DY4 and DY5 respectfully.
Category 3 Outcomes: Our goal is to establish baseline rates of potentially preventable re-admission rates during DY2 and to increase individuals level of satisfaction with the preventable re-admission rates through telemedicine psychiatric consults from 25% in DY3 up to 75% in DY5.

PROJECT DESCRIPTION

Purchase and locate telemedicine equipment into emergency departments (ED) and place mental health crisis workers onsite to assess patients who present to the ED with psychiatric crises. The MH worker(s) will coordinate assessments by psychiatrists via teleconference equipment as needed, to evaluate appropriateness of inpatient psychiatric admission or outpatient treatment follow-up. Location of additional equipment and staff into the local community mental health clinics for the adult mental health Intake Department will provide linkage and improved access to psychiatrist for a more intense outpatient follow up or follow along in order to prevent readmission presentations to the ED. Likewise, timely access in the community for routine adult mental health Intake services for eligibility determination and initiation of outpatient mental health services through technology assisted services will avoid initial ED visits and reduce the burden on the local ED resources. The project will be implemented first in Brazoria County at the Angleton Danbury Medical Center ED and the counties local community adult mental health Intake departments then expand to reach a broader patient base in Galveston County.

Project goal(s):

Project goals are to remove barriers and to improve the infrastructure for access to and the delivery of behavioral health services. By providing electronic health care services in Emergency Departments (ED) and the local community mental healthcare provider Intake departments, it increases patient access to mental health services and treatment. Utilize the expertise of Board Certified psychiatrists to determine most appropriate level of care to include a wide-range of pharmacological management options, and extensive community resource options with the help of on-site crisis workers, thus reducing the need for hospitalization, readmission, or other higher level of care services unnecessarily. Making an open access style of Intake adult mental health service available in the community through electronic health care provision will reduce the need for ED visits and hospitalizations by linking the individuals into outpatient services in a timely and convenient manner. The location of technology assisted services into the local community clinic will allow for expanded service hours and availability of a psychiatrist thus reducing the length of time individuals need to wait to be seen for their eligibility determinations.

Anticipated challenges:

When mental health patients present to the ED, ED personnel triage the psychiatric crisis and either contact the MH Crisis Hotline or order the patient be transported and admitted to an inpatient psychiatric facility. This takes valuable ED personnel time from addressing physical health issues and sometimes results in unnecessary inpatient psychiatric admissions for situations that could be treated on an outpatient basis or with substance abuse treatment. With the addition of expanded service availability for emergent and routine mental health psychiatrist availability, the system may easily be overwhelmed with inappropriate referrals or individuals seeking the services outside of the intended purpose. Ongoing education with community stakeholders and ongoing staff training should aide in reducing the challenges.

The 5-year expected outcome(s):

The long range goal is to decrease Behavioral Health and Substance Abuse 30 Day Readmission Rates based on hospital admission and discharge data information. Implementation of telemedicine services in Angleton Danbury Medical Center will work closely with adult MH routine services in Angleton to provide or link to more expedient, long term behavioral health

and substance abuse treatment in our local on site clinic settings. Once this is established, the program will be expanded to an agreed upon Galveston County location where the same type of services will be provided and linked to the local outpatient clinic closest to that facility. This should prevent a patient from being readmitted to an inpatient facility as they will receive continuous and fluid intervention therefore there should not be a lapse of treatment. This along with coordination with community stakeholders and patient satisfaction should lend it to become a successful treatment option for quality care as long as the patient requires it. The 5-year expected outcome will be to have at least two successfully operating telemedicine expansion projects in both Galveston and Brazoria Counties with the option of expanding to other local Emergency Departments/Clinic Settings in order to continue expanding more expedient treatment on a long term basis.

Regional goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

From 01/01/2012 – 6/30/2012 Gulf Coast Center Mental Health crisis workers performed 717 triage assessments in Brazoria County and Galveston County Emergency Departments. In most of those situations access to psychiatrists was not available and the treating medical personnel opted for the patients to be transported for admission to an inpatient psychiatric facility instead of exploring/considering other outpatient options. During the same time period the capacity for routine adult mental health Intake Department has been limited in its capacity due to the lack of service providers able to reach into all of the local communities thus producing lengthy waits for services.

RATIONALE:

Introducing Telemedicine Access to ED and Adult MH Routine Services will enhance behavioral and substance treatment in our catchment areas. By introducing telemedicine services to local emergency departments will 1) ease the demand on Emergency Department personnel when patients present to the ED with psychiatric issues/crises, 2) avoid unnecessary psychiatric hospitalizations of people who would be better served in less costly outpatient mental health or substance abuse treatment services, and 3) frees up inpatient psychiatric beds for use in severe psychiatric crises.

The supply ratios for a number of health professionals, including primary care physicians and mental health professionals, are lowest in rural, border and other health professional shortage areas. Data for 2009 indicated that out of the 254 counties in Texas, 118 counties are designated as whole county primary care Health Professional Shortage Areas (HPSAs) due to primary care doctor to patient ratios of 1:3500 or less, and 173 counties (68 percent of the state) are designated as whole county mental health HPSAs[1]. With the implementation of the project and the ongoing service measurement, improvement and feedback measures in place, the inpatient readmissions, initial admissions, and overall patient satisfaction with the access to service provision should be greatly improved.

This project option is 1.11.2 Implement technology-assisted behavioral health services from psychologist, psychiatrist, substance abuse counselors, peers and other qualified providers. The

core components involved in the introduction of Telemedicine Access to ED and Adult MH Routine Services are listed here:

a) Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations. – Component is partially fulfilled. Will expand current manual to include routine access to adult mental health services.
b) Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications. – The component has already been fulfilled.
c) Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer. – Qualified behavioral health providers will be identified and trained during initial implementation of project.

_____

Martin LA, Nelson EC, Lloyd RC, Nolan TW. Whole System Measures. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org).

d) Identify modifiers needed to track encounters performed via telehealth technology. – This component has already been fulfilled.
e) Develop and implement data collection and reporting standards for electronically delivered services – Current collection and reporting methodology will be expanded to include access to adult routine behavioral health services.
f) Review the intervention(s) impact on access to specialty care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. – Regularly scheduled program staffing meetings will be held in order to review current processes and identify needed areas of improvement, and implement improvements.
g) Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully-functional telehealth, telemonitoring, telementoring, or telemedicine program. Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations. – Will expand project to additional hospitals and provider clinics in the servicing area. The regularly scheduled program staffing meetings will be utilized to continue the review of processes, to identify, and to implement improvements needed in the project.

h) Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions). – Will utilize hospital admission/crisis episode data and patient satisfaction survey.

The procurement of equipment to improve access infrastructure in the local community will result in improved patient care and satisfaction through ready access and unnecessary inpatient admissions. Keeping the staff trained on procedure and equipment updates will ensure the program maintains a commitment to improvement and patient satisfaction.

The Telemedicine Access to ED and Adult MH Routine Services project will implement the following process milestones: P-4 Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment (Equipment will be procured during year two and increased with location expansions during subsequent years.); P-8 Training for providers / peers on use of equipment / software (this milestone will begin in DY2 and continue in DY3 and DY4 as additional staff and equipment are implemented); P-9 Milestone: Development of manual of telemedicine or telehealth operations with administrative protocols and clinical guidelines ; P-14 Milestone: Participate in face-to-face meetings at least twice per year with other providers in the RHP to promote collaborative learning around shared or similar projects, identify "lessons learned" and opportunities to scale all or part of the project to a broader patient population, as well as key challenges associated with expansion of the project, including special considerations for safety-net populations. The quality improvement milestone is I-15 to assess consumer, peer and provider satisfaction with the telemedicine process.

Unique Community Need Identification numbers:

CN.5. Mental/Behavioral Health Provider Shortage Health Resources Services Administration

CN. 10. High ED Utilization Rates

Expansion or enhancement:

This is a new project of expansion and provision of telepsychiatry services into local emergency departments and the Gulf Coast Center Adult Intake Department. This innovated service expansion will increase patient access to mental health services and treatment that is currently not available. Utilization of expert Board Certified Psychiatrists to determine most appropriate level of care to include wide range of pharmacological management options and extensive community resource options with the help of on-site crisis workers will reduce the need for hospitalizations or other higher level of care services unnecessarily. The introduction of telepsychiatry into the local clinic Intake Department will provide additional service providers to the area and increase access to the service delivery system.

We are currently not receiving state or federal funding for this project.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Outcome Domain 3 – Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRs) supports the project as evidenced in IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate. Rationale: Readmission to a hospital setting can tax an overburdened and limited behavioral healthcare and substance abuse treatment system. Often times these readmissions could be avoided if the patient could receive quality, individualized care sooner and not be placed in an inpatient facility without follow up or placed on a waiting list until an available slot is open.

This project chose IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)

a Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission.

b Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission

Data Source: Hospital admission and discharge reports and local encounter data reporting system.

RELATIONSHIP TO OTHER PROJECTS:

Other projects proposed by the Gulf Coast Center that are related to the Telemedicine Access to ED and Adult MH Routine Services project because they, too, address the need to provide alternatives to inpatient psychiatric hospitalization and/or criminal justice involvement. They are the Adult Ambulatory Detox project and the Crisis Respite Expansion to Brazoria County project. This project's focus on placing telemedicine equipment and mental health crisis workers in emergency departments and emphasis on psychiatric and behavioral crises ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2.. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

The Gulf Coast Center will be the Performing Provider in conjunction with contracted private providers and other community resources as available or needed. This project focuses on the implementation of technology-assisted services to support, coordinate, or deliver behavioral heatlh services along with these other Category 1 projects in our RHP: 135222109.1.4 - Telemedicine access to ED and adult mental health routine services; 109372601.1.2 - Providing psychiatry telemedicine clinics to RHP 2 and the state of Texas.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

Population Affected: By stationing telemedicine equipment and qualified mental health personnel directly in Emergency Departments, and at the front door of services for the Gulf

Coast Center as proposed in this project, there will be significant impact on a relatively large portion of the populations. Starting with a key community hospital in Brazoria County is critical, especially considering that the lack of access to community resources specifically mental health care in Brazoria County is below that of not only the State average, but also that of the US - as indicated in RHP2's Community Needs Assessment (CNA). Of those that will be impacted by this proposed project, almost all will be either uninsured or on Medicaid. *Severity*: Per the June 2012 Qualitative Community Health Assessment for Brazoria County, almost 50% of responders stated that the increase to the number of places for mental health services was very important (highest ranking). The severity of the situation is further stress by the lack of access to community resources specifically mental health care in Brazoria County is below that of not only the State average, but also that of the US - as indicated in RHP2's Community Needs Assessment (CNA). Additionally indicated in the CNA for Brazoria and Galveston counties is that there are long wait list for mental health care; and the rate of access to a psychiatrist in Brazoria County is also below not only that of the State average but also that of the US. Placing telemedicine equipment in the ED's as well as the Intake Department of the Center (consider the front door into services), would provide access to mental health clinicians and psychiatrics currently unavailable. Currently there are no telemedicine services for Behavioral Health provided in the Emergency Departments (ED) or the Center's Intake Department. The lack of this takes valuable ED personnel time from addressing physical health issues and emergencies, and delays appropriate response to the mental health issue that brought the individual to the Emergency Department; and many times results in unnecessary inpatient psychiatric admissions for situations that could be treated on an outpatient basis or with substance abuse treatment or other community resources. Without immediate access to a psychiatrist at the Intake Department, delays assessment completion and entry into services. *Cost-Effectiveness*: The Texas Council of Community Centers presented in their 2011 Mental Health Funding Savings report to the Texas LBB that the cost of an Emergency Department visit for a person presenting with a Mental Health crisis was $1,256 per visit. The estimated total four year cost of the proposed program is approximately $1 million; and over 2,000 individuals during the four year period projected to be served by the program for an approximate per person cost of $516 or only 40% of an ED visit. *Community Benefit*: The proposed project will improve access to appropriate services sooner when needed, improve overall quality of the service provision by minimizing Emergency Department wait time or being placed on a wait list, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing a cost effective alternative, is an innovative approach to addressing the lack of access to mental health services, and will work in collaboration with other community resources including but not limited to local community hospitals and emergency departments, the County Mental Health Deputies, local law enforcement, and NAMI Gulf Coast.

135222109.1.4	1.11.2	A-H	TELEMEDICINE ACCESS TO ED AND ADULT MH ROUTINE SERVICES
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	**135222109.3.4**	**IT 3.8**	**Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-4 Milestone: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment **P-4.1. Metric: Inventory of new equipment purchased** **a. Data Source: Review of inventory or receipts for purchase of equipment** **b. Rationale/Evidence: See project goal.** Baseline/Goal: No telemedicine equipment is currently available at the ED of Angleton Danbury Medical Center or routine access adult mental health project location. Equipment will be procured during year two and expanded during subsequent years. Data Source: Review of inventory or receipts for purchase of equipment. Milestone 1 Estimated Incentive Payment (maximum amount): $200,280 **Milestone 2** P-8 Milestone: Training for providers / peers on use of equipment / software	**Milestone 4** P-4 Milestone: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment **P-4.1. Metric: Inventory of new equipment purchased** **a. Data Source: Review of inventory or receipts for purchase of equipment** **b. Rationale/Evidence: See project goal.** Baseline/Goal: No telemedicine equipment is currently available at the ED in Galveston County or routine access adult mental health project expansion location. Equipment will be procured during year two and expanded during subsequent years. Data Source: Review of inventory or receipts for purchase of equipment. Milestone 4 Estimated Incentive Payment (maximum amount): $146,621 **Milestone 5** P-8 Milestone: Training for additional providers / peers on use of equipment / software P-8.1. Metric: Documentation of completions of training on use of equipment / software **a. Data Source: Training roster.** **b. Rationale/Evidence: See project goal.** Baseline/Goal: Current training is partially fulfilled for Crisis staff. Once equipment is	**Milestone 8** P-8 Milestone: Training for additional providers / peers on use of equipment / software **P-8.1. Metric: Documentation of completions of training on use of equipment / software** **a. Data Source: Training roster.** **b. Rationale/Evidence: See project goal.** Baseline/Goal: Current training is partially fulfilled for Crisis staff. Once equipment is purchased, training will be fulfilled for adult mental health routine access staff and any additional trainings required for Crisis staff. Initial training completed for all additional program staff related to access telemedicine. Data Source: Human Resources training rosters. Milestone 8 Estimated Incentive Payment (maximum amount): $ 411,733 **Milestone 9** I-15 Milestone: Satisfaction with telemental services I-15.1. Metric: 50% of consumer,	**Milestone 10** I-15 Milestone: Satisfaction with telemental services I-15.1. Metric: 75% of consumer, peer and provider surveys indicate satisfaction with telemental services a. Numerator: Number of patients, peers and providers reporting satisfaction b. Denominator: Number of patients, peers and providers surveyed c. Data Source: Satisfaction survey results. d. Rationale/Evidence: See project goal. This would be measured at baseline and various points during the project to measure satisfaction. Goal: The goal of the milestone is for 75% of individuals utilizing telemental services to indicate satisfaction with the access services. Milestone 10 Estimated Incentive Payment: $ 485,896

135222109.1.4	1.11.2	A-H	TELEMEDICINE ACCESS TO ED AND ADULT MH ROUTINE SERVICES
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.4	IT 3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
P-8.1. Metric: Documentation of completions of training on use of equipment / software **a. Data Source: Training roster.** **b. Rationale/Evidence: See project goal.** Baseline/Goal: Current training is partially fulfilled for Crisis staff. Once equipment is purchased, training will be fulfilled for adult mental health routine access staff and any additional trainings required for Crisis staff. Initial training completed for all program staff related to access telemedicine during year two. Data Source: Human Resources training rosters. Milestone 2 Estimated Incentive Payment (maximum amount): $200,280 **Milestone 3** P-9 Milestone: Development of manual of telemedicine or telehealth	purchased, training will be fulfilled for adult mental health routine access staff and any additional trainings required for Crisis staff. Initial training completed for all additional program staff related to access telemedicine. Data Source: Human Resources training rosters. Milestone 5 Estimated Incentive Payment (maximum amount): $146,621 **Milestone 6** Milestone: P-14 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). P-14.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized in the RHP Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems	peer and provider surveys indicate satisfaction with telemental services a. Numerator: Number of patients, peers and providers reporting satisfaction b. Denominator: Number of patients, peers and providers surveyed c. Data Source: Satisfaction survey results. d. Rationale/Evidence: See project goal. This would be measured at baseline and various points during the project to measure satisfaction. Goal: The goal of the milestone is for 50% of individuals utilizing telemental services to indicate satisfaction with the access services. Milestone 9 Estimated Incentive Payment (maximum amount): $176,456	

135222109.1.4	1.11.2	A-H	TELEMEDICINE ACCESS TO ED AND ADULT MH ROUTINE SERVICES
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.4	IT 3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
operations with administrative protocols and clinical guidelines. **P-9.1. Metric: Documentation of completion of manual and of use of manual in training sessions of providers/peers.** **a. Data Source: Operations manual with written protocols and guidelines** Baseline/Goal: Manual for crisis telemedicine is complete, some revisions are required for addition of routine access project. Telemedicine manual and clinical guidelines will be revised during year two. Data Source: Operations manual with written protocols and guidelines. Milestone 3 Estimated Incentive Payment (maximum amount): $200,279	promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 6 Estimated Incentive Payment (maximum amount): $146,621 **Milestone 7** I-15 Milestone: Satisfaction with telemental services I-15.1. Metric: 25% of consumer, peer and provider surveys indicate satisfaction with telemental services a. Numerator: Number of patients, peers and providers reporting satisfaction b. Denominator: Number of patients, peers and providers surveyed c. Data Source: Satisfaction survey results. d. Rationale/Evidence: See project goal. This would be measured at baseline and various points during the project to measure satisfaction. Goal: The goal of the milestone is for 25% of individuals utilizing telemental services to indicate satisfaction with the access services. Milestone 7 Estimated Incentive Payment (maximum amount): $146,622		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $600,839	Year 3 Estimated Milestone Bundle Amount: $ 586,485	Year 4 Estimated Milestone Bundle Amount: $ 588,189	Year 5 Estimated Milestone Bundle Amount: $ 485,896

135222109.1.4	1.11.2	A-H	TELEMEDICINE ACCESS TO ED AND ADULT MH ROUTINE SERVICES	
Gulf Coast Center				135222109
Related Category 3 Outcome Measure(s):	135222109.3.4	IT 3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,261,409				

PROJECT OPTION: 1.13.1 Development of behavioral health crisis stabilization services as alternatives to hospitalization.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 135222109.1.5
PERFORMING PROVIDER NAME/TPI: Gulf Coast Center/ 135222109
Title of project
Behavioral Health Crisis Stabilization Alternatives to Hospitalization: Crisis Respite & Response – Intellectual & Developmental Disabilities (IDD)
Provider: The Gulf Coast Center (GCC) is the local intellectual and developmental disability authority through the Texas Department of Aging and Disability Services (DADS) and the mental health authority and substance abuse recovery provider through the Texas Department of State Health Services (DSHS) for Brazoria and Galveston Counties. The Center is one of 39 community centers in the State of Texas through the auspices of the DADS and DSHS. The Gulf Coast Center IDD Services is currently charged with providing General Revenue (GR) services to 135 individuals, both adults and children, while also functioning as the service coordination authority to approximately 855 people enrolled in both GR programs and Texas Home Living and Home and Community-based Service (HCS) Medicaid Waiver programs. Galveston County covers 873 square miles and is divided into three distinct geographic areas: the mainland, Galveston Island, and Port Bolivar. As one of the largest counties in Texas, Brazoria County covers 1386 square miles.
Intervention: Provide short-term emergency respite for persons with Intellectual and Developmental Disabilities/Autism Spectrum Disorder (IDD/ASD) who experience a behavioral crisis that requires intervention from law enforcement, Gulf Coast Center's Mobile Crisis Outreach Team (MCOT), or Emergency Departments. These services would be available to people with IDD/ASD.
Need for project: Brazoria County District Attorney's office and law enforcement officials met with Gulf Coast Center crisis services and IDD services regarding need for alternative interventions for persons with IDD/ASD who have behavioral crises requiring that the person be removed from the home for their own protection or for the protection of caregivers. When a person with IDD/ASD has a behavioral crisis that cannot be resolved and places them at risk of harming themselves or others, they may be either incarcerated or hospitalized because appropriate behavioral interventions are unavailable.
Target population: This project will focus on people with Intellectual and Developmental Disabilities/Autism Spectrum Disorder (IDD/ASD) who experience a behavioral crisis that requires intervention from law enforcement, Gulf Coast Center's Mobile Crisis Outreach Team (MCOT), or Emergency Departments. Approximately 70% of the target population are Medicaid eligible or are low income uninsured.
Category 1 expected patient benefits: provide 1) temporary emergency respite for the person with IDD/ASD and their caregiver and 2) behavioral assessment to determine causes and appropriate interventions for people without other funding options for behavioral supports.

Category 3 Outcomes: It is anticipated that 12 people will be diverted from the jail and/or psychiatric hospitalization and participate in crisis respite interventions specific for people with IDD/ASD in each of years 3 and 4 and that by year 5, 18 people will be diverted which will be a 50% increase in services.

PROJECT DESCRIPTION:

Provide short-term emergency respite for persons with Intellectual and Developmental Disabilities/Autism Spectrum Disorder (IDD/ASD) who experience a behavioral crisis that requires intervention from law enforcement, Gulf Coast Center's Mobile Crisis Outreach Team (MCOT), or Emergency Departments. These services would be available to people with IDD/ASD.

Project goal(s):

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail, or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.[1]

Individuals with IDD/ASD have difficulty accessing behavioral health services due to lack of available providers that accept Medicaid, the primary insurance coverage for adults with disabilities; there is also a long wait for available appointments due to the small pool of providers. Brazoria County is designated as a medically underserved area with limited number of professionals who accept Medicaid and/or provide psychological/behavioral related services. When a person with IDD/ASD has a behaviorally related incident, care givers usually contact law enforcement for intervention. The past results have been either incarceration or temporary psychiatric inpatient hospitalization, neither of which appropriately addresses the behavioral aspects of the outburst.

The Gulf Coast Center's goal is to develop a behavioral crisis response system that will provide 1) temporary emergency respite for the person with IDD/ASD and the care giver and 2) behavioral assessment to determine causes and appropriate interventions for people without other funding options for behavioral supports.

Anticipated challenges:

Caregivers of people with IDD/ASD who have behavioral crises in which they are at risk of harming themselves or others, contact law enforcement for intervention or call the Crisis

[1] **Behavioral Health NEWS BRIEF Vol. 7 Issue 3 -** May 25, 2012 , http://www.dshs.state.tx.us/sa/_BHNB/

Hotline. They have limited or no resources for behavioral supports. Law enforcement have, on occasion, made arrests and placed persons with IDD/ASD in jail for their own protection. Some of the people with IDD/ASD have been inappropriately admitted to psychiatric inpatient hospitals, but are quickly discharged if there is no mental illness diagnosis. Upon discharge, caregivers may be reluctant to take the person back due to fears for safety or lack of training in behavioral intervention. There are little to no resources for safe temporary respite while behavioral supports and/or residential alternatives are sought.

The 5-year expected outcome(s):

Decrease in behavioral health admissions and readmissions to criminal justice settings such as jails or prisons for people with IDD

Regional goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention

STARTING POINT/BASELINE:

Brazoria County District Attorney's office and law enforcement officials met with Gulf Coast Center crisis services and IDD services regarding need for alternative interventions for persons with IDD/ASD who have behavioral crises requiring that the person be removed from the home for their own protection or for the protection of caregivers. When a person with IDD/ASD has a behavioral crisis that cannot be resolved and places them at risk of harming themselves or others, they may be either incarcerated or hospitalized because more appropriate behavioral interventions are unavailable. It is estimated that 12 people with IDD will receive project interventions and be diverted from incarceration or inpatient hospitalization.

RATIONALE:

Relation between Project Choices and Community Needs:

The Region is limited in mental health, behavioral health, and substance abuse resources (CN.5, CN.6).[2] Rates of psychologists and psychiatrists are well below both the State and U.S. averages. There are only an estimated 122 psychologists and 75 psychiatrists for the entire Region. The rate of psychologists in RHP2 is 8.7 per 100,000 and the rate for psychiatrists is 5.3 per 100,000. Additionally, there are just 28 substance abuse facilities and 5 detox facilities for the 16 county Region (CN.6). Most of these resources do not provide interventions to persons with intellectual and development disabilities. This gap in resources is the reason The Gulf Coast Center to select: Project Option 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system, and the following components:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of

[2] Psychologists, psychiatrists, substance abuse facilities, and detox facilities data from Substance Abuse and Mental Health Services Administration.

hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).

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 acceptable and 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

The Crisis Respite Response IDD program will implement the following Process Measures: 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 services providers; P-4: Hire and train staff to implement identified crisis stabilization services; P-6: Evaluate and continuously improve crisis services; P-9: 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. GCC will participate in meetings with other community health centers participating in the waiver through our regional collaborative ETBHN to discuss similar projects. The Improvement Measure will be I-12: Utilization of appropriate crisis alternatives with the goal to reduce preventable inpatient admission, number of people cycling through multiple systems (criminal justice, emergency departments and inpatient psychiatric system).

Unique Community Need Identification numbers:

CN.5 Mental/Behavioral Health Provider Shortage (Number of Mental Health HPSAs:9, Number of Partial Mental Health HPSAs: 6, Rate of Lisc.Psychologists per 100,000 pop. 8.2, Rate of Psychiatrists:4.2) according to Health Resources and Services Administration (HRSA) Area Resource File (ARF), US HHSC HRSA, Health Professions Workforce Center, TX Dept State Health Services

Expansion or enhancement:

This project REPRESENTS a new initiative for the Gulf Coast Center. The Gulf Coast Center does not currently receive state or federal funding for this project.

Related Category 3 Outcome Measure(s):

The Outcome Domain 9 – Right Care, Right Setting supports the project as evidenced in IT-9.1 Rationale**:** Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. The supporting Category 3 process milestones are:

P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans; P-2 Establish baseline rates; and P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Each of these process milestones supports the core components of the project option.

RELATIONSHIP TO OTHER PROJECTS:

Two other projects proposed by the Gulf Coast Center are related to the Crisis Respite & Response - IDD project because they too address the need to provide alternatives to inpatient psychiatric hospitalization and/or criminal justice involvement. They are the Telemedicine Access to ED project and the Crisis Respite - Brazoria County project. This project's focus on providing short-term and emergency respite services and emphasis on serving individuals with Intellectual and Developmental Disabilities/ Autisim Spectrum Disorder ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 096166602.2.5. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

The Gulf Coast Center will be the Performing Provider; but will, as it does now, collaborate and link with available community resources and participating private providers as available. This project focuses on the development of behavioral health crisis stabilization services along with these other Category 1 projects in our RHP: 135222109.1.1 - Behavioral health alternative to hospitalization: crisis respite expansion to Brazoria County; 135222109.1.3 - Behavioral health alternative to hospitalization: ambulatory detox; 135222109.1.5-Behavioral health crisis stabilization alternatives to hospitalization: crisis respite & response-intellectual & developmental disabilities.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share

and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

Project Valuation:

Population Affected: Though a relative small portion of the population will be served by this project (approximately 42 individuals over the four year period); all will be either uninsured or on Medicaid. *Severity*: In both Brazoria and Galveston Counties Qualitative Community Health Assessments, the need due to the lack of behavioral healthcare support and services consistently was ranked as a high priority. And though persons with Intellectual and Developmental Disabilities (IDD) is not specifically noted; the need for additional supports and services - especially as it relates to providing crisis respite services - is critical. Local law enforcement and representatives from the counties District Attorney's offices, have identified this as a critical need. There are no short term emergency respite alternatives for persons with IDD; and as such, these individuals inappropriately end up in local jails or waiting in local emergency departments or hospitalized in a mental health psychiatric inpatient unit - and at a time when specialized care and attention is needed...exasperating their crisis situation, not providing appropriate care, and possibly creating disruption in or even loss of their living situation. *Cost-Effectiveness*: The proposed project is expected to cost approximately $250,000 per year or $1 million for the four year project; and serve an estimated total of 42 individuals...for an estimated $24,000 per person served. Whereas they may appear high, for the service provided and the savings within the community resulting from the diversion of an un-necessary incarceration or hospitalization; the cost is considered reasonable. *Community Benefit*: The proposed project will improve access to appropriate services sooner when needed, improve overall quality of the services received by the individual and family, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing an appropriate alternative upfront, is a new and transformative initiative for behavioral health services by creating an immediately available and appropriate alternative for someone with an intellectual disability presenting in crisis that would not result in immediate incarceration or inappropriate hospitalization, and will work in collaboration with other community resources including but not limited to the Mental Health Deputies, local law enforcement, local community hospitals, Mobile Crisis Outreach Team, and the Arc of the Gulf Coast.

135222109.1.5	1.13.1	1.13.1.A-E	Behavioral Health Crisis Stabilization Alternatives to Hospitalization: Crisis Respite &Response – Intellectual & Developmental Disabilities (IDD)
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.5	IT-9.1	Decrease in Mental Health Admissions to Criminal Justice Settings Such as Jails or Prisons

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 : P-1. Conduct 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. Metric 1 P-1.1. Metric: Number of meetings and participants Baseline/Goal: Program did not exist in 2012/ Collaborate resources to assess best interventions to address behavioral health needs of persons with IDD/ASD requiring law enforcement or Mobile Crisis Outreach Team intervention. Data Source: attendance lists Milestone 1 Estimated Incentive Payment (maximum amount): $205,550 **Milestone 2:** P-4 Hire and train staff to implement identified crisis stabilization services Metric 1 P-4.1- Metric: Number of staff hired and trained Baseline/Goal: Program did not exist	**Milestone 3** P-6 Milestone: Evaluate and continuously improve crisis services Metric 1 P-6.1 Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline/Goal: Modify project as necessary to insure most appropriate behavioral interventions are implemented for people with IDD/ASD Data Source: Project reports include 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) Milestone 3 Estimated Incentive Payment: $200,640 **Milestone 4 P-9** Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared	**Milestone 5** : I-12 Milestone: Utilization of appropriate crisis alternatives Metric I-12.1.: 25% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people with IDD receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health crisis services in Brazoria and Galveston County. This would be measured every 6 months throughout the project to determine if there was an increase. c. Data source: Claims, encounter, and clinical record data. d. Rationale: see project goals. Milestone 5 Estimated Incentive Payment: $ 402,445	**Milestone 6** : I-12 Milestone: Utilization of appropriate crisis alternatives Metric I-12.1.: 40% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people with IDD receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health crisis services in Brazoria and Galveston County. This would be measured every 6 months throughout the project to determine if there was an increase. c. Data source: Claims, encounter, and clinical record data. d. Rationale: see project goals. Milestone 6 Estimated Incentive Payment: $ 332,455

135222109.1.5	1.13.1	1.13.1.A-E	Behavioral Health Crisis Stabilization Alternatives to Hospitalization: Crisis Respite &Response – Intellectual & Developmental Disabilities (IDD)
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.5	IT-9.1	Decrease in Mental Health Admissions to Criminal Justice Settings Such as Jails or Prisons

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
in 2012/ Employ and/or contract staff (psychologists and respite providers) who specialize in ABA behavioral interventions and implementation of behavior plans. Data Source: Contracts, staff rosters, training records and training curricula Milestone 2 Estimated Incentive Payment: $205,551	or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Metric: P-9.1 Participate in semi-annual face-to-face meetings or seminars organized in the RHP Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 4 Estimated Incentive Payment (maximum amount): $200,639		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $411,101	Year 3 Estimated Milestone Bundle Amount: $ 401,279	Year 4 Estimated Milestone Bundle Amount: $ 402,445	Year 5 Estimated Milestone Bundle Amount: $ 332,455
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,547,280			

Project Option: 1.1.2 Expand Existing Primary Care Capacity

Unique RHP project identification number: **284333601.1.1-Pass 2**
Performing Provider name/TPI: Liberty Dayton Regional Medical Center/*284333601*
Title of project: **Project 1.1: Expand Primary Care Capacity**
A brief description of the provider, including the provider's size and role as a provider in the region's health care infrastructure
Liberty Dayton Regional Medical Center is a 25-bed Critical Access Hospital located in Liberty, Texas serving the medical needs of the surrounding areas. We offer inpatient services such as general acute care, swing bed or skilled nursing care and emergency care. Our medical staff is trained and certified in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Trauma.
Clearly state the intervention(s).
This project proposes to expand existing primary care capacity by expanding clinic space and hiring new staff. We will expand primary care clinic space by leasing additional clinic space for increased clinic visits. Finally, we will expand primary care clinic staffing by recruiting one FP or IM physician and one mid-level practitioner, as well as recruiting a certified QI leader and social worker. We will train our nurses and physicians to properly triage, assess and refer these type of patients to a medical home.
Core Components:
The core components we selected are Expand Clinic Space, Expand Clinic Hours, and Expand Staffing. In order to meet the expected increase in utilization, we will have to expand our space. Our current clinic is only set up for one physician. Without more space, we will not be able to achieve our goals. Even with more space, we will have to increase the hours the clinic is open. We expect to increase our hours of operation on weekdays and open on Saturdays. In order to service the expected increase in visits, we will need to increase our staffing. We plan to add additional providers and support personnel.
A brief description of the need for the project including data as appropriate
Liberty County's median household income is lower than the average for both Texas and the US. In addition, the percentage of county residents that are unemployed, living at or below the poverty line and incarcerated are higher than the Texas and US average (CN.1). The percent of County residents on Medicaid or have no insurance are also higher than the Texas and US average (CN.2). The majority of these residents do not have a medical home and typically rely on the Emergency Department for their healthcare needs (CN.3). Many simply do not seek care because of the cost (CN.1).
While we do not expect all 21,000 people to advantage of this project, we do expect to be able to transition many of these into our clinic. We estimate increasing our clinic visits each DY as follows:

DY 2	2,500
DY 3	3,000
DY 4	3,500
DY 5	4,500

Who is the target population for the project, including number of patients the project will serve and how Medicaid and/or indigent patients will benefit from the project. Our target population is residents of Liberty County. Currently, 40% of the patients we serve have no insurance and 25% are Medicaid, and we estimate that 30% of our ED encounters are from patients who utilize our emergency room for primary care services.

Clearly state the expected benefit of the project to patients based on: Category 1 milestones

Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Our goal is to transition these patients to the primary care setting.

Category 3 outcome measures

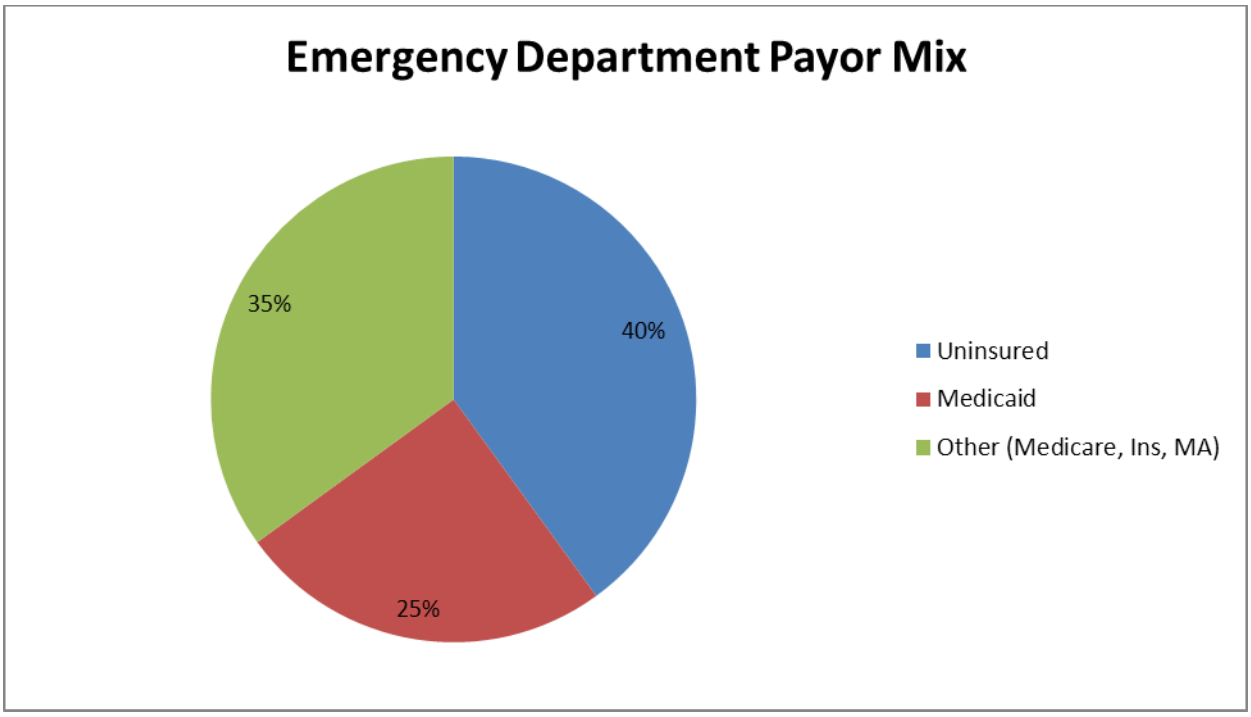
The overall initiative is to improve the health of these patients. We know the cost to treat these patients in a medical home is much less expensive than treating them in the ED. Also, the health conditions of these patients can be better managed in a medical home, thus reducing and /or eliminating the need for ED visit.

Project Description:

This project proposes to expand existing primary care capacity by expanding clinic space and hiring new staff. We will expand primary care clinic space by leasing additional clinic space for increased clinic visits. Finally, we will expand primary care clinic staffing by recruiting one FP or IM physician and one mid-level practitioner, as well as recruiting a certified QI leader and social worker. We will train our nurses and physicians to properly triage, assess and refer these types of patients to a medical home.

Project Goals: Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Projects plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care. To increase LDRMC's ability to provide "the right care at the right time in the right setting" – to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently.

The **challenges** we face are many. We are a rural health system with very high ED utilization. As illustrated below, 40% patients we serve have no insurance and 25% are Medicaid.



In order to reduce non-urgent and chronic encounters in the ED, we have to have the ability to place them in medical homes. The supply of family practice physicians and internal medicine physicians are very low. In addition, these specialties do not want to practice in rural areas, mainly because of the uncertainty that rural hospitals and clinics can survive, based on their populations and financial health. Also, the cost to recruit and pay these physicians are very expensive. The average yearly salary or guarantee is between $200,000.00 to $400,000.00. Recruiting Mid-level practitioners are getting just as hard to find as physicians. The cost to recruit and employee mid-levels can run as high $200,000.00. Access to capital to fund these professionals is very hard to obtain, mainly due to our rural location and low operating margins.

Placing the non-urgent and chronic patients presenting to our ED, into our clinic will create a crisis situation. Our current staff will not be able to keep up with the demand. Those patients in our service area that don't utilize the ED or utilize any healthcare resources will add even greater pressure when we put them into our clinic. Also the other practitioners in private practice will not see patients that have no insurance or money to pay for services. Most are not accepting Medicaid patients.

The **five-year expected outcome** is to substantially improve LDRMC's primary care capacity, as evidenced by a reduction of of non-urgent and chronic encounters in our Emergency Department by 5% over the period of DY 2 through DY 5. We estimate that 30% of our ED encounters are from patients who utilize our emergency room for primary care services.

Relation to Regional goals: This project addresses the following Region 2 goal: "Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that include health promotion and disease prevention."

Starting Point/Baseline: We estimate at least 30% of our current ED utilization are non-urgent and /or chronic encounters. We plan to establish a baseline by the end of June, 2013. During

this time period, we plan to train our nurses and physicians to properly triage, assess and refer these type of patients to a medical home. We have established baseline for clinic visits at 4,800 for a full year. We estimate that there are 21,000 people in Liberty County that could be affected. Provided we are able to recruit the needed personal, we should be able to meet and exceed our goals for each DSRIP year as follows:

DY 2 - 2,500
DY 3 - 2,500
DY 4 - 2,500
DY 5 - 2,500

Rationale: LDRMC is the sole source of health care for tens of thousands of residents Liberty County. We have served this community for over fifty years and we plan to do so for at the fifty. Under health care reform, we anticipate the influx of thousands of newly insured patients seeking access to care. Given that reality, we expect to be needed by our community more than ever. However, in order to insure our ability to compete and thrive, we recognize that we must become more efficient and more effective in how we provide care. We embrace the challenge to win the loyalty of our patients, to meet and exceed standards of quality and safety, and to contain costs – to do more with less.

Liberty County's median household income is lower than the average for both Texas and the US. In addition, the percentage of county residents that are unemployed, living at or below the poverty line and incarcerated are higher than the Texas and US average (CN.1). The percent of County residents on Medicaid or have no insurance are also higher than the Texas and US average (CN.2). The majority of these residents do not have a medical home and typically rely on the Emergency Department for their healthcare needs (CN.3). Many simply do not seek care because of the cost (CN.1). Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Our goal to transition these patients to the primary care setting, will be a challenge.

Expansion or Enhancement: This is a new initiative for Liberty Dayton Regional Medical Center. We realize that the cost (to treat these type of patients) to the Hospital, Liberty County, State of Texas, and the Federal government are extremely high and out of control. In order to survive in the era of Healthcare reform, LDRMC took this initiative not only to control cost, but to build a healthier community.

Related Category 3 Outcome Measure: Our Category 3 Outcome measure is IT 9.2, ED appropriate utilization

As stated above, we have to transition the non-urgent and chronic patient out of the ED and into a medical home. The cost to the Healthcare Industry, as well as the health of these patients, is well documented. This is one of the major reasons the federal government passed Healthcare Reform legislation (ACA). In order for this project to succeed, we must recruit, train, and retain additional physicians and mid-level practitioners. We also must be able to recruit and retain other ancillary professionals, such as registered nurses, social workers, quality improvement specialist, and health information management specialist.

The overall initiative is to improve the health of these patients. We know the cost to treat these patients in a medical home is much less expensive than treating them in the ED. Also, the

health conditions of these patients can be better managed in a medical home, thus reducing and /or eliminating the need for ED visit.

We selected process milestones P-1 to meet the additional visits expected. Our current facilities are inadequate to meet our expected needs. P-2 was also selected to meet the expected increase in visits. We do not presently have the staffing (provider and support personnel) to deliver high quality of care, to the expected increase in our patient base.

Project Valuation: We have valued this project to be $6,489,142.00 over the 4 years covered in this waiver period.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity--Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

284333601.1.1.	1.1.2 Expand existing primary care capacity	1.1.2 (a-c)	EXPAND PRIMARY CARE CAPACITY
Liberty Dayton Regional Medical Center			2843336-01
Related Category 3 Outcome Measure(s)	135222109.3.1	IT-9.2	ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-1 Establish additional/expand existing/relocate primary care clinics Metric : P-1.1 Number of additional clinics or expanded hours or space Baseline/Goal: Documentation of detailed expansion plans. Lease additional clinic space for increased clinic visits. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. Milestone 1 Estimated Incentive Payment : $614,644.50 **Milestone 2** P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: Recruit FP or IM physicians & Mid-level practitioners. Recruit 1 physicians and 1 Mid-level practitioner. Data Source: Documentation of	**Milestone 3:** P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: Recruit certified 1 QI leader and 1 social worker. Milestone 3 Estimated Incentive Payment: $713,632.00 **Milestone 4** P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 P-4.1: Increased number of hours at primary care clinic over baseline Baseline/Goal: Hours increased Data Source: Clinic documentation Milestone 4 Estimated Incentive Payment: $356,816.00 **Milestone 5** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 I-12.1: Documentation of	**Milestone 6:** P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: Recruit QI 2 support personnel and 2 LVNs Milestone 6 Estimated Incentive Payment: $718,166.50 **Milestone 7** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Increase clinic visits by 5% over DY 3 Data Source: Clinic Registry Milestone 7 Estimated Incentive Payment: $718,166.50 Data Source: Clinic Registry	**Milestone 8:** P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: Recruit 1 Mid-level, 1 RN and 1 LVN. Milestone 8 Estimated Incentive Payment: $618,950.00 **Milestone 9** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Increase clinic visits by 5% over DY 4 Data Source: Clinic Registry Milestone 9 Estimated Incentive Payment: $618,950.00 Data Source: Clinic Registry

284333601.1.1.	1.1.2 Expand existing primary care capacity	1.1.2 (a-c)	EXPAND PRIMARY CARE CAPACITY
Liberty Dayton Regional Medical Center			2843336-01
Related Category 3 Outcome Measure(s)	135222109.3.1	IT-9.2	ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
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: $614,644.50	increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Increase clinic visits by 5% over baseline Data Source: Clinic Registry Milestone 5 Estimated Incentive Payment $356,816.00		
Year 2 Estimated Milestone Bundle Amount:: $1,229,289	Year 3 Estimated Milestone Bundle Amount: $1,427,264.00	Year 4 Estimated Milestone Bundle Amount: $1,436,333	Year 5 Estimated Milestone Bundle Amount: $1,237,900
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $5,330,786			

PROJECT OPTION: 1.1.2 Expand Primary Care Capacity

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 139172412.1.1
PERFORMING PROVIDER NAME/TPI: Memorial Medical Center of East Texas-Lufkin/139172412
Title of Project: 1.1 Expand Primary Care Capacity
Provider: Memorial Medical Center of East Texas—Lufkin ("Memorial") is a 271 bed acute care facility in Lufkin, Texas, which has the largest emergency room (32 private patient rooms) in the East Texas area. Memorial serves a three county primary service area with a population of approximately 142,268 and a nine county secondary service area with a population of approximately 239,338.
Intervention(s): This project will expand primary care capacity by establishing additional and/or expanding existing primary care clinics and training and/or hiring additional primary care providers and staff.
Need for the project: Due to a lack of primary care capacity 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. Memorial currently employs 5 Primary Care Physicians, 2 Primary Care Nurse Practitioners and 3 OB/GYN who provide services in Memorial's service area. Through the implementation of this project, Memorial would recruit 4 new primary care physicians within the next 4 years.
Target population: The target population is adults age 18 and over with multiple chronic medical conditions who reside in Memorial's primary and secondary service areas. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. Memorial had approximately 87,700 patient encounters last year, and approximately 30% of these encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients benefiting from this project will be Medicaid and uninsured patients.
Category 1 or 2 expected patient benefits: 4 new primary care physicians will be recruited to provide services in Memorial's service area within the next 4 years. Volume of clinic visits to MMA providers will increase by 5% over the baseline in year 4 and an additional 5% over the baseline (10% total) in year 5.
Category 3 outcomes: The flu and pneumonia admission rate will decrease by 2% over the baseline by year 4, and will decrease by 4% over the baseline by year 5.
PROJECT DESCRIPTION
We will expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. The target population is adults age 18 and over with multiple chronic medical

conditions who reside in Memorial Health System of East Texas' service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. When used as a reference, the Texas Medical Foundation data defines the "Lufkin Community" as the following zip codes: 75834, 75845, 75864, 75901, 75902, 75903, 75904, 75915, 75926, 75929, 75934, 75936, 75939, 75941, 75944, 75949, 75960, 75969, 75976, and 75980. Through the expansion of clinic hours, we estimate that this project will serve approximately 250 - 450 additional patients each year, as measured by the projected number of additional patient visits/encounters. Through the recruitment of four additional primary care physicians by the end of DY5, we estimate that this project will serve approximately 2,880 - 5,750 patients in DY3, 5,760 - 11,520 patients in DY4, and 8,640 - 17,280 patients in DY5, as measured by the projected number of additional patient visits/encounters. In the previous year, approximately 30% of Memorial's patient encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients served/benefiting from this project will be Medicaid and uninsured patients.

Project Goal(s):

The project will address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care.

Anticipated Challenges:

Milestone 1 Establish additional/expand existing/relocate primary care clinics.

1. Funding for additions to existing structures or acquisition of additional facilities.
2. Lack of primary care providers to staff the clinics.
3. Willingness of existing providers to work routine weekend or after hours clinic time.

The responses to these challenges are:

1. Use internal facilities staff to make renovations/upgrades to existing structures. Utilize several vacant offices in hospital-owned local buildings.
2. Recruit mid-levels or "grow our own" using local Nursing program which has recently added a Family Nurse Practitioner option.

Milestone 2 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.

1. To identify providers who are well suited for the lifestyle of this rural location. Limited access to cultural events, entertainment, churches of some faiths, private secondary schools or even luxury car dealerships or "organic" grocery stores are impediments that will not change in the near future. Our recruiting plans are focused on those providers whose interests are well suited for this location. Another strategy is to focus on local students who are in medical school or residency to recruit them back to the area.

2. Memorial Medical Center of East Texas' affiliated Memorial Medical Associates has a recruiting program in place. Options open to new providers are office space, practice management, access to a state of the art physician EMR and start up assistance.

The 5-Year Expected Outcome(s):

4 new primary care physicians will be recruited to the Memorial Health System of East Texas service area within the next 4 years. Volume of clinic visits to MMA providers will increase by 5% in year 4 and an additional 5% (10%) in year 5.

Regional Goals:

Region Wide 2 Goals

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce.

STARTING POINT/BASELINE:

There are currently 5 Primary Care Physicians, 2 Primary Care Nurse Practitioners and 3 OB/GYNs employed by Memorial Health System of East Texas.

RATIONALE:

Relation Between Project Choices and Community Needs

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

The primary service area counties served by Memorial Health System of East Texas have higher than State average rates of adult smoking, obesity and physical activity. They also have a higher than State average rate of Preventable Hospitalizations.[1]

Unique Community Need Identification Numbers:

CN.3 Primary Care Physician Shortage
CN.4 Specialty Care Physician Shortage
CN.8 Mid-Level Provider Shortage
CN.10 High ED Utilization Rates

[1] Texas Region 2 Health Partnership, UTMB.

CN.15 Chronic Diseases: Pulmonary Diseases

Expansion or Enhancement:

This project significantly enhances an existing delivery system reform by Memorial Medical Center of East Texas and its affiliated Memorial Medical Associates. An additional physician liaison/recruiter was hired in late September and is currently in training.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

IT-2.10 Flu and Pneumonia Admission Rate

Rationale/Evidence: Hospitalizations for Bacterial Pneumonia are considered "potentially preventable," because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. Using 6 month Medicare Claims Data Ending Q1 2012, 33% of all hospital discharges in the Lufkin Community were DRG 194. 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.

Rank for Health Outcomes for the 3 counties in Memorial Health System of East Texas' primary service areas (Angelina, Polk and San Augustine) are 177, 220 and 214 of 221 respectively. Smoking rate for Angelina County is 24% and Polk County is 27% vs. State average of 19%. No data on smoking is available for San Augustine County is available.

DRG 194 Simple Pneumonia is the 5th most common admitting diagnosis for Texas. For the Lufkin Community, DRG 194 is the number one reason for hospital admission and represents 33% of all readmissions.

RELATIONSHIP TO OTHER PROJECTS:

This project is related to Lufkin project 1.2.2 Increase Training of Primary Care Workforce-outreach in that both projects aim to increase patients' access to primary care in the community. Further, by expanding primary care facilities and staff, this project will facilitate the training of additional primary care providers.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the

transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

1.1.2 Expand Primary Care Capacity

A. Population Affected
   - Measure: All adults over 18 years in primary service area (107,428).
   - Score: 3 points awarded for significant population affected, and one extra point for Medicaid/Uninsured population.

B. Severity
   - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.

C. Cost Effectiveness
   - Score: 4 points awarded for a low cost per person.

D. Community Benefit
   - Score: 4 points awarded; 1 for access; 1 for quality; 1 for cost; 1 for collaborative.

139172412.1.1	1.1.2	N/A	EXPAND PRIMARY CARE CAPACITY	
Memorial Medical Center of East Texas-Lufkin				139172412
Related Category 3 Outcome Measure(s):	**139172412.3.1**	**IT-2.10**	**Flu and Pneumonia Admission Rate**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-1 Establish additional/ expand existing/ relocate primary care clinics. **Metric P-1.1** Number of additional clinics or expanded hours or space Baseline/Goal: We currently have 5 sites with a total of 5 Primary Care Physicians, 2 APNs and 3 OB/Gyns. Hours of operation vary but are all between 8 am and 5 pm M-F. Data Source: Clinic records. Goal: Expand clinic hours of operation by four additional hours during evenings or weekends. Milestone 1 Estimated Incentive Payment *(maximum amount):* $514,887	**Milestone 2**: P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. **Metric P-5.1** Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: We currently have 5 sites with a total of 5 Primary Care Physicians, 2 APNs and 3 OB/Gyns. Hours of operation vary but are all between 8 am and 5 pm M-F. Goal: Hire one additional primary care physician Data Source: Employment contracts, agreements and HR records. Milestone 2 Estimated Incentive Payment *(maximum amount):* $561,714	**Milestone 3**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Total number of visits for reporting period. Goal: 5% increase in primary care clinic volume of visits over DY3 Data Source: Registry, EHR, claims or other Performing Provider source. Milestone 3 Estimated Incentive Payment: $563,347	**Milestone 4**: I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Total number of visits for reporting period. Goal: 5% increase in primary care clinic volume of visits over DY4 Data Source: Registry, EHR, claims or other Performing Provider source. Milestone 4 Estimated Incentive Payment: $465,374
Year 2 Estimated Milestone Bundle Amount: *(add incentive payment amounts from each milestone):* $514,887	Year 3 Estimated Milestone Bundle Amount: $561,714	Year 4 Estimated Milestone Bundle Amount: $563,347	Year 5 Estimated Milestone Bundle Amount: $465,374
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,105,321			

PROJECT OPTION*:* 1.2.2- Increase Training of Primary Care Workforce-outreach

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 139172412.1.2
PERFORMING PROVIDER NAME/TPI: Memorial Medical Center of East Texas-Lufkin/139172412
Provider: Memorial Medical Center of East Texas—Lufkin ("Memorial") is a 271 bed acute care facility in Lufkin, Texas, which has the largest emergency room (32 private patient rooms) in the East Texas area. Memorial serves a three county primary service area with a population of approximately 142,268 and a nine county secondary service area with a population of approximately 239,338.
Intervention(s): This project increases training of the primary care workforce in the service area by expanding an existing outreach program at Hudson High School that allows high school students to become LVNs at High School Graduation or create other similar programs elsewhere in the service area. The goal for this project is to train more workforce members to serve as primary care providers, clinicians, and staff to help address the substantial primary care workforce shortage and to update training programs to include more organized care delivery models. This project may apply to primary care physicians (including residents in training), nurse practitioners, physician assistants, and other clinicians/staff (e.g., health coaches, community health workers/promoters) in the following service areas: family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics.
Need for the project: Recruitment of Health Care Professionals from outside the Polk County, San Augustine County, and Angelina County area is challenging and those recruited often do not have the social skills to relate to the population they are serving. "Grow your own" programs either through entry level programs such as the LVN program or loan repayment programs that allow locals to return to the area for a lower income than offered in the metropolitan areas are invaluable in overcoming these barriers. There is currently only one program at Hudson High School that allows high school students to become LVNs at High School Graduation.
Target population: The target population of participants in the primary care training outreach program are students who graduate from high schools in Memorial's primary and secondary service areas. The target population of patients who shall benefit from the increase in trained primary care providers will be adults age 18 and over with multiple chronic medical conditions in the primary service area and secondary service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. Memorial had approximately 87,700 patient encounters last year, and approximately 30% of these encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients benefiting from this project will be Medicaid and uninsured patients.

Category 1 or 2 expected patient benefits: Of the students participating in the primary care graduate/training outreach project, 5 participants will accept full-time positions to provide primary services in the community by DY5.

Category 3 outcomes: The congestive heart failure admission rate will decrease by 2% over the baseline by year 4, and will decrease by 4% over the baseline by year 5.

PROJECT DESCRIPTION:

This project increases training of the primary care workforce in the service area by expanding an existing outreach program at Hudson High School that allows high school students to become LVNs at High School Graduation or create other similar programs elsewhere in the service area. Target population is adults age 18 and over with multiple chronic medical conditions who reside in Memorial Health System of East Texas' service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. When used as a reference, the Texas Medical Foundation data defines the "Lufkin Community" as the following zip codes: 75834, 75845, 75864, 75901, 75902, 75903, 75904, 75915, 75926, 75929, 75934, 75936, 75939, 75941, 75944, 75949, 75960, 75969, 75976, and 75980. Through the retention of 5 additional primary care providers participating in Memorial's graduate/training program by the end of DY5, we estimate that this project will serve approximately 1,000 - 2,500 patients in DY3, 4,000 - 7,500 patients in DY4, and 8,500 - 12,500 patients in DY5, as measured by the number of patients that may be served by each primary care provider retained. In the previous year, approximately 30% of Memorial's patient encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients served/benefiting from this project will be Medicaid and uninsured patients.

Project Goal(s):

Texas has a growing shortage of primary care doctors and nurses and other health care professionals due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this Waiver. It is difficult to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. The extended primary care workforce will also be trained to operate in patient-centered medical homes. A greater focus on primary care will be crucial to the success of an integrated health care system. Furthermore, in order to effectively operate in a medical home model, there is a need for residency and training programs to expand the capabilities of primary care providers and other staff to effectively provide team-based care and manage population health. Therefore, the need to expand the responsibilities of primary care workforce

members will be even more important. In summary, the goal for this project is to train more workforce members to serve as primary care providers, clinicians, and staff to help address the substantial primary care workforce shortage and to update training programs to include more organized care delivery models. This project may apply to primary care physicians (including residents in training), nurse practitioners, physician assistants, and other clinicians/staff (e.g., health coaches, community health workers/promotoras) in the following service areas: family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics.

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.[1]

Anticipated Challenges:

3. Lack of college preparatory level high school work in smaller school districts in the service area make the pool of students unprepared to successfully undertake college level courses. Instilling a sense of confidence in their abilities is a challenge that can be overcome by successful mentoring programs and shadowing experiences for 9th-10th grade level students.

4. Financial support for living expenses while in school. While there are many scholarships available to pay tuition, books and fees, there are few to assist with living expenses. Students who must work over 16 hours per week to support themselves do not have the study time necessary to be successful in academically rigorous programs.

5. To identify providers who are well suited for the lifestyle of this rural location. Limited access to cultural events, entertainment, churches of some faiths, private secondary schools

[1] 2010 physician supply extracted from "Physician Characteristics and Distribution in the U.S., " 20122012 Edition, published by American Medical Association. U.S. and Texas population estimates, 2010, extracted from U.S. Census Bureau American Fact Finder Website. Prepared by: Medical Education Dept., Texas Medical Association, 2/2012.

or even luxury car dealerships or "organic" grocery stores are impediments that will not change in the near future. Our recruiting plans are focused on those providers whose interests are well suited for this location. Another strategy is to focus on local students who are in medical school or residency to recruit them back to the area.

The 5-Year Expected Outcome(s):

By the end of DY5, the Congestive Heart Failure Admission rate (CHF) will be reduced by 4% reduction in

Regional Goals:

Region Wide 2 Goals

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce.

STARTING POINT/BASELINE:

There is currently one program at Hudson High School that allows high school students to become LVNs at High School Graduation. The goal is to expand the program or create other similar programs elsewhere in the service area.

RATIONALE:

Relation Between Project Choices and Community Needs:

Of the 3 counties in Memorial Health System of East Texas' primary service area only Angelina County, where the Hudson school district is located, has slightly better than State average for Children in Poverty, High School graduation rate, children in single parent households and unemployment. Both Polk and San Augustine Counties have markedly worse than the State average in all these measures. Recruitment of Health Care Professionals from outside the area is challenging and those recruited often do not have the social skills to relate to the population they are serving. "Grow your own" programs either through entry level programs such as the LVN program or loan repayment programs that allow locals to return to the area for a lower income than offered in the metropolitan areas are invaluable in overcoming these barriers.

Unique Community Need Identification Numbers:

CN.3 Primary Care Physician Shortage
CN.4 Specialty Care Physician Shortage
CN.8 Mid-Level Provider Shortage
CN.9 Pharmacist Shortage
CN.10 High ED Utilization Rates
CN.11 30 Day Readmission Rates
CN.14 Chronic Diseases: Heart & Vascular Related Diseases & Disorders

Expansion or Enhancement:
This project is both an expansion of an existing program at Hudson High School and an enhancement of recruiting efforts in their infancy.

RELATED CATEGORY 3 OUTCOME MEASURE(S)*:*
Year 2, Process Milestone P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
Process Milestone P-3 Develop and test data systems.
Year 3, Process Milestone P-4 Conduct PDSA cycles to improve data collection and intervention activities.
Year 4, OD-2-Potentially Preventable Admissions.
IT-2.1 Congestive Heart Failure Admission rate (CHF)
Year 5, OD-2-Potentially Preventable Admissions.
IT-2.1 Congestive Heart Failure Admission rate (CHF)
Managing CHF requires a multidisciplinary team including Nurse Educators, Dietitians, Pharmacists, Physical and Occupational Therapists and Social Workers working with the PCP. When any of these specialties are lacking the approach is fragmented and increased hospitalizations result.

RELATIONSHIP TO OTHER PROJECTS:
This project is related to Lufkin project 1.1 Expand Primary Care Capacity in that both projects aim to increase patients' access to primary care in the community. Further, expanding primary care facilities and staff will facilitate the training of additional primary care providers involved in this project. This project's focus on expanding the primary care workforce to increase access and capacity and emphasis on disease management programs and patient centered medical homes ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 094092602.2.1, 284333601.1.1, 109372601.1.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:
This project focuses on the expansion of the primary care workforce along with these other Category 1 projects in our RHP: 109372601.1.3- Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement.

PLAN FOR LEARNING COLLABORATIVE:
Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

1.2.2 Increase Training of Primary Care Workforce

E. Population Affected

- Measure: All adults over 18 years with chronic diseases in primary and secondary markets.
- Score: 3 points awarded for significant population affected, and 1 extra point for Medicaid/Uninsured population.

F. Severity

- Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.

G. Cost Effectiveness

- Score: 4 points awarded for a low cost per person.

H. Community Benefit

- Score: 5 points awarded; 1 for access; 1 for quality; 1 for cost; 1 for transformative; 1 for collaborative.

139172412.1.2	1.2.2		INCREASE TRAINING OF PRIMARY CARE WORKFORCE-OUTREACH	
Memorial Medical Center of East Texas-Lufkin				139172412
Related Category 3 Outcome Measure(s):	139172412.3.2	IT-2.1	Congestive Heart Failure Admission Rate (CHF)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-7 Create a primary care career pipeline program for secondary school students (specifications to be provided in the RHP plan). **Metric 1:** P-7.1 Documentation of primary care pipeline program development and implementation. Goal: Develop and implement primary care pipeline program Data Source: Program materials. Milestone 1 Estimated Incentive Payment *(maximum amount):* $545,174	**Milestone 2**: P-5 Implement loan repayment program for primary care providers. **Metric 2:** P-5.1 Documentation of Program Baseline/Goal: There are currently no primary care providers, nurses or allied health professionals whose loans have been repaid. The goal is for one student to receive a complete or partial loan repayment award for accepting a position. Data Source: Program materials Milestone 2 Estimated Incentive Payment: $594,756		**Milestone** 3: I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities **Metric 3:** I-12.1 Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline. Goal: Increase the total number of new graduate/trainees accepting positions by 300% over year 3—meaning that there will be 2 new graduate/trainees accepting positions in DY4 and 3 total for DY3-DY4. Data Source: Documentation, such as HR documents compared to class lists. Milestone 3 Estimated Incentive Payment: $596,485	**Milestone 4**: I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities **Metric 4:** I-12.1 Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline. Goal: Increase the total number of graduate/trainees accepting positions by 500% over year 3—meaning that there will be 2 new graduate/trainees accepting positions in DY5 and 5 total for DY3-DY5. Data Source: Documentation, such as HR documents compared to class lists. Milestone 4 Estimated Incentive Payment: $492,748
Year 2 Estimated Milestone Bundle Amount*:* $545,174	Year 3 Estimated Milestone Bundle Amount: $594,756		Year 4 Estimated Milestone Bundle Amount: $596,485	Year 5 Estimated Milestone Bundle Amount: $492,748
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,229,164				

PROJECT OPTION: 1.1.1 - Expand Primary Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 131030203.1.1
PERFORMING PROVIDER NAME/TPI: Nacogdoches Memorial Hospital/ TPI: 131030203

Title of project*:* Expand Primary Care Capacity

- Provider: Nacogdoches Memorial Hospital is a 216 bed hospital serving as the county hospital district in Nacogdoches. Nacogdoches serves as the county seat for Nacogdoches County. It is one of the largest towns in the region with a population of 32,996 individuals. Nacogdoches County is a 946.5 square mile area and has a population totaling 64,524 reported by the Census Bureau for 2010.
- Intervention(s): This project will expand the capacity of primary care by establishing a new primary care clinic to better accommodate the needs of the indigent and underserved populations of Nacogdoches County.
- Need for the project: Currently, in Nacogdoches County, indigent and Medicaid patients frequently access primary care through the emergency department due to limited independent primary care physicians willing to serve this population.
- Target population: The target population is Medicaid and uninsured patients in the Nacogdoches service area. Approximately 44% of the Nacogdoches County population is either Medicaid clients or uninsured.
- Category 1 or 2 expected patient benefits: The project seeks to provide 1,260 patient visits in DY2, 10,920 visits in DY3, and 13,000 in DY4 and DY5.
- Category 3 outcomes: IT-1.7: Our goal is to increase the number of patients with adequately controlled high blood pressure in DY4 and DY5 by 5% over baseline and in DY5 by 10% over baseline.

PROJECT DESCRIPTION:
Establish a new primary care clinic to provide primary and preventive care to the indigent and underserved populations of Nacogdoches County.

Project goal(s):
Expand the capacity of primary care by establishing a new primary care clinic to better accommodate the needs of the indigent and underserved populations of Nacogdoches County. The aim of the project is for patients to have enhanced access to services allowing them to receive the right care at the right time in the right setting.

Anticipated challenges:
Memorial Hospital anticipates two main challenges to improving access to primary care; patient responsibility and access to complimentary services. One challenge is patient responsibility and participating in their care management plan. They may not comply with their provider's recommendations, may not return for follow-up visits, and may not take medications as prescribed. Another challenge will be limited patient access to medication assistance and transportation to ensure access to services.

To address these challenges, the established primary care clinic will provide a wrap-around system of care which will include a primary care provider, a case manager and community health workers to assess patients' barriers to actively participate in their care. Case managers and community health workers will connect patients to community services that will complement the care provided at the clinic.

The 5-year expected outcome(s):

The 5-year expected outcomes for Expanding Primary Care is controlling blood pressure as well as the more general goals of improving access to primary care and reducing the health consequences of uncontrolled high blood pressure in the population (such as stroke).

Regional goals:

This project contributes to the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

Currently, in Nacogdoches County, indigent and Medicaid patients frequently access primary care through the emergency department due to limited independent primary care physicians willing to serve this population. Physicians in Nacogdoches may be listed as Medicaid providers yet they are no longer taking current Medicaid patients. Patients turned away often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes putting patients at risk for frequent morbidity, disability, frequent readmissions and premature death.

The primary duty of the emergency department is to stabilize and treat emergent situations; they are not intended to deliver comprehensive and ongoing disease management. Their ability to offer preventive care and screenings is limited. Because these patients lack the ability to readily access medical advice and often do not consistently follow medical advice, they often present to the emergency department when their condition has become life-threatening and requires hospitalization.

RATIONALE:

Relation between Project Choices and Community Needs:

In our current system, there are more patients receiving services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner in the primary care setting. This results in costly, less coordinated care lacking appropriate follow-up. Patients may experience barriers in accessing primary care services due to the barriers such as 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 learn to better utilize the primary care system. This improved access will result in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

It is well known that the national supply of primary care does not meet the demand for primary care services. Nacogdoches County is designated as a Health Professions Shortage Area for primary medical care as well as a Medically Underserved Area with designation from the governor's office. Also, Nacogdoches currently has one FQHC providing care to the Medicaid and indigent population. With this project of establishing a primary care clinic, Memorial Hospital aims to provide more preventive and primary care in order to keep individuals and families healthy therefore avoiding more costly emergency department and inpatient care.

The first process milestone will occur in Year 2. Memorial Hospital will expand primary care capacity with the establishment of an additional primary care clinic. The metrics, baseline and goal have been chosen to reasonably meet this goal in Year 2. In Year 3, the process milestone will be to hire and train additional primary care providers and staff for the clinic. These metrics, baseline and goal will document the additional staff hired and trained in Year 3. In Years 4 and 5, the improvement milestones of increasing primary care clinic visits will provide evidence of the uninsured patients accessing services. These milestones have a target metric of a 10% increase of patient visits in Year 4 over baseline and then a 20% increase over baseline in Year 5.

Unique Community Need Identification numbers:

CN.2, CN.3, CN.10, CN.14

Expansion or enhancement:

This project is a new initiative for Memorial Hospital; which primarily provides disease-focused care and will be switching to a more health-focused direction of care. This new primary care clinic will treat patients on a patient-centered disease management model. The clinic will collaborate with the hospital to ensure that patients are provided the right care in the right setting.

Current related projects funded by the U.S. DHHS include, East Texas Community Health Services, Inc. (the local FQHC). No part of this DSRIP proposal is currently funded by DHHS.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

The Outcome Measure chosen for this project is [IT-1.7] Controlling High Blood Pressure. The following Process and Outcome Improvement milestones have been selected:

Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Process Milestone 2 [P-2]: Establish baseline rates.

Outcome Improvement Target 1 & 2 [IT-1.7]: Controlling high blood pressure.

This outcome measure was chosen due to one-third of the people in Nacogdoches living with high blood pressure. It is proven that aggressive treatment of high blood pressure reduces

mortality from heart disease, stroke and renal failure; results are particularly striking in the elderly population who are more likely to have heart failure. Measuring the improvements in blood pressure will enable Memorial Hospital to measure how well the new primary care clinic is managing chronic disease and related risk factors.

RELATIONSHIP TO OTHER PROJECTS:

This DSRIP project proposal, Expand Primary Care Capacity by establishing a primary care clinic will serve as the central hub for the other Memorial Hospital projects. The project, Expand Primary Care Capacity- Perinatal Care (131030203.1.2) will serve as a referral source for mothers and children to receive primary care once their postpartum care is complete. The project, Implement a Chronic Disease Management Registry (131030203.1.3), will ensure a continual and efficient management of the primary care clinic's patients with chronic disease. The case management of clinic patients will be documented in the care registry. Clinic patients with chronic disease will be referred to the project, Establish Self-Management Programs for Health Promotion (131030203.2.1), for education and training on chronic disease self-management. This project's focus on expanding primary care capacity through a new primary care clinic and emphasis on the indigent and underserved of Nacogdoches County receiving the right care at the right time in the right setting ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). The new primary care clinic will have the capacity to provide 1,260 patient visits in Y2, 10,920 visits in Y3, and 13,000 each in Years 4 and 5. This clinic will be able to reach a larger portion of the uninsured population. Since Nacogdoches residents are limited to one other primary care clinic, providing this new resource will be beneficial to Nacogdoches. The project is expected to cost approximately $6.6 million over the four years. The clinic expects to provide approximately 38,180 visits during the four year period; the estimated cost is $173 per visit. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, is transformative and will be a collaborative approach to healthcare improvement in Nacogdoches.

131030203.1.1	1.1.1	NONE	EXPANDING PRIMARY CARE CAPACITY	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	**131030203.3.1**	**IT 1.7**	**Controlling High Blood Pressure**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish an additional primary care clinic. Metric 1 [P-1.1.]: One additional clinic in Nacogdoches is established. Baseline/Goal: In 2012, primary care for the Medicaid and indigent population is limited to one primary care clinic in Nacogdoches; goal of two total primary care clinics. Data Source: New primary care schedule, MH document or other plans as designated by MH. Milestone 1 Estimated Incentive Payment: $1,715,921	**Milestone 2** [P-5]: Hire and train additional primary care providers and staff. Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: Number of providers and staff in Year 2; goal to increase staff in Year 3 for full clinic capacity. Data Source: Documentation of completion of all items for this measure. MH report, policy, contract or other documentation. Milestone 2 Estimated Incentive Payment: $1,709,779		**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Baseline is the number of patient visits in Year 3; Goal of 10% increase in Year 4. Data Source: Registry, EHR, claims or other MH data. Milestone 3 Estimated Incentive Payment: $1,726,299	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Base line is the number of patient visits in Year ; 3 Goal of 20% over baseline. Data Source: Registry, EHR, claims or other MH data. Milestone 4 Estimated Incentive Payment: $1,445,324
Year 2 Estimated Milestone Bundle Amount: $1,715,921	Year 3 Estimated Milestone Bundle Amount: $1,709,779		Year 4 Estimated Milestone Bundle Amount: $1,726,299	Year 5 Estimated Milestone Bundle Amount: $1,445,324
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,597,323				

PROJECT OPTION: 1.1.2 – Expand Primary Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 131030203.1.2
PERFORMING PROVIDER: Nacogdoches Memorial Hospital/TPI: 131030203

Title of project: Expand Primary Care Capacity- Perinatal Care

- Provider: Nacogdoches Memorial Hospital is a 216 bed hospital serving as the county hospital district in Nacogdoches. Nacogdoches serves as the county seat for Nacogdoches County. It is one of the largest towns in the region with a population of 32,996 individuals. Nacogdoches County is a 946.5 square mile area and has a population totaling 64,524 reported by the Census Bureau for 2010.
- Intervention(s): This project will expand the capacity of primary care adding a certified nurse midwife and additional support staff to increase service capacity to the indigent and underserved populations of Nacogdoches County at the Nacogdoches Regional Maternal Child Health Program (RMCHP) clinic.
- Need for the project: Recent cuts in healthcare funding across the state have forced the reduction in the local workforce of a provider and support staff in the RMCHP clinic in Nacogdoches. With these cuts the clinic was required to reduce patient visits, yet has had an increase in patient deliveries.
- Target population: The target population is Medicaid eligible and low-income pregnant women in Nacogdoches and surrounding counties. Only 60% of women who delivered in Nacogdoches County received prenatal care.
- Category 1 or 2 expected patient benefits: The project seeks to provide approximately 1,200 patent visits in DY2, 3,200 visits in DY3, and 9,600 in DY4 and DY5.
- Category 3 outcomes:
    - IT-8.1 Rate 1: Our goal is to increase the percentages of deliveries that received prenatal care visits in the first trimester by 10% in DY3, by 15% in DY4 and by 20% in DY5. Rate 2: Our goal is to increase the percentage of deliveries that had a postpartum visit by 10% in DY 3, by 15% in DY4 and by 20% in DY5.

IT-8.2: Our goal is to decrease the number of babies born at low-birth weight by 0.5% in DY 3, by 1.0% in DY4 and by 1.5% in DY5.

PROJECT DESCRIPTION:

This project will expand primary care in a maternal/child clinic by adding a certified nurse midwife (CNM) and additional support staff to increase service capacity to the indigent and underserved populations of Nacogdoches County.

Project goal(s):

The goal of this project is to expand the current staff by one CNM and appropriate support staff at the Nacogdoches Regional Maternal Child Health Program (RMCHP) clinic.

Anticipated challenges:

Memorial Hospital anticipates two main challenges to expanding access to primary care. These are increasing community awareness of expanded patient capacity and patient responsibility for participating in prenatal and postpartum care. Once a new CNM is hired, the clinic will be able to serve more clients. It will also be important for the clinic to promote its increased capacity so that the underserved will be aware of available services. Another anticipated challenge is the patient's responsibility to participate in their prenatal and postpartum care plan; they may not comply with their provider's recommendations and may not return for follow-up visits. To address this challenge, the CNM and clinic support staff will provide consistent patient education on the importance of prenatal and postpartum care, and communicate regularly with patients through reminder and follow-up phone calls.

The 5-year expected outcome(s):

The 5-year expected outcomes for the project: Expand Primary Care Capacity- Perinatal Care includes the following: 1) Timeliness of Prenatal/Postnatal Care and 2) Percentage of Low Birth-Weight Births. The effectiveness of this project will be measured by improving the rates of women who receive prenatal and postpartum care and decreasing the percentage of low birth-weight births.

Regional goals:

This project contributes to the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

Access to prompt quality prenatal care is essential in the care of the pregnant woman and her unborn child. Recent cuts in healthcare funding in the state have forced the reduction in the local workforce of a UTMB provider and support staff in the RMCHP clinic in Nacogdoches, as well as a 0.4 physician FTE from the hospital. This problem has pushed the next available appointment out to three weeks even with the support of providers and staff from other RMCHP clinics that travel to Nacogdoches to help with access. With these cuts the clinic has seen a reduction in patient visits, yet an increase in patient deliveries. In FY 2011 (Sept. 2010 – August 2011) patient visits were 14,319 and in FY 2012 (Sept. 2011 – August 2012) visits were 12,332; a decrease of 1,987 visits. The increase in births in clinic patients was 28 more in 2012 than in 2011.

RATIONALE:

Relation between Project Choices and Community Needs:

In Nacogdoches, there is a need for improved perinatal care. Based on 2005-2009 birth statistics, only 60.1% of women who delivered received prenatal care and 7.6% of births were of low birth-weight. The rate of infant mortality and births to teen mothers for the county are higher than Texas and US averages.

To address these needs, Memorial Hospital has chosen Process Milestone P-5: Hire/Train additional OBGYN provider, this milestone will occur in Year 2. The metrics, baseline and goal have been chosen to reasonably meet this goal in Year 2. In Years 3-5, the Improvement Milestone I-12 of increasing primary care clinic volume of visits will provide evidence of improved access for patients seeking services. These milestones have a target metric of a 25% increase in Years 3 over baseline, 50% increase over baseline in Year 4 and 95% increase over baseline in Year 5.

The addition of another CNM will expand access to care for low-income pregnant women in Nacogdoches and surrounding counties. The partnership of Memorial Hospital and the UTMB RMCHP clinic provides a continuity of care model that has served the county well in the past. The vast majority of the patients who receive prenatal care at the clinic deliver at the local hospital with the hospital CNMs; very high risk women require delivery at UTMB in Galveston with the Maternal-Fetal Medicine Specialists physicians.

Increasing the capacity for obstetric care for women in Nacogdoches will improve the primary care system by allowing patients to receive essential perinatal care in an appropriate setting.

Required core project components:

a) Expand primary care clinic space. This DSRIP project does not address expanding additional space because the current clinic already has sufficient space necessary for the additional staff included and patients to be served in this project.

b) Expand primary care clinic hours. This DSRIP project does not plan to expand clinic hours. Currently the clinic is open 8 a.m. to 5 p.m. Monday to Friday, with extended hours to 7 p.m. on Tuesdays.

c) Expand primary care clinic staffing. This project includes the expansion of the primary clinic staffing to meet the needs of the underserved in Nacogdoches County. The expanded staff at

the maternal/child clinic would be able to conduct 4,800 patient visits per year at full operating capacity. This expansion would allow the clinic to see an additional estimated 14,000 visits over the four year period.

Unique Community Need Identification numbers:

CN.2 and CN.3

Expansion or enhancement:

This project represents an enhancement of the current primary care system of Memorial Hospital. Expanding the current staff at the Nacogdoches Regional Maternal Child Health Program (RMCHP) already established clinic will expand access to care for low-income pregnant women in Nacogdoches and surrounding counties.

Current related projects funded by the U.S. DHHS include, East Texas Community Health Services, Inc. (the local FQHC). No part of this DSRIP proposal is currently funded by DHHS.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

The first Outcome Measure for this project is [IT-8.1] Timeliness of Prenatal/Postnatal Care. The following Process and Outcome Improvement milestones have been selected:

Process Milestone 1 [P-2]: Establish baseline rates.

Outcome Improvement Milestone 1-3: [8.1] Timeliness of Prenatal/Postnatal Care (Years 3-5).

This outcome measure was chosen because only 60.1% of births in Nacogdoches received any prenatal care. Measuring this outcome will be effective for perinatal care; it is a recommended CHIPRA Core Measure.

The second Outcome Measure for this project is [IT-8.2] Percentage of Low Birth-weight Births. The following Process and Outcome Improvement milestones have been selected:

Process Milestone 1 [P-2]: Establish baseline rates.

Outcome Improvement Milestones 1-3: [8.2] Percentage of Low Birth-Weight births (Years 3-5).

This outcome measure was chosen because 7.1% of births in Nacogdoches were of low birth-weight. Measuring this outcome will be effective for perinatal care; it is a recommended CHIPRA Core Measure.

RELATIONSHIP TO OTHER PROJECTS:

This DSRIP PROJECT proposal, Expand Primary Care Capacity-Perinatal Care relates to the other Memorial Hospital projects through the project Expand Primary Care Capacity (131030203.1.1), which establishes a primary care clinic that will serve as the central hub for DSRIP projects. The Perinatal Care project will refer mothers and children to the primary care clinic upon completion of their postpartum care. The project, Implement a Chronic Disease Management Registry (131030203.1.3), will ensure a continual and efficient management of the primary care clinic's patients with chronic disease. The case management of clinic patients will be documented in the care registry. Clinic patients with chronic disease will be referred to the project, Establish Self-Management Programs for Health Promotion (131030203.2.1), for education and training on chronic disease self-management. This project's focus on expanding primary care and emphasis on perinatal care for the indigent and underserved populations of Nacogdoches county ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3,

109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 121805903.1.3, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

Project Valuation:

The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). The expanded staff at the maternal/child clinic would be able to conduct 4,800 patient visits per year at full operating capacity. This expansion would allow the clinic to see an additional estimated 14,000 visits over the four year period. This clinic would be able to reach a larger portion of the uninsured population. This project is expected to cost about $1.2 million over the four years; the estimated cost is $86 per visit. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, is transformative and will be a collaborative approach to healthcare improvement in Nacogdoches.

131030203.1.2	1.1.2	1.1.2 (a-c)	EXPAND PRIMARY CARE CAPACITY-PERINATAL CARE	
Nacogdoches Memorial Hospital				**131030203**
Related Category 3 Outcome Measure(s):	**131030203.3.2** **131030203.3.3**	**IT -8.1 and 8.2**	**Timeliness of Prenatal/Postnatal Care** **Percentage of Low Birth-weight Births**	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Hire/Train additional OBGYN provider. Metric 1 [P-5.1]: Documentation of increased number of nurse midwives and necessary support staff. Baseline/Goal: In 2012, the single maternal/child clinic in Nacogdoches has one nurse midwife for the indigent/Medicaid population; Goal of two nurse midwives and necessary support staff. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Performing Provider report, policy, contract or other documentation. Milestone 1 Estimated Incentive Payment: $321,974	**Milestone 2 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Number of patient visits in Year 2; Goal of 25% increase in Year 3. Data Source: Registry and EHR. Milestone 2 Estimated Incentive Payment: $319,926		**Milestone 3 [I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Number of patient visits in Year 2; Goal of 50% increase in Year 4 over baseline. Data Source: Registry and EHR. Milestone 3 Estimated Incentive Payment: $325,433	**Milestone 4** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Number of patient visits in Year 2; Goal of 95% increase in Year 5 over baseline. Data Source: Registry and EHR. Milestone 4 Estimated Incentive Payment: $231,775
Year 2 Estimated Milestone Bundle Amount: $321,974	Year 3 Estimated Milestone Bundle Amount: $319,926		Year 4 Estimated Milestone Bundle Amount: $325,433	Year 5 Estimated Milestone Bundle Amount: $231,775
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,199,108				

PROJECT OPTION: 1.3.1-Implement a Chronic Disease Management Registry

UNIQUE RHP PROJECT IDENTIFICATION NUMBER*:* 131030203.1.3
PERFORMING PROVIDER NAME/TPI: Nacogdoches Memorial Hospital/131030203

Title of project: Implement a Chronic Disease Management Registry

- Provider: Nacogdoches Memorial Hospital is a 216 bed hospital serving as the county hospital district in Nacogdoches. Nacogdoches serves as the county seat for Nacogdoches County. It is one of the largest towns in the region with a population of 32,996 individuals. Nacogdoches County is a 946.5 square mile area and has a population totaling 64,524 reported by the Census Bureau for 2010.
- Intervention(s): This project will implement a functional chronic disease management registry to improve primary and preventative care to the Medicaid and underserved populations of Nacogdoches County.
- Need for the project: Currently, Memorial Hospital does not have an effective or efficient plan to care for patients with chronic diseases. This project will prevent Medicaid and underserved patients from receiving care in the emergency room, when the chronic disease has evolved into an acute medical emergency.
- Target population: The target population is Medicaid and uninsured patients in Nacogdoches and surrounding counties with diabetes, pre-diabetes or related risk factors Comparing an estimation of Memorial Hospital clinic visits and the rate of diabetes in the community (9.3% or 6,194 diabetics); the clinic will provide approximately 60,060 patient visits over the four year period, if 9.3% are patients with diabetes, an 5,585 patient visits for diabetics are estimated.
- Category 1 or 2 expected patient benefits: The project seeks to provide approximately 15,015 patient visits related to chronic disease in DY2-DY5.
- Category 3 outcomes:

IT-1.10: Our goal is to increase the percentages of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c control by 5% in DY2, by 10% in DY4 and by 15% in DY5.

PROJECT DESCRIPTION:

Implement a functional chronic disease management registry to improve primary and preventive care to the indigent and underserved populations of Nacogdoches County.

Project goal(s):

Implement a disease management registry in four primary care clinics in Nacogdoches County for one or more patient populations diagnosed with diabetes, pre-diabetes or related risk factors By tracking key patient information, a disease registry can help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions.

Anticipated challenges:

Memorial Hospital anticipates two main challenges to implementing a chronic disease management registry; patient responsibility and transitioning staff to utilizing the disease management system.

One challenge is patient responsibility and participation in their chronic disease management plan. They may not comply with their provider's recommendations, may not return for follow-up visits, and may not take medications as prescribed. Also exists is the challenge of limited patient access to medication assistance and transportation to ensure access to services. To address these challenges, the primary care clinics will provide a wrap-around system of care which would include a primary care provider, a case manager, and community health workers to assess patients' barriers to actively participate in their care. Case managers and community health workers can assist with connecting patients to community services that will complement the care provided at the clinic.

Another challenge will be the training and transitioning of clinic staff to using the chronic disease management registry. Staff may not be familiar with real time data entry and health information management. It will be essential for providers to embrace the efficiency offered by the registry to effectively manage the care of their patients.

The 5-year expected outcome(s):

The 5-year expected outcome for the project: Implement a Chronic Disease Management Registry is to impact the health of diabetics by improving HbA1c control. The effectiveness of this project will be measured by the reduction of patients 18-75 years of age with diabetes (type 1 or type 2) who exhibit HbA1c control.

Regional goals:

This project contributes to the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

Currently, Memorial Hospital does not have an effective or efficient plan to care for patients with chronic diseases. The individuals who have Medicare or private insurance can be seen by primary care physicians in their offices. In this setting, the patient is seen for approximately 15 minutes and then scheduled for a follow up appointment several months in the future. Few, if any, patients receive education related to managing their disease or precautions necessary to improve and maintain good health. Uninsured patients or those with Medicaid are even less

fortunate because their sole means of receiving care is from the emergency room, when the chronic disease has evolved into an acute medical emergency.

RATIONALE:

Relation between Project Choices and Community Needs

Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care. By tracking patient information, a disease registry helps physicians and other members of the care team to identify and reach out to patients with gaps in care, disease risk factors, or with suboptimal quality indicators. These registries can also be used to prompt providers through point-of-care alerts to ensure that appropriate and timely care is provided during patient visits. With the increased sophistication and integration of information systems, computerized disease registries are being used to improve the quality of care both at the point where care is delivered and in between visits.

By enabling chronic disease management and care coordination to be the center of patient care, the disease and care coordination registry will increase efficiency in Memorial Hospital primary care clinics. Social workers, case managers and community health workers will work face-to-face and by phone to assist patients in setting up appointments and educating them on how to manage their disease and improve their overall health.

In Nacogdoches we currently have one FQHC providing care to the Medicaid and indigent population. With this project of implementing a chronic disease management registry, Memorial Hospital will aim to provide more preventive and primary care in order to manage chronic diseases and therefore avoid more costly ED and inpatient care.

To properly implement this project the following milestones and metrics have been selected. In Year 2 the process milestone is: Memorial Hospital will implement a functional disease management registry in two MH clinic locations. The metrics, baseline and goal have been chosen to reasonably meet this goal in Year 2. In Year 3, the process milestone will be to continue the implementation of the registry into two additional clinics. In Years 4 and 5, the improvement milestones of performing routine follow-up monitoring and will provide evidence of adherence to the disease management program. These milestones have target metrics of a 10% increase over baseline of patients adhering to the recommended program regimen and managed in the patient care registry in Year 4 and then a 20% increase over baseline in Year 5. A quality improvement process milestone has been selected for the project: in Years 3-5, clinic staff will attend 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. In Years 4-5, clinic staff will implement the “raise the floor” improvement initiatives established at the semiannual meetings.

Required core project components:

a) Enter patient data into unique chronic disease registry. As primary care clinics implement the chronic disease management registry, data from patients with diabetes or related risk factors will be entered. This effort will be phased in with registry implementation at two of the clinics

in Year 2 and registry implementation at the other two clinics in Year 3. Patient data will be entered at initial implementation and on an ongoing basis as new patients visit the clinic.
b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need. Clinic staff will work as a care management team and will utilize registry data before, during and after patient visits to improve patient disease status. Staff, including but not limited to social workers, case managers and community health workers will work face-to-face and by phone to assist patients in setting up appointments and educating them on how to manage their disease and improve their overall health.
c) Use registry reports to develop and implement targeted QI plan. Registry reports will be regularly utilized to ensure the effective management of patients in the registry. The reports will include but are not limited to data on staff performance related to contacting and educating patients, patient disease and risk factor status improvements, and patient disease management compliance (taking medications, improving health behaviors and attending disease management classes).
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. As mentioned above, a quality improvement process milestone has been selected for the project; clinic staff will attend face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects; and clinic staff will implement "raise the floor" improvement initiatives as established at the semiannual meetings.

Unique Community Need Identification numbers:

CN.1, CN.2, CN.3, CN.10, CN.11, CN.12

Expansion or enhancement:

This project is a new initiative for Memorial Hospital which currently serves as a provider primarily providing disease-focused care and will switch to provide more health-focused care. Implementing an efficient and effective chronic disease management registry will treat patients with a patient-centered disease management model. This project will collaborate with the entire Memorial Hospital system of care to ensure that patients are provided the right care in the right setting.

Current related projects funded by the U.S. DHHS include, East Texas Community Health Services, Inc. (the local FQHC). No part of this DSRIP proposal is currently funded by DHHS.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

The Outcome Measure chosen for this project is [IT-1.10]: Diabetes Care: HbA1c poor control. The following Process and Outcome Improvement milestones have been selected:

Process Milestone 2 [P-2]: Establish baseline rates.

Outcome Improvement Target 1 [IT-1.10]: Improvement Target: Diabetes Care: HbA1c poor control.

Outcome Improvement Target 2 [IT-1.10]: Diabetes Care: HbA1c poor control.

This outcome measure was chosen because of the high diabetes death rate in Nacogdoches County. Measuring the improvements in HbA1c will enable Memorial Hospital to see how effectively the chronic disease management registry is managing chronic disease and related risk factors.

RELATIONSHIP TO OTHER PROJECTS:

This DSRIP project proposal, Implement a Chronic Disease Management Registry, relates to the other Memorial Hospital projects through the project Expand Primary Care Capacity (131030203.1.1), which establishes a primary care clinic that will serve as the central hub for DSRIP projects. The Expand Primary Care Capacity- Perinatal Care (131030203.1.2) project will refer mothers and children to the primary care clinic upon completion of their postpartum care. This project ensures continual and efficient management of the primary care clinic's patients with chronic disease. The case management of clinic patients will be documented in the care registry. Clinic patients with chronic disease will be referred to the project, Establish Self-Management Programs for Health Promotion (131030203.2.1), for education and training on chronic disease self-management. This project's focus on implementing a chronic disease management registry in primary care clinics in Nacogdoches County and emphasis on multiple chronic diseases ties to these Category 1 and 2 projects in our RHP: 131030203.1.3, 094092602.1.4, 094092602.1.5, 138296208.2.1, 094092602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of chronic disease registry along with these other Category 1 projects in our RHP: 131030203.1.3 - Implement a chronic disease management registry; 094092602.1.4 - Transplantation chronic disease management registry; 094092602.1.5-Implement and utilize disease management registry.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

The population of Nacogdoches County is 64,524. Based on the CNA, the uninsured population is 43.3% (approximately 28,000). The new primary care clinic will provide approximately 60,060 patient visits over the four year project timeframe. Based on usage in Memorial Hospital's current clinics, 25% of the patients served will be expected to have one or more chronic conditions. The project is expected to cost $699,554 over four years. If the project provides 15,015 patient visits related to chronic disease, the cost will be about $47 per visit. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, is transformative and will be a collaborative approach to healthcare improvement in Nacogdoches.

131030203.1.3	1.3.1	1.3.1 (a-d)	IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY	
Nacogdoches Memorial Hospital				131030203
Related Category 3 Outcome Measure(s):	131030203.3.4	IT 1.10	Diabetes care: HbA1c poor control (>9.0%)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-4]: Implement a functional disease management registry. Metric 1 [P-4.1.]: Registry functionality is available in 50% of MH clinic locations. Baseline/Goal: In 2012, none of the MH clinics have a disease management registry; goal of two clinics implementing the registry. Data Source: Documentation of adoption and installation of registry. Milestone 1 Estimated Incentive Payment: $185,987	**Milestone2** [P-4]: Implement a functional disease management registry. Metric 1 [P-4.1.]: Registry functionality is available in 100% of MH clinic locations. Baseline/Goal: In Year 3, only two of the four MH clinics have a disease management registry; goal of all four clinics implementing the registry. Data Source: Documentation of adoption and installation of registry. Milestone 2 Estimated Incentive Payment: $92,481.50 **Milestone 3 [P-14]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: In Y2, clinic staff have not participated in collaborative learning meetings; goal of participation in at least	**Milestone 4** [I-18]: Perform routine follow-up monitoring to ensure adherence to the disease management program. Metric 1 [I-18.1]: As measured by the number of patients adhering to the recommended program regimen compared to the total number of patients following a program regimen – using the patient registry. Baseline/Goal: Number of patients managed in the patient registry in Year 3; Goal of 10% increase in Year 4 over baseline. Data Source: Registry, EHR, claims or other MH data. Milestone 4 Estimated Incentive Payment: $93,858.50 **Milestone 5 [P-14]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: In Y3, clinic staff	**Milestone 6** [I-18]: Perform routine follow-up monitoring to ensure adherence to the disease management program. Metric 1 [I-18.1]: As measured by the number of patients adhering to the recommended program regimen compared to the total number of patients following a program regimen– using the patient registry. Baseline/Goal: Number of patients managed in the registry in Year 3; Goal of 20% increase in Year 5 over baseline. Data Source: Registry, EHR, claims or other MH data. Milestone 6 Estimated Incentive Payment: $70,443.50 **Milestone 7 [P-14]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: In Y4, clinic staff

131030203.1.3	1.3.1	1.3.1 (a-d)	IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY	
Nacogdoches Memorial Hospital				131030203
Related Category 3 Outcome Measure(s):	131030203.3.4	IT 1.10	Diabetes care: HbA1c poor control (>9.0%)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	two collaborative learning meetings per year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment $92,481.50	participated in at least two collaborative meetings; goal of implementing the "raise the floor" improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 5 Estimated Incentive Payment $93,858.50	participated in at least two collaborative meetings and implemented improvement initiatives; goal of implementing additional "raise the floor" improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 Estimated Incentive Payment: $70,443.50
Year 2 Estimated Milestone Bundle Amount: $185,987	Year 3 Estimated Milestone Bundle Amount: $184,963	Year 4 Estimated Milestone Bundle Amount: $187,717	Year 5 Estimated Milestone Bundle Amount: $140,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $699,554			

PROJECT OPTION: 1.9.2 Improve Access to Specialty Care
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 131030203.1.4-Pass 3
Performing Provider Name/TPI: Nacogdoches Memorial Hospital/ TPI: 131030203

Title of project: Expand Specialty Care Capacity

Category Project Area: 1.9 - Expand Specialty Care Capacity

- Provider: Nacogdoches Memorial Hospital is a 216 bed hospital serving as the county hospital district in Nacogdoches. Nacogdoches serves as the county seat for Nacogdoches County. It is one of the largest towns in the region with a population of 32,996 individuals. Nacogdoches County is a 946.5 square mile area and has a population totaling 64,524 reported by the Census Bureau for 2010.
- Intervention(s)***:*** This project will improve access to specialty care by increasing service availability with extended hours, provide specialty care clinic locations, and ensure transparent, standardized referrals across the system for the Medicaid and underserved populations of Nacogdoches County.
- Need for the project: Currently access to specialty care is limited for the underserved population in Nacogdoches County. This project will allow Medicaid and underserved patients to access to the following specialty care: orthopedics, cardiology, gastroenterology, urology, otolaryngology, pulmonology, ophthalmology, podiatry and general surgery
- Target population: The target population is Medicaid and uninsured patients in Nacogdoches and surrounding counties.
- Category 1 or 2 expected patient benefits: The new specialty care clinic will have the capacity to provide approximately 210 patient visits in Y2, 350 visits each in Years 3, 4 and 5.
- Category 3 outcomes:
    - IT- 3.5: Acute Myocardial Infarction (AMI) 30 Day readmission rate: In Year 4, the Outcome Improvement Target will be a 5% reduction in the baseline of the 30-day readmission rate for AMI Year 3. In Year 5, the Outcome Improvement Target will be a 8% reduction in the baseline of the 30-day readmission rate for AMI Year 3

Project Description:
This project will improve access to specialty care by increasing service availability with extended hours, provide a multi-specialty care clinic location, and ensure transparent, standardized referrals across the system for the Medicaid, indigent and underserved populations of Nacogdoches County.

Project goal(s):
Expand the capacity of specialty care by expanding specialty care services to better accommodate the needs of the Medicaid, indigent and underserved populations of Nacogdoches County. This project will provide Medicaid and underserved patients access to the following specialty care services: orthopedics, cardiology, gastroenterology, urology, otolaryngology, pulmonology, ophthalmology, podiatry and general surgery. The aim of the

project is for patients to have enhanced access to services allowing them to receive the right care at the right time in the right setting.

Anticipated challenges:

Memorial Hospital anticipates two main challenges to improving access to specialty care; patient responsibility and access to complimentary services. One challenge is patient responsibility and participating in their care management plan. Patient participation is effected by medication non-compliance, not following physician recommendations and not returning to follow-up visits. Another challenge will be limited patient access to medication assistance and transportation to ensure access to services.

To address these challenges, the established specialty care clinic will provide a wrap-around system of care which will include a specialty care provider, primary care provider, a case manager and community health workers to assess patients' barriers to actively participate in their care. Case managers and community health workers will connect patients to community services that will complement the care provided at the clinic.

The 5-year expected outcome(s):

The 5-year expected outcomes for Expanding Specialty Care is to reduce the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index Acute Myocardial Infarctions (AMI). The project will also indirectly improve patient and provider management to control blood pressure, COPD and CHF. The project will work to improve access to the follow specialty services: preventative eye care for diabetics, diabetic foot exams and wound care, GI specialists for cancer screens, urological care, general surgery, orthopedics, pulmonology and ENT diagnostics. More general goals of the project are improving access to specialty care and reducing the health consequences of uncontrolled chronic and acute diseases in the underserved population.

Regional goals:

This project contributes to the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

Starting Point/Baseline:

Currently, in Nacogdoches County, indigent and Medicaid patients frequently have no access to specialty care or access it through the emergency department due to their limited financial resources. Physicians in Nacogdoches may be listed as Medicaid providers yet they are no longer taking current Medicaid patients. Patients turned away often have multiple chronic conditions. Without regular specialty care, chronic conditions are likely to become acute episodes putting patients at risk for frequent morbidity, disability, frequent readmissions and premature death. Underserved patients usually present to the emergency department when their condition has become life-threatening and requires hospitalization. The primary duty of

the emergency department is to stabilize and treat emergent situations; they are not intended to deliver comprehensive and ongoing disease management. Expanded access to specialty care may prevent patients from utilizing the emergency department when a convenient clinic visit may be all that is required.

Rationale:

Relation between Project Choices and Community Needs:

In our current system, there are more patients receiving services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner in the specialty care setting. This results in costly, less coordinated care lacking appropriate follow-up. Patients may experience problems accessing specialty care services due to the barriers such as 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 specialty care setting. By enhancing access points, available appointment times, patient awareness of available services and overall specialty care capacity; patients and their families will learn to utilize the specialty care system. This improved access will result in improved health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Based on the CNA, the rate of preventable hospital stays (an indicator of lack of access to appropriate care) for the county is much higher than the Texas rate. Also, high rates of visits to the emergency department (ED) can indicate lack of access to appropriate care or inappropriate utilization. The rate of ED visits for Nacogdoches County is in the bottom 10% of all counties in Texas.

To properly implement this project the following milestones and metrics have been selected. In Year 2 the process milestone is: Memorial Hospital will expand specialty care capacity with the establishment of a multi-specialty care clinic. The metrics, baseline and goal have been chosen to reasonably meet this goal in Year 2. In Year 3, the process milestone is to increase the number of clinic hours available for the most impacted medical specialties. The metrics, baseline and goal will document the increased number of clinic hours available in Year 3. In Years 4 and 5, the improvement milestones of increasing the number of referrals of targeted patients will provide evidence of the uninsured patients accessing specialty care services. These milestones have a target metric of a 25% increase of patient referrals in Year 4 over the baseline established in Year 3 and a 40% increase of patient referrals in Year 5 over baseline.

In Year 3, process milestones and metrics have been chosen to measure clinic staff participation in face-to-face learning opportunities to promote collaborative learning around the RHP. In Years 4 and 5, the process milestones and metrics will measure clinic staff participation in the learning opportunities as well as document the implementation of improvement initiatives.

Required Core Components:

a) Increase service availability with extended hours. This project will create a new specialty care clinic with extended service hours. In Year 2, when the clinic is being developed, clinic

administers will determine an appropriate schedule to best meet the needs of the patient population.
b) Increase number of specialty clinic locations. This project will provide an additional clinic location for the Nacogdoches community.
c) Implement transparent, standardized referrals across the system. The specialty care clinic will be housed within a new primary care clinic as proposed in DSRIP project, 131030203.1.1, this along with the three clinics currently operating within the Memorial Hospital health care system will provide a transparent and standardized referral 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. As mentioned above, a quality improvement process milestone has been selected for the project; clinic staff will attend face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects; and clinic staff will implement "raise the floor" improvement initiatives as established at the semiannual meetings.

Unique Community Need Identification numbers:
CN.1, CN.2, CN.4, CN.10, CN.11, CN.12, CN.13, CN.14, CN.15
Expansion or enhancement
This project is a new initiative for Memorial Hospital; which primarily provides disease-focused care and will be implementing more health-focused intiatives. This new specialty care clinic will be an expansion of healthcare services to treat patients on a patient-centered model. The specialty clinic will collaborate with the hospital to ensure that patients are provided the right care in the right setting.
Currently, there are no related projects funded by the U.S. DHHS. No part of this DSRIP proposal is currently funded by DHHS.
Related Category 3 Outcome Measures:
The Outcome Measure chosen for this project is [IT-3.5] Acute Myocardial Infarction (AMI) 30 day readmission rate. The following Process and Outcome Improvement milestones have been selected:
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Process Milestone 2 [P-2]: Establish baseline rates.

Outcome Improvement Target 1 & 2 [IT-3.5]: Acute Myocardial Infarction (AMI) 30 day readmission rate. This outcome measure was chosen because of the relationship between hospital readmissions and quality of care being well documented. If AMI patients are discharged from the hospital after their index admission to the appropriate specialist and care management plan, their risk of hospital readmission is reduced.
Relationship to other Projects:

This DSRIP project proposal Expand Specialty Care Capacity will link with the other Nacogdoches DSRIP projects. The project Expand Primary Care Capacity (131030203.1.1) will serve as the central hub for all Memorial Hospital projects, clinic primary care providers will refer patients to specialists located within the same clinic location, often times they will conduct specialty visits on the same appointment day to avoid transportation barriers related with return visits. The project Implement a Chronic Disease Management Registry (131030203.1.3), will ensure a continual and efficient management of the clinic's patients with chronic disease. The case management of clinic patients will be documented in the care registry. Clinic patients with chronic disease will be referred to the project, Establish Self-Management Programs for Health Promotion (131030203.2.1), for education and training on chronic disease self-management. This project's focus on expanding access to specialty care and emphasis on burn and trauma care ties to these Category 1 and 2 projects in our RHP: 109372601.2.1, 109372601.1.1, 131030203.1.4, 094092602.1.10. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the improvement of access to specialty care along with these other Category 1 projects in our RHP: 0818444501.1.1 - Expanded psychiatry delivery program; 109372601.1.1-Expand specialty Brazoria County and 131030203.1.4- Improve Access to Specialty Care.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). The new specialty care clinic will have the capacity to provide approximately 210 patient visits in Y2, 350 visits each in Years 3, 4 and 5. This clinic will be able to reach a larger portion of the uninsured population. Since Nacogdoches residents have limited access to specialty care, providing this new resource will be beneficial to Nacogdoches. The project is expected to cost approximately $2 million over the four years. The clinic expects

to provide approximately 1,260 visits during the four year period. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, is transformative and will be a collaborative approach to healthcare improvement in Nacogdoches.

131030203.1.4	1.9.2	1.9.2 (a-d)	Expanding Specialty Care Capacity	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	**131030203.3.7**	**IT 3.5**	**Acute Myocardial Infarction (AMI) 30 Day readmission rate [IT-3.5]**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-11]: Launch/expand a multi-specialty care clinic Metric 1 [P-11.1.]: Establish/expand a specialty care clinic. Baseline/Goal: In 2012, a specialty care clinic for the Medicaid and indigent population is not available. Goal: Establish a multi-specialty care clinic. Data Source: Documentation of an expanded specialty care clinic. Milestone 1 Estimated Incentive Payment: $509,904	**Milestone 2 [I-22]**: Increase the number of clinic hours available for most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of clinic hours for targeted specialties. Baseline/Goal: Number of clinic hours in Year 2; Goal to increase clinic hours by 25% in Year 3. Data Source: Documentation of clinic schedules. Milestone 2 Estimated Incentive Payment: $264,852.50 **Milestone 3 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: In Y2, clinic staff have not participated in collaborative learning meetings; goal of participation in at least two collaborative learning meetings per year.		**Milestone 4** [I-29]: Increase the number of referrals of targeted patients to the specialty care clinic. Metric 1 [I-29.1]: Targeted referral rate. Baseline/Goal: Number of referrals of targeted patients in Year 3; Goal of 25% increase in Year 4. Data Source: Registry and EHR Milestone4 Estimated Incentive Payment: $273,913.50 **Milestone 5 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: In Y3, clinic staff participated in at least two collaborative meetings; goal of implementing the "raise the floor" improvement initiatives.	**Milestone 6** [I-29]: Increase the number of referrals of targeted patients to the specialty care clinic. Metric 1 [I-29.1]: Targeted referral rate. Baseline/Goal: Number of referrals of targeted patients in Year 3; Goal of 40% increase over baseline in Year 5. Data Source: Registry and EHR Milestone6 Estimated Incentive Payment: $217,813.50 **Milestone 7 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: In Y4, clinic staff participated in at least two collaborative meetings; goal of implementing the "raise the floor"

131030203.1.4	1.9.2	1.9.2 (a-d)	Expanding Specialty Care Capacity	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	**131030203.3.7**	**IT 3.5**	**Acute Myocardial Infarction (AMI) 30 Day readmission rate [IT-3.5]**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment*:* $264,852.50		Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 5 Estimated Incentive Payment*:* $273,913.50	improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 Estimated Incentive Payment*:* $217,813.50
Year 2 Estimated Milestone Bundle Amount: $509,904	Year 3 Estimated Milestone Bundle Amount: $529,705		Year 4 Estimated Milestone Bundle Amount: $547,827	Year 5 Estimated Milestone Bundle Amount: $435,627
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,023,063				

PROJECT OPTION: 1.1.2 Expand Existing Primary Care Capacity
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 261955689.1.1-Pass 2

PERFORMANCE PROVIDER: Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital

Provider: Sabine County Hospital is a JCAHO accredited 25-bed critical access hospital located in Hemphill in Sabine County, Texas. The county encompasses 577 square miles with approximately 15% of the total area covered in water through 2 area large lakes. The hospital has a Level IV Trauma Center and is the only hospital within a 35 mile radius. The nearest large acute care facilities are located in Nacogdoches and Lufkin, both approximately 60 miles away. The county has a population of 10,864 and is a HPSA and MUA with a score of 18.
Intervention: It is being proposed that Sabine County Hospital will expand the capacity of primary care to better accommodate the needs of the patient population and community in the county so that patients can receive the right care at the right time in the right setting. The goal has been set to expand the capacity of primary care to better accommodate the needs of the patient population and community in the county. This will be done by increasing rural health clinics from 1 to 2 in Hemphill, Texas and to expand the hours of operation at the Toledo Bend Family Medicine Clinic from 24 hours per week to 40 hours per week. We also plan on recruiting two additional doctors to the community. Through the establishment of an additional RHC and additional primary care provider recruitment, we will be able to more effectively provide urgent care, routine care and preventive care to the community, particularly those in the area who may be more financially and resource-challenged and cannot travel to larger cities for healthcare needs.
Need for the Project: The direst current challenge existing in the county is that the current community is served by only two MD's. Both of those MD's have well-established practices, but are senior physicians over the age of 70 years. With physician recruitment being a challenge in a small rural community, the last search took over 1 year before placement was achieved. Physician recruitment costs to underserved rural areas are frequently much higher than in urban areas and can run upwards of $250,000 when factoring in recruitment expenses such as agency fees, site visits, advertising and including signing bonuses and relocation costs (Modern Healthcare source). The community does not have the urban amenities or available housing that is attractive to younger physicians and their families for lifestyle choices. Many patients utilize the ED for non-emergent medical care as they do not wish to wait lengthy time periods for clinic appointments. Patient satisfaction in the existing clinic indicates frustration by patients in trying to receive timely appointment times since current employed providers also provide ED staffing and are spread thin. A new clinic with expanded hours coupled with new providers will enable us to provide expanded primary care for all age ranges and economic circumstances.
In Region 2 planning meetings and in the review of community assessment needs, the lack of primary care was evidenced not only in the rural areas such as Sabine County but also in the more urban areas as well by the majority of the participating providers as evidenced in their projected DSRIP plans.

Target Population: Young families with limited resources, particularly Medicaid, and indigent or uninsured patient population will be expected to utilize these new expanded resources.

Clearly state the expected benefit of the project to patients based on:

Describe Project It is being proposed that Sabine County Hospital will expand the capacity of primary care to better accommodate the needs of the patient population and community in the county so that patients can receive the right care at the right time in the right setting. This will be done by increasing rural health clinics from 1 to 2 in Hemphill, Texas and to expand the hours of operation at the Toledo Bend Family Medicine Clinic from 24 hours per week to 40 hours per week. We also plan on recruiting two additional doctors to the community.

Project Goals:

The goal has been set to expand the capacity of primary care to better accommodate the needs of the patient population and community in the county. Through the establishment of an additional RHC and additional primary care provider recruitment, we will be able to more effectively provide urgent care, routine care and preventive care to the community, particularly those in the area who may be more financially and resource-challenged and cannot travel to larger cities for healthcare needs.

Anticipated Challenges:

The direst current challenge existing in the county is that the current community is served by only two MD's. Both of those MD's have well-established practices, but are senior physicians over the age of 70 years. With physician recruitment being a challenge in a small rural community, the last search took over 1 year before placement was achieved. Physician recruitment costs to underserved rural areas are frequently much higher than in urban areas and can run upwards of $250,000 when factoring in recruitment expenses such as agency fees, site visits, advertising and including signing bonuses and relocation costs (Modern Healthcare source). The community does not have the urban amenities or available housing that is attractive to younger physicians and their families for lifestyle choices. Many patients utilize the ED for non-emergent medical care as they do not wish to wait lengthy time periods for clinic appointments. Patient satisfaction in the existing clinic indicates frustration by patients in trying to receive timely appointment times since current employed providers also provide ED staffing and are spread thin. A new clinic with expanded hours coupled with new providers will enable us to provide expanded primary care for all age ranges and economic circumstances.

5-Year Expected Outcomes Over the 5 year period of this plan the expected outcomes will be to establish a second rural health clinic, recruit two new primary care provider MD's in the community and expand hours on the newly established second clinic from 24 to at least 40 hours per week. Through the establishment of the new rural health clinic and the addition of 2 more primary care physicians, over 20,000 patient healthcare visits can be rendered in a more appropriate setting after the baseline is established in the first DY year through the course of this project. With additional sources of primary care in the county, it is anticipated that persons will decrease utilization of the ED for urgent care needs and more preventative healthcare can be expanded to minimize reoccurrences of chronic care conditions such as diabetes.

Regional Goals

Starting Point/Baseline: The second clinic, Toledo Bend Family Medicine, has been established but has not yet been deemed a rural health clinic as of 10/1/2012. The clinic hours began at 4

hours per week and are now at 24 per week. Approximately 10 patients per day are now being seen without any advertisement during the period before a Medicare or Medicaid provider number has been issued. Currently one mid-level provider sees patients at the clinic 3 days per week with 1 MD as Medical Director who is only at the clinic once every 10 days. At this current rate, it would equate to a baseline for patient visits of 1,560 per year.

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. Identified as one of the goals in the community needs assessment of the RHP 2 was to expand health care access and capacity for the region. 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 cares system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services. Medicaid and indigent care patients will receive a greater level of care through utilization of clinic resources for primary care, urgent care and preventative healthcare rather than seeking medical services through the ED as is currently being exhibited.

- Project Option: 1.1.2 Expand existing primary care capacity
- Project Components: (b) Expand primary care clinic hours (c) Expand primary care clinic staffing. As noted above we will be expanding hours and increasing staffing, but this project doesn't include an expansion of space, which is the project core component "a." This was excluded because a new clinic space was purchased in January 2012 which provided an additional 4,000 square foot clinic facility complete with 8 exam rooms and 1 procedure room.

Process milestones: P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours. P-X. Establish a baseline in order to me asure improvement over self. I -12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services

Improvement milestones:

This combination of project option, components and milestones was chosen because of a documented community need. In comparing Sabine County in the community needs analysis, with both Texas and U.S. statistics, primary care providers rate per 100,000, the county ranks at 27.6 as compared to Texas with 69.5 and US statistics of 91. A long-range plan for MD succession planning was developed to address the shortage. In RHP Region 2 planning meetings and in the review of our community assessment needs, the lack of primary care was evidenced not only in the rural areas such as Sabine County but also in the more urban areas as well by the majority of the participating providers as evidenced in their projected DSRIP plans.

Unique Community Need Identification Numbers: CN.1, CN.3

Expansion or Enhancement

Related Category 3 Outcome Measure(s):

- Patient Satisfaction IT 6.1 with the focus on the standalone measure of how well patients are getting timely care, appointments, and information has been selected as the Outcome Domain for this project.
- In 2011, per hospital ER admission rates, approximately 72% of all ED visits were for non-emergent reasons due to a lack of primary care providers being able to support increasing demands for clinic appointment visits.
- With the establishment of an additional outpatient rural health clinic and the addition of 2 more primary care doctors, patients will have expanded options for optimal care delivery systems and thus decreases the utilization of the ED for non-emergent purposes. Satisfaction of the new services by established survey means will enable SCH to determine the effectiveness of the services being offered.

  As the lower income population of the community become established with a regular primary care provider and are satisfied with that care model instead of utilizing the ED, more continuous care and monitoring of their chronic health needs will result in lower ED utilization and hospital admissions and reduce mortality.

Relationship to other Projects:

This project's focus on expanding primary care capacity and emphasis on receiving the right care in the right setting ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 121805903.1.3, 284333601.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Criteria	Narrative	Score (1-5)
Achieves Waiver Goals Scale: 1 to 5 1=Minimal impact on waiver goals 5=Greatest impact on all waiver goals	This project will achieve the following waiver goals: • Triple Aim: assuring patients receive high-quality and patient-centered care, in the most cost effective ways by reducing the utilization of the ED for non-emergent care. • Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties • Further develop and maintain a coordinated care delivery system • Improve outcomes while containing cost growth by providing primary care services in a less costly setting such as the rural health clinic instead of the ED.	**5**
Addresses Community Need(s) Scale: 1 to 5	Relative to your other proposed projects, to what extent does this project address community needs? Needs have been identified in: 1. Shortage of primary care physicians with 50% less than the Texas average and 66% less than the US average per 100,000 population. 2. Sabine Co. has been identified as both a HPSA and an MUA.	**5**

Criteria	Narrative	Score (1-5)
Project Scope/Size Scale: 1 to 5 1=Small numbers/percent of population impacted 5=Large numbers/percent of population impacted	Relative to your other proposed projects, how "big" is this project? Performing Providers should consider targeted improvements/increases in • Patient visits/encounters are estimated to reach at least 4,000 annually with the establishment of the new clinic serving the population 40 hours per week. • With two new providers to be recruited, the impact to provide services can be up to 5,500 persons which are over 50% of the county population. • If the ED volume decreases by 10%, figuring an average ED charge per patient at only $ 500.00- the resulting savings would show a decrease of $ 192,000 annually or potentially $ 960,000 over the course of the DSRIP project.	**5**
Project Investment Scale: 1 to 5 1=Small investment required 5=Large investment required	Relative to your other proposed projects, how large is the expected investment to successfully implement this project and achieve milestones and metrics? Performing Providers should consider: • Human resources: Cost to recruit 2 new primary care providers (figuring salary, recruitment fees, moving expenses, signing bonuses) is estimated at $640,000. • Equipment purchase and maintenance: $20,000 for additional computer equipment and license fees on the EMR for 2 more providers • Legal and professional fees : Minimal • Time to implement: It may take up to a year per provider for recruitment and an additional 2-3 months for start-up. • Risk assessment: Having 2 providers over the age of 70 currently is posing a HUGE risk for the community's healthcare services.	**5**

261955689.1.1	1.1.2	1.1.2.B, C.	Expand Primary Care Capacity
Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital		261955689	
Related Category 3	261955689.3.1	OD-6, IT-6.1(1)	Percent improvement over baseline of patient satisfaction scores
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-4. Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1 P-4.1. Increased number of hours at primary care clinic over baseline. Baseline/Goal: 24 hours per week Data Source: Clinic schedule Milestone 1 Estimated Incentive Payment: $580,497.50 **Milestone 2** P-X. Establish a baseline in order to measure improvement over self. Metric 1 P-X.1. Compilation of baseline data from DY 1. Baseline/Goal: Establish baseline for capacity. October 2012 level of operations are at 1,560 patient visits per year annualized. Data Source: EHR reports	**Milestone 3**I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Documentation of increased number of visits in DY 2 over base period. Goal: Increase in clinic visits over base period by 10%. Data Source: EHR reports Metric 2 I-12.2. Documentation of increased number of unique patients encountered in the clinic in DY 2 over base period. Goal: Increase in clinic unique patient encounters over base period by 5%. Data Source: EHR reports indicating the total number of unique patient encounters in DY 2 and DY 1. Milestone 3 Estimated Incentive Payment: 1,268,679	**Milestone 3** P-4. Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1 P-4.1. Increased number of hours at primary care clinic over baseline. Baseline/Goal: Increased number of hours at primary care clinic over baseline by 20%. Data Source: Clinic schedule Milestone 3 Estimated Incentive Payment: $1,267,353	**Milestone 4** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Documentation of increased number of visits in DY 2 over base period. Goal: Increase in clinic visits over previous year by 15%. Data Source: EHR reports Metric 2 I-12.2. Documentation of increased number of unique patients encountered in the clinic in DY 2 over base period. Goal: Increase in clinic unique patient encounters over base period by 10%. Data Source: EHR reports indicating the total number of unique patient encounters in DY 2 and DY 1. Milestone 4 Estimated Incentive Payment: $1,053,139

261955689.1.1	1.1.2	1.1.2.B, C.	Expand Primary Care Capacity
Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital		261955689	
Related Category 3	**261955689.3.1**	**OD-6, IT-6.1(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)**
indicating the number of clinic visits and unique patients, annualized. Milestone 2 Estimated Incentive Payment: $580,497.50			
Year 2 Estimated Milestone Bundle Amount: $1,160,995	Year3 Estimated Milestone Bundle Amount: $1,268,679	Year 4 Estimated Milestone Bundle Amount: $1,267,353	Year 5 Estimated Milestone Bundle Amount: $1,053,139
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,750,166			

PROJECT OPTION: 1.9.3 Expand Specialty Care Capacity
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.1.1

PERFORMING PROVIDER/TPI: Spindletop Center/096166602

Project Title: Specialty Psychiatric Clinic

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop Center will open a psychiatric specialty clinic to increase the availability of affordable treatment for psychiatric diagnoses such as anxiety, depressive, adjustment, obsessive compulsive and post-traumatic stress disorders. This clinic will provide mental health care for diagnoses other than the "priority population" that Spindletop currently serves: i.e., people with schizophrenia, bipolar disorder, and severe depression.

Need for project: The Region 2 Community Needs Assessment has identified the need for expanded mental health care in our area. Because of Spindletop's existing funding limitations, we cannot extend our behavioral health care to include clients who may not have the diagnoses we are funded to serve: schizophrenia, bipolar disorder, and severe depression. Hundreds of citizens with other mental health issues are currently untreated because they do not have the financial resources to afford mental health care; these people often end up in ED's or the criminal justice system due to this lack of care.

Target: This project is targeted to uninsured or indigent adults in our 4-county area who have psychiatric disorders other than schizophrenia, bipolar disorder, and severe depression. In the prior 12 months, approximately 1,000 people were assessed by Spindletop's intake process as being ineligible for our services because they did not meet the "priority population" criteria; however, about 90% of these had mental health diagnoses that could be served in the proposed psychiatric specialty clinic. Spindletop's current mental health adult client base is 54% Medicaid with most of the remainder being indigent. Therefore, it is likely that almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome by the end of demonstration year 5 is to increase the days of operation for the psychiatric specialty clinic to 4 days per week, expanding the availability of appointments for mental health care in our region.

For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including equipping the facility, hiring personnel, and integrating existing systems. In demonstration years 3-5, the improvement milestones will be increasing the number of specialty psychiatric clinic available appointments, beginning with 2 days of appointments a week in DY3 and increasing to 4 days a week in DY5. This would be approximately 1000 additional psychiatric appointments in DY3, 1650 appointments in DY4, and 2000 appointments in DY5. The number of patients served would depend on the severity of the mental health diagnoses and the frequency of visits for each patient; however, an average number of patients seen in a year could be about 184 for DY3, 276 for DY4, and 368 for DY5.

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded behavioral health care for an underserved population, measuring the availability and timeliness of behavioral health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access care that will lead to improved behavioral health. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

PROJECT DESCRIPTION:

Goal: The goal of this project is to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services.

Description: To increase the availability of affordable treatment for psychiatric diagnoses such as anxiety, depressive, adjustment, obsessive compulsive and post-traumatic stress disorders, Spindletop Center will open a psychiatric specialty clinic. This clinic for other diagnoses will provide hundreds of citizens in Jefferson, Orange, Hardin, and Chambers counties with mental health care which was previously unavailable and may reduce hospital ED visits or hospitalizations.

Challenges: As noted in the Community Needs Assessment for Region 2, access to affordable mental health care is a problem in our area. Spindletop Center's funding is limited to providing services for primarily indigent or Medicaid-eligible clients who have the most severe behavioral health diagnoses, including schizophrenia, bipolar disorder, and major depression. Because of this funding limitation, uninsured or indigent people outside this targeted population who have other psychiatric needs may not be able to obtain care. Funds from the 1115 Waiver will allow Spindletop to provide services to this targeted population.

Outcomes: The expected outcome by the end of demonstration year 5 is to increase the days of operation for the psychiatric specialty clinic to 4 days per week, expanding the availability of appointments for mental health care in our region.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

Spindletop Center currently provides mental health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression. We have identified a community need for affordable care for other behavioral health diagnoses, such as anxiety, depressive, adjustment, obsessive compulsive and post-traumatic stress disorders. Since this is a new project, we do not have a baseline.

Intake and assessments, scheduling, billing, electronic health records systems, community supports, training, and other functions for mental health treatment are already in place for the clients we currently treat. Some existing staff could be utilized to support this specialty clinic.

RATIONALE:

The Region 2 Community Needs Assessment has identified the need for expanded mental health care in our area. Because of our existing funding limitations, we cannot expand our behavioral health care to include clients who may not have the diagnoses we are funded to serve. DSRIP funding would allow us to serve a broader range of clients in our community.

The specialty psychiatric clinic proposed in this plan relates to community needs CN.1, CN.2, CN.4, and CN.5.

This project represents an expansion of Spindletop's services to a new client base. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Selecting a location for the specialty clinic either in existing facilities or in another location. If in another location, leasing space.
- Equipping offices for client visits.
- Hiring/training additional staff as needed.
- Referring clients to the specialty clinic through Spindletop's intake/assessment department.
- Providing appropriate community supports for specialty clinic clients.
- Monitoring results of the clinic regularly to track the effectiveness of the program.

For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including equipping the facility, hiring personnel, and integrating existing systems. In demonstration years 3-5, the improvement milestones will be increasing the number of specialty psychiatric clinic available appointments, beginning with 2 days of appointments a week (approximately 1000 appointments annually) in DY3 (1650 appointments annually) and increasing to 4 days a week (2000 appointments annually) in DY5.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded behavioral health care for an underserved population, measuring the availability and timeliness of behavioral health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access care that will lead to improved behavioral health. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

RELATIONSHIP TO OTHER PROJECTS AND MEASURES:

This project relates to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to this program. The project to integrate primary care with behavioral health #096166602.2.1 could also benefit clients of the specialty psychiatric clinic. This project's focus on increasing access to psychiatric treatment through clinic expansion and emphasis on reducing ED visits and hospitalizations ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS AND MEASURES:

This project focuses on the improvement of access to affordable psychiatric specialty care by opening a clinic. There are no other related Category 1 similar projects in our RHP. **PROJECT VALUATION:**

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits.

Another valuation factor used for this project is the monetary value for a behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.1.1	1.9.3	1.9.3	Specialty Psychiatric Clinic	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Complete the plan for equipping a specialty clinic, hiring personnel, and integrating existing systems Metric 1 P-X.1: Goal: Project plans based on evidence/experience and which address the project goals Data Source: Project documentation Milestone 1 Estimated Incentive Payment *:* $448,491	**Milestone 2** I-X: Expand specialty psychiatric clinic available appointments Metric 1 [I-X.1]: Baseline/Goal: Increase days of operation for Psychiatric Specialty Outpatient Clinic to 2 days per week, or approximately 1000 patient appointments. Data Source: Scheduling records Milestone 2 Estimated Incentive Payment: $492,496		**Milestone 3** I-X: Expand specialty psychiatric clinic available appointments Metric 1 [I-X.1]: Baseline/Goal: Increase days of operation for Psychiatric Specialty Outpatient Clinic to 3 days per week, or approximately 1650 patient appointments. Data Source: Scheduling records Milestone 3 Estimated Incentive Payment: $526,839	**Milestone 4** I-X: Expand specialty psychiatric clinic available appointments Metric 1 [I-X.1]: Baseline/Goal: Increase days of operation for Psychiatric Specialty Outpatient Clinic to 4 days per week, or approximately 2000 patient appointments. Data Source: Scheduling records Milestone 4 Estimated Incentive Payment: $509,048
Year 2 Estimated Milestone Bundle Amount: $448,491	Year 3 Estimated Milestone Bundle Amount: $492,496		Year 4 Estimated Milestone Bundle Amount: $526,839	Year 5 Estimated Milestone Bundle Amount: $509,048
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,976,874				

PROJECT OPTION: : 1.13.2 Development of behavioral health crisis stabilization services as alternatives to hospitalization

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.1.6 Pass 3b

PERFORMING PROVIDER/TPI: Spindletop Center/096166602

Project Title: Extended Crisis Stabilization Program

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop will develop a longer-term crisis intervention and stabilization service capability to improve access to behavioral health care in the most appropriate, cost-effective setting. This includes identifying available beds for patients requiring behavioral health treatment longer than the typical 3-7 days, developing an assessment protocol to determine appropriate candidates for longer term treatment based on prior inpatient admissions, high risk factors, and history of prior non-compliance with treatment, and developing a specialized treatment protocol for extended crisis stabilization.

Need for project: A high percentage of behavioral health clients who are in crisis need longer than the typical 3-7 day stay in an inpatient setting in order to stabilize and prevent "revolving door" hospital and ED admissions. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-base crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays.

There are currently no long-term options for people in behavioral health crisis in Region 2; they are released after a short inpatient stay and frequently decompensate, getting picked up by law enforcement and taken to jail or back to the ED for further intervention. The State Hospital system is currently accepting primarily clients that come from the court system and are on a forensic commitment, resulting in fewer long-term beds available at the State level.

Target: This project program is targeted primarily to the 2200 adult mental health clients that Spindletop serves. 54% of these clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome by the end of demonstration year 5 is to provide extended crisis stabilization services for 60 patients per year to reduce hospital recidivism, ED visits, and incarceration for this target population.

- For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including developing the assessment and treatment protocols, hiring staff as needed, and identifying referral sources and community services. In demonstration years 3-5, the improvement milestones will be the number of clients served in the extended crisis stabilization program, beginning with 30 in year 3 and increasing to 50 in year 4 and 60 in year 5.
- Spindletop has selected improvement outcome measure OD-9, Right Care, Right Setting, option IT-9.2, ED appropriate utilization, reduce Emergency Department visits for Behavioral Health because the ultimate outcome of this project is to treat behavioral health crises clients in a more appropriate setting than more costly Emergency Departments and to reduce hospital recidivism.

PROJECT DESCRIPTION:

Goal: The goal of this project is to develop a longer-term crisis intervention and stabilization service capability to improve access to behavioral health care in the most appropriate, cost-effective setting. A high percentage of behavioral health clients who are in crisis need longer than the typical 3-7 day stay in an inpatient setting in order to stabilize and prevent "revolving door" hospital and ED admissions. A longer-term behavioral health crisis stabilization service will reduce hospital recidivism, inappropriate ED admissions, and jail incarceration.

Challenges: Because of our existing funding limitations, we cannot extend crisis services beyond short-term stays for our behavioral health clients, resulting in more frequent ED visits, hospital stays, or incarcerations. With 1115 Waiver funds, the period that behavioral health crisis clients can receive services will be extended to improve outcomes and reduce the likelihood of clients returning to the hospital or being incarcerated.

Outcomes: The expected outcome by the end of demonstration year 5 is to provide extended crisis stabilization services for 60 patients per year to reduce hospital recidivism, ED visits, and incarceration for this target population.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

BAPTIST Hospital currently provides short-term (typically 3-7 days) inpatient services for behavioral health clients. Spindletop Center has behavioral health crisis teams that can identify clients who will require extended crisis stabilization and whose needs are not being addressed by any existing community resources.

During DY3, we will establish a baseline for improvement in subsequent years.

RATIONALE:

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-base crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.

As noted in the Community Needs Assessment for Region 2, access to affordable mental health care is a problem in our area. Due to a lack of funding, there are currently no long-term options for people in behavioral health crisis in Region 2; they are currently released after a short inpatient stay and frequently decompensate, getting picked up by law enforcement and taken to jail or back to the ED for further intervention. The State Hospital system is currently accepting primarily clients that come from the court system and are on a forensic commitment, resulting in fewer long-term beds available at the State level.

The extended crisis stabilization project proposed in this plan relates to community needs CN.1, CN.2, CN.5, CN.6, CN.10, and CN.11.

This project represents an expansion of Baptist Hospital and Spindletop's short-term inpatient crisis services. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Identifying available beds for patients requiring behavioral health treatment longer than the typical 3-7 days in order to achieve crisis stabilization, create greater treatment compliance, and prevent future recidivism.
- Developing an assessment protocol to determine appropriate candidates for longer term treatment based on prior inpatient admissions, high risk factors, and history of prior non-compliance with treatment.
- Developing a specialized treatment protocol for extended crisis stabilization.
- Establishing a continuity of care system with local agencies and resources.
- Hiring/training additional staff as needed.
- .

- The quality improvement component of the project will consist of initially identifying the number of mental health hospital bed-days and ED admissions for the prior 12 months, especially for frequent users of mental health hospital services who would benefit from extended crisis stabilization. The bed-days and ED admissions for those mental health clients who participate in the extended crisis program will be measured at six-month intervals to determine if the treatment is effective in reducing hospitalizations and ED admissions. If needed, the treatment program will be adapted to improve results

For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including developing the assessment and treatment protocols, hiring staff as needed, and identifying referral sources and community services.

In demonstration years 3-5, the improvement milestones will be the number of clients served in the extended crisis stabilization program, beginning with 30 in year 3 and increasing to 50 in year 4 and 60 in year 5.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Spindletop has selected improvement outcome measure OD-9, Right Care, Right Setting, option IT-9.2, ED appropriate utilization, reduce Emergency Department visits for Behavioral Health because the ultimate outcome of this project is to treat behavioral health crises clients in a more appropriate setting than more costly Emergency Departments and to reduce hospital recidivism.

RELATIONSHIP TO OTHER PROJECTS AND MEASURES:

This project is closely related to Spindletop's Inpatient Detox Services project 096166602.1.7 since some behavioral health crisis patients may have co-occurring substance abuse issues, and establishing a Detox unit will make more psychiatric hospital capacity available for the Extended Crisis Stabilization program. It also relates to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to this program. This project's focus on long term crisis stabilization and intervention service capacity and emphasis on behavioral health in the right setting ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS AND MEASURES:

This project focuses on the development of a longer-term crisis intervention and stablization service capability to improve access to behavioral health care. There are no other related Category 1 similar projects in our RHP. This project focuses on the development of a longer-

term crisis intervention and stablization service capability to improve access to behavioral health care. There are no other related Category 1 similar projects in our RHP.

PROJECT VALUATION:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits.

Another valuation factor used for this project is the monetary value for a behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.1.6	1.13.2	1.13.2	Extended Crisis Stabilization	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	096166602.3.15	IT-9.2	ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Complete the plan for providing extended crisis stabilization services, developing protocols, and hiring personnel as needed Metric 1 P-X.1: Completed project plan, protocols, personnel hired Goal: Project plan completed Data Source: Project documentation Milestone 1 Estimated Incentive Payment : $700,454	**Milestone 2** I-X: Provide extended crisis services Metric 1 [I-X.1]: Number of clients receiving extended crisis services Baseline/Goal: 30 clients receiving extended crisis services Data Source: Hospital admissions records Milestone 2 Estimated Incentive Payment: $769,182		**Milestone 3** I-X: Provide extended crisis services Metric 1 [I-X.1]: Number of clients receiving extended crisis services Baseline/Goal: 50 clients receiving extended crisis services Data Source: Hospital admissions records Milestone 3 Estimated Incentive Payment: $822,819	**Milestone 4** I-X: Provide extended crisis services Metric 1 [I-X.1]: Number of clients receiving extended crisis services Baseline/Goal: 60 clients receiving extended crisis services Data Source: Hospital admissions records Milestone 4 Estimated Incentive Payment: $795,032
Year 2 Estimated Milestone Bundle Amount: $700,454	Year 3 Estimated Milestone Bundle Amount: $769,182		Year 4 Estimated Milestone Bundle Amount: $822,819	Year 5 Estimated Milestone Bundle Amount: $795,032
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,087,487				

PROJECT OPTION: : 1.12.4 Implement an evidence-based project to provide an intervention to enhance service availability of appropriate levels of behavioral health care in an innovative manner.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.1.3

PERFORMING PROVIDER/TPI: Spindletop Center/096166602

Project Area: 1.12. Enhance service availability of appropriate levels of behavioral health care
Project Title: Youth Respite/Residential Treatment

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop will provide early intervention and intensive wraparound services and supports for youth ages 10-17 in Jefferson, Orange, Hardin, and Chambers counties with behavioral health issues by opening a 16-bed short-term respite/residential treatment facility for this targeted population to reduce unnecessary use of more expensive hospital treatment, state institutions, or criminal justice incarceration. In the Spindletop facility, youth will receive counseling and individual and group skills training, including training related to substance abuse problems, peer and family relations, anger management, and other psychological and psychosocial relationships.

Need for project: Since there is not currently a youth respite facility in our area, this population is either underserved in our community or over-served in state hospitals or institutions. Youth are often sent to a long-term facility out of the area or to a local hospital for a short-term stay, or they may end up in the criminal justice system. Any of these options are very costly. When youth are sent to facilities that are distant from their families, counseling for the whole family is more difficult. As a result, youth are frequently kept in the institutions longer than they would be if local programs were available. Untreated youth continue to struggle in a volatile home situation contributing to runaway behavior and/or family frustration and unsuccessful attempts at self-help

Target: This respite program is targeted primarily to youth ages 10-17 in the more than 600 child and adolescent mental health clients that Spindletop serves. 88% of these clients are on

Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome by the end of demonstration year 5 is to provide respite for 50 youth per year with appropriate counseling and skills training with the goal of reducing hospitalizations, recidivism, placement outside the community, and incarceration; lowering drug use; increasing completion of school; and increasing the ability of the youth to stay in the home without incident.

For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including equipping the facility, contracting with the facility manager, hiring any additional staff needed, developing the training curriculum, and identifying referral sources and community services. In demonstration years 3-5, the improvement milestones will be the number of youth served in the program, beginning with 35in year 3 and increasing to 40 inyears 4-5. Since the residential facility can only accommodate 16 youth at a time, the growth will be limited.

Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.1 for this project. The measure will be the decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population.

Project Description:

Goal: The goal of this project is to expand community-based behavioral health service options for youth aged 10-17 in Jefferson, Orange, Hardin, and Chambers counties.

Description: To achieve this goal, Spindletop will expand its capacity to provide early intervention and intensive wraparound services and supports for youth ages 10-17 in Jefferson, Orange, Hardin, and Chambers counties with behavioral health issues by opening a 16-bed short-term respite/residential treatment facility for this targeted population to reduce unnecessary use of more expensive hospital treatment, state institutions, or criminal justice incarceration.

In the Spindletop facility, youth will receive counseling and individual and group skills training, including training related to substance abuse problems, peer and family relations, anger management, and other psychological and psychosocial relationships. Providing respite closer to the home offers the advantage of engaging family members in family counseling and parent training, as well as assistance with school-related, legal, and social issues. The emphasis of the program will be on assisting youth to stay out of costly hospitals, state institutions, jail, or youth detention centers, to reduce incidents of abuse and neglect, and to utilize case management services and referrals with community partners to develop long-term solutions to the youth's current problems.

Challenges: Lack of funding has prevented Spindletop from providing a youth respite/residential treatment program. Funds from the 1115 Waiver will allow us to meet this challenge.

Other challenges include poor relationship skills within the family of youth with behavioral health problems as well as the ability of the families to overcome resistance to change and embrace the concepts proposed by the staff within the respite program. The youth may have critical legal issues, school-related problems, and drug and alcohol problems which will need to be identified and resolved in order for the youth to move through the system successfully. Developing the training programs and community referrals and networks described in this project will help overcome these challenges.

Outcomes: The expected outcome by the end of DY5 is to provide a respite facility where 50 youth per year with behavioral health issues can receive appropriate counseling and skills training with the goal of reducing hospitalizations, recidivism, placement outside the community, and incarceration; lowering drug use; increasing completion of school; and increasing the ability of the youth to stay in the home without incident.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop currently provides outpatient behavioral health services for children and adolescents. We have identified a need for respite/short-term residential treatment for some of our clients. Since this is a new service, we do not have a baseline of clients currently served.

Spindletop has an existing facility that is easily adaptable for youth respite care. We currently contract with the Wood Group to manage our adult respite facility and could contract with them for youth respite also. We have an experienced administrator/Licensed Professional Counselor that can organize and manage the facility clinical operations.

Rationale:

Since there is currently not a youth respite facility in our area, this population is either underserved in our community or over-served in state hospitals or institutions. Youth are often sent to a long-term facility out of the area or to a local hospital for a short-term stay, or they may end up in the criminal justice system. Any of these options are very costly. When youth are sent to facilities that are distant from their families, counseling for the whole family is more difficult. As a result, youth are frequently kept in the institutions longer than they would be if local programs were available. Untreated youth continue to struggle in a volatile home situation contributing to runaway behavior and/or family frustration and unsuccessful attempts at self-help.

The youth respite/residential treatment program proposed in this plan relates to community needs CN.5, CN.6 and CN.10.

This new respite/residential treatment project addresses these needs by supplementing the outpatient services Spindletop currently provides. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- An existing Spindletop building will be equipped to house 16 youth residents.
- A contract with the Wood Group will be executed to manage the facility.
- Additional staff will be hired and/or contracted to operate the facility as needed.
- A training curriculum targeted to have the greatest impact on youth will be developed. A curriculum specific to the needs of parents/legally authorized representatives, and youth identified to have behavioral health problems will be developed, including case managements services, education, and referrals to outside services if required.
- Youth who might benefit from this respite program will be identified and assessed in Spindletop's child and adolescent behavioral health program.
- Referral sources and a network of services within the community will be identified, including those that address school requirements and related transportation issues.
- For ongoing quality improvement, results of the program will be measured in six-month intervals to track the effectiveness of the program in meeting the goals of the project. Adjustments to the programs will be made as needed.

For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including equipping the facility, contracting with the facility manager, hiring any additional staff needed, developing the training curriculum, and identifying referral sources and community services.

In demonstration years 3-5, the improvement milestones will be the number of youth served in the program, beginning with 30 in year 3 and increasing to 35 in year 4, and 40 in year 5 . These are new, unduplicated numbers of youth served each year in the facility. Since the residential facility can only accommodate 16 youth at a time, the growth will be limited.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.1 for this project. The measure will be the decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population. Data will be collected on these to establish a baseline in DY2 with targets established for subsequent years. Providing youth respite services in an appropriate local setting is not only more beneficial for clients, it also will reduce overall costs of health care and criminal justice.

Relationship to Other Projects and Measures:

This project relates to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to the youth program. The project to integrate primary care with behavioral health #096166602.2.1 could also benefit youth who are in the respite/residential treatment program. This project's focus on establishing a wellness clinic and emphasis on the behavioral and physical health of youth ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1,

136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on the establishment of a wellness clinic that would provide a transition provider accepting of Medicaid/CHIP and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning. There are no other related Category 1 similar projects in our RHP.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration. Another valuation factor used for this project is the monetary value for a behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.*1.3*	*1.12*	*1.12.4*	**Youth Respite/Residential Treatment**
Spindletop Center			*096166602*
Related Category 3 Outcome Measure(s):	*096166602.3.3*	*OD-9 IT-9.1*	*Right Care, Right Setting- Decrease in mental health admissions and readmissions to criminal justice settings*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Design plan for community-based behavioral health service option--respite care for youth ages 10-17) Metric 1 P-X.1: Goal: Project plans based on evidence/experience and which address the project goals Data Source: Project documentation Milestone 1 Estimated Incentive Payment *:* $488,717	**Milestone 2** I-X: Youth served in respite facility Metric 1 [I-X.1]: Baseline/Goal: 30 youth served during year Data Source: Respite admission records Milestone 2 Estimated Incentive Payment: $536,669	**Milestone 3** I-X: Youth served in respite facility Metric 1 [I-X.1]: Baseline/Goal: 35 new youth served during year Data Source: Respite admission records Milestone 3 Estimated Incentive Payment: $574,092	**Milestone 4** I-X: Youth served in respite facility Metric 1 [I-X.1]: Baseline/Goal: 40 new youth served during year Data Source: Respite admission records Milestone 4 Estimated Incentive Payment: $554,705
Year 2 Estimated Milestone Bundle Amount: $488,717	Year 3 Estimated Milestone Bundle Amount: $536,669	Year 4 Estimated Milestone Bundle Amount: $574,092	Year 5 Estimated Milestone Bundle Amount: $554,705
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,154,183			

PROJECT OPTION: : 1.12.4 Implement an evidence-based project to provide an intervention to enhance service availability of appropriate levels of behavioral health care in an innovative manner.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.1.7 Pass 3b

PERFORMING PROVIDER/TPI: Spindletop Center/096166602

DSRIP Category/Project Area: 1.12 Enhance service availability of appropriate levels of behavioral health care

Project Option: Project Title: Inpatient Detox Services

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop will work with Baptist Hospital of Beaumont to equip a 10-bed unit within the Behavioral Health Hospital for the express purpose of providing medical detox services for residents of southeast Texas. A separate detox program including protocols for various addictive substances and continuity of care systems for long-term addiction treatment will be developed.

Need for project: The Region 2 Community Needs Assessment notes that there are very limited drug and alcohol treatment services in our 4-county area yet our region has a high percentage of uninsured patients with addiction issues. Due to a lack of funding, there is currently no designated facility in our area for providing detox services and no organized coordination of care for people with addictions.

Target: This project program is targeted primarily to the adult population with substance abuse addiction in the counties we serve. For Spindletop's substance abuse clients, 15% are on Medicaid, with most of the remainder being indigent. Based on that data, it is likely that almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome by the end of DY5 is to provide detox services for 300 patients per year to assist them with overcoming addictions and to reduce hospital recidivism, ED visits, and incarceration for this target population.

- For demonstration year 2, the process milestone is to design the community-based specialized intervention for target population, including developing a project plan,

engaging an architect and contractor to remodel existing space, and obtaining state approval as needed. In year 3, the design phase will be continued, including completion of the remodel, obtaining equipment, developing treatment protocols, hiring/training staff, and identifying referral sources and a network of services for patients completing the detox program. In demonstration years 4-5, the improvement milestones will be the number of patients served in the program, beginning with 250 in year 4 and increasing to 300 in year 5.

- For demonstration years 4-5, Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.2 for this project. The measure will be the reduction in Emergency Department visits for Substance Abuse as evidenced by an increase in referrals of patients to the Detox unit instead of having treatment in the ED.

Project Description:

Goal: The goal of this project is to expand community-based behavioral health service options for adults with substance abuse addictions in Jefferson, Orange, Hardin, and Chambers counties. Since there is a significant gap in the care and coordination of people needing detoxification ("detox") from both legal and illegal substances in the 4-county area of southeast Texas, this project will provide an intervention for this targeted population by implementing a specialty inpatient detox program.

Description: To achieve this goal, we will equip a 10-bed unit within the Behavioral Health Hospital at Baptist Hospital of Beaumont for the express purpose of providing medical detox services for residents of southeast Texas. A separate detox program including protocols for various addictive substances and continuity of care systems for long-term addiction treatment will be developed. Spindletop Center will work closely with Baptist Hospital to coordinate outpatient substance abuse care for patients who receive these detox services, increasing the number of referrals to less expensive outpatient addiction programs.

Challenges: The primary challenge for providing inpatient detox services in our area is a lack of funding. The 1115 Waiver funds will pay for detox services that will address this unmet need in our community. Many residential programs do not accept patients who are currently intoxicated, but a large percentage of these patients cannot stop using substances without close medical supervision. This project will provide that supervision.

Outcomes: The expected outcome by the end of demonstration year 5 is to provide a facility for detox services for 300 patients per year to assist them with overcoming addictions and to reduce hospital recidivism, ED visits, and incarceration for this target population.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

The Baptist Behavioral Health Hospital provides inpatient psychiatric care for behavioral health patients, but it does not have a detox program. We have identified space in the Hospital that could be adapted for a detox facility. With supplemental staff, the detox program could be coordinated with this existing care for those patients who have both substance abuse addictions and behavioral health issues.

Spindletop currently provides outpatient substance abuse services, including individual and group counseling and community services. Patients served by the detox program could utilize these services.

Since this detox program is a new service, we do not have a baseline of patients currently served; this will be established in DY3.

Rationale:

The Region 2 Community Needs Assessment notes that there are very limited drug and alcohol treatment services in our 4-county area yet our region has a high percentage of uninsured patients with addiction issues. Due to a lack of funding, there is currently no designated facility in our area for providing detox services and no organized coordination of care for people with addictions, making this project a new initiative for Spindletop Center. In addition, addiction and detox issues must be dealt with prior to treating the frequently seen concurrent behavioral health issues. The State has focused enforcement activities to shut down fraudulently operating "pain clinics," resulting in many people who are addicted and have no source of obtaining their medications, yet need medical assistance to cope with life-threatening withdrawal symptoms. These patients are typically high utilizers of emergency rooms and often are not eligible to enter any addiction treatment program until medically detoxed. Providing inpatient detox services will improve the health of the community and reduce health care costs in our region.

The inpatient detox services proposed in this plan relate to community needs CN.5, CN.6, CN.10, CN.11, CN.16, and CN.17.

No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- A 10-bed unit within the Behavioral Health Hospital at Baptist Hospital of Beaumont will be equipped for the express purpose of providing medical detox services for residents of southeast Texas. This includes a remodel of existing hospital space and purchasing of appropriate equipment and furnishings.
- Medical detox protocols for various addictive substances will be developed.
- Detox specialty staff will be hired and trained.
- Continuity of care systems for long-term addiction treatment will be designed. This will involve coordination with SETMA, the local substance abuse network authority and programs at Spindletop.
- Referral sources and a network of services within the community will be identified.

- As a quality improvement, results will be measured in six-month intervals to track the effectiveness of the program in reducing hospital recidivism and ED utilization by the patients who have participated in the detox program. Adjustments to treatment plans and/or other improvements to the program will be made as needed.

For demonstration year 2, the process milestone is to design the community-based specialized intervention for target population, including developing a project plan, engaging an architect and contractor to remodel existing space, and obtaining state approval as needed. In year 3, the design phase will be continued, including completion of the remodel, obtaining equipment, developing treatment protocols, hiring/training staff, and identifying referral sources and a network of services for patients completing the detox program.

In demonstration years 4-5, the improvement milestones will be the number of patients served in the program, beginning with 250 in year 4 and increasing to 300 in year 5. Substance abuse patients will be treated in an appropriate detoxification program instead of in ED's or regular hospitalizations.

Related Category 3 Outcome Measure:

For demonstration years 4-5, Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.2 for this project. The measure will be the reduction in Emergency Department visits for Substance Abuse patients.

The process milestone selected for demonstration year 2 is P-1 to engage SETMA, the local substance abuse network authority, in developing a community network for patients after detox services are completed. For DY3, the process milestone is P-2, establish baseline rates. Data will be accumulated regarding current referrals from ED's for detox and the number of patients who receive detox services in the ED's.

The ultimate outcome of this project is to provide detox services in an appropriate setting and to develop continuity of care that will encourage patients to adhere to addiction treatment plans. This will reduce overall health care system costs by decreasing ED visits and hospital recidivism. It will also improve the health and quality of life for the patients. Justice system costs may be reduced as well.

Relationship to Other Projects and Measures:

This project is closely related to Spindletop's Extended Crisis Observation #0962166602.1.6 project since some behavioral health crisis patients may have co-occurring substance abuse issues. It also relates to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to this program and to Spindletop's project to expand outpatient substance abuse treatment #096166602.2.8. The project to integrate primary care with behavioral health #096166602.2.1 could also benefit patients who are in the detox program. This project's focus on establishing a wellness clinic and emphasis on the behavioral and physical health of youth ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.6, 135222109.1.3, 135222109.1.10, 135222109.1.11,

096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on the establishment of a wellness clinic that would provide a transition provider accepting of Medicaid/CHIP and complex psychiatric history while promoting physical health further enhancing each youth's complete overall functioning. There are no other related Category 1 similar projects in our RHP.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration. A health economic study that included these factors was also used to value the project.

096166602.1.7	1.12	1.12.4	Inpatient Detox Services	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.4** **096166602.3.16**	**OD-9 IT-9.2**	**Right Care, Right Setting-ED appropriate utilization** **Reduction in Emergency Department visits for Substance Abuse**	
Year 2 **(10/1/2012 – 9/30/2013)**		**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Design community-based behavioral health service option to provide a detox facility, including a project plan, engaging an architect and contractor to remodel existing space, & obtaining state approval as needed Metric 1 P-X-1: Goal: Project plans based on evidence/experience and which address the project goals Data Source: Project documentation Milestone 1 Estimated Incentive Payment *:* $1,701,104		**Milestone 2** P-X: Design community-based behavioral health service option to provide a detox facility, including completion of remodel, obtaining equipment, hiring/training staff, developing treatment protocols, Metric 1 P-X-1: Goal: Project plans based on evidence/experience and which address the project goals Data Source: Project documentation Milestone 2 Estimated Incentive Payment: $1,868,012	**Milestone 3** I-X: Patients served in detox facility Metric 1 [I-X.1]: Baseline/Goal: 250 served during year Data Source: Hospital admission records Milestone 3 Estimated Incentive Payment: $1,998,274	**Milestone 4** I-X: Patients served in detox facility Metric 1 [I-X.1]: Baseline/Goal: 300 served during year Data Source: Hospital admission records Milestone 4 Estimated Incentive Payment: $1,930,793
Year 2 Estimated Milestone Bundle Amount: $1,701,104		Year 3 Estimated Milestone Bundle Amount: $1,868,012	Year 4 Estimated Milestone Bundle Amount: $1,998,274	Year 5 Estimated Milestone Bundle Amount: $1,930,793
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $7,498,183				

PROJECT OPTION: 1.11.3 Implement technology-assisted services to support, coordinate, or deliver behavioral health services

UNIQUE RHP IDENTIFICATION NUMBER: 096166602.1.5-Pass 2

PERFORMING PROVIDER/TPI: Spindletop Center**/**096166602

Project Area: 1.11. Implement technology-assisted services to support, coordinate, or deliver behavioral health services

Project Title: Client Health Information Access Portal

Provider: Spindletop Center is a public entity community center that provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties. Orange, Hardin, Chambers counties and parts of Jefferson count have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

Intervention: Spindletop will develop a web-based portal where secure client-focused health information can be accessed . and will train our mental health clients with only basic computer skills to use the portal. This will support the behavioral health services Spindletop currently delivers by encouraging compliance with medication regimens, making individual healthcare information available to clients, and fostering peer support. Wi-Fi enabled tablets will be purchased by Spindletop and made available for select clients to check out to access their health information.

Need for project: The strategic plan of the U.S. Department of Health and Human Services' (HHS) Office of the National Coordinator for Health Information Technology (ONC) identified patients' participation as a "critical, yet currently underutilized, component in improving health and the overall health care system" and that "the single biggest lever to individual empowerment [over their health care] is access to data[1]." . Healthcare providers are providing systems for electronic distribution of client health information via email or websites, but clients of intensive Medicaid services often have little or no access to the electronic devices that help them find and use healthcare information being provided via the internet. By developing the web-based portal, training clients how to access the information, and making electronic notebooks available for client use, this project would help our clients take charge of their own health and use resources that may have been out of reach to them.

[1] Office of the National Coordinator for Health Information Technology, *The Federal Health IT Strategic Plan 2011-2015,* [Internet]. Washington (DC): Department of Health and Human Services, http://www.healthit.gov/sites/default/files/utility/final-federal-health-it-strategic-plan-0911.pdf

Target: This project program is targeted to the 2900 adult, child, and adolescent behavioral health clients that Spindletop serves. 54% of these adults and 88% of the child and adolescent clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome of this program by the end of demonstration year 5 is to to improve the health care of Spindletop mental health clients and decrease health care costs by improving client access to health care information through the development of the client portal, training 1400 outpatient clients to access the information, and making electronic notebooks available for client use

For demonstration year 2, the process milestone is to hire a project manager, purchase initial hardware/software, and contract with professional vendors to install software and deploy hardware. In DY3, the improvement milestone will be to continue development of the portal, test equipment, create training materials, and develop portal content;

approximately 50 clients will be trained to test the program in DY3. In DY 4, the improvement milestone will be to train 600 additional Spindletop behavioral health outpatient consumers to access the client portal. In DY 5, the improvement milestone will be a reduction in ED visits for the clients who have been trained to use the client portal in DY3-4; the baseline for the ED visits will be established in DY4. This improvement milestone was selected since the goal of the project is to improve the health of the clients and reduce healthcare costs. Spindletop will continue to train additional clients in DY5.

Category 3 outcomes:

The Category 3 outcome measure is IT-6.2, percent improvement over baseline of patient satisfaction scores, patients getting timely health information. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients.

Description:

Goal: The goal of this project is to support client health care, health-related education, public health and health administration by using the internet for clients to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

Description: Spindletop will develop a web-based portal where client-focused health information can be securely housed and easily accessed by users with only basic computer skills. Outpatient clients will be trained on the use of the portal, and Spindletop will purchase electronic notebooks to be available for clients to use the program. The client web portal will be designed to provide immediate access to client-centered information, services, discussion groups, and alerts. Over time the portal will improve as recommendations by the user groups are adopted and the site content grows. Specifically the client portal will offer and improve access to the following:

1. Electronic Access to Client-Centered Information
    a. Healthcare summary (Continuity of Care document) updated regularly
    b. Summary of services and treatment plans
    c. Secured site to update client profile/ healthcare information for providers

    d. Peer-created discussion forums
2. Access to Information and Electronic Communication Tools
    a. Request official medical record
    b. Clients Rights Handbook
    c. Links to additional service providers and resource sites
    d. 800 numbers for information or complaints
    e. Links to Center message boards Like Twitter and Facebook
3. Alerts and Notifications
    a. Link to request email notices
        i. Appointment reminders
        ii. Medication reminders
        iii. Emergency contact
    b. Spindletop holiday schedule or emergency closings
    c. New services and current events
    d. Satisfaction surveys

Challenges: Developing the client access portal will require the expertise of numerous outside vendors and will take up to one year to purchase and install equipment and configure the software. By using industry standard software like MS-SharePoint and contracting with qualified partners and consultants, we will ensure that the platform is developed expeditiously and securely.

Training service providers and clients to use an internet-ready device (tablet pc) to access the client portal will require hands-on instruction in a structured classroom environment. To meet this challenge, one full-time project manager will be hired to provide comprehensive training to staff and clients, act as the liaison between the center's clinical and IT staff, develop and maintain the client portal, and be the site's webmaster.

Outcomes: The expected outcome of this program by the end of demonstration year 5 is to increase client access to health care information through the development of the client portal and training of 1400 outpatient consumers on its use. Engaging clients in their healthcare management should improve their overall health, and system-wide healthcare costs should decrease.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop currently has an external website with information that remains fairly static. We also have a Facebook and Twitter presence, but we do little to publicize this for client use. Although we have experience with SharePoint, this is limited to employee secure information and is not client-directed or accessible. Some staff use tablet pc's but are able to share what

they know on a limited basis. Client email addresses are collected when available, but we do not currently use email to disseminate health information

Rationale:

The Region 2 Community Needs Assessment has identified the need for expanded mental health care in our area and for better coordination of care. The strategic plan of the U.S. Department of Health and Human Services' (HHS) Office of the National Coordinator for Health Information Technology (ONC) identified patients' participation as a "critical, yet currently underutilized, component in improving health and the overall health care system" and that "the single biggest lever to individual empowerment [over their health care] is access to data." Healthcare providers have begun to provide systems for electronic distribution of client health information via email or websites; however, one key factor limiting the success of these programs is that clients of intensive Medicaid services are often those who have little or no access to the devices (laptops, tablets, or smartphones) that help them find and use healthcare information being provided via the internet. The ONC's 2011-2015 strategic plan cites that "only 7 percent of Americans have used a web site access their health information online." As more and more services and health information are available online, this project would help our clients with the computer training that would enable them to take charge of their own health and use resources that may have been out of reach to them.

A study found that patients who received enhanced levels of healthcare support, including telephone, mail, e-mail, and the internet, had 5.3% lower overall medical costs, 12.5% fewer hospital admissions, and 9.9% fewer pressure-sensitive surgeries[2]. Numerous other studies have emphasized the importance of e-health in helping patients actively manage their healthcare. Through the use of a client-centered web portal, healthcare information from Spindletop's EHR can be shared with clients in a secure and timely manner, thus improving care and reducing costs. Moreover, the training and equipment we provide through this project will be utilized to access other providers and resources both online and in the community which creates additional opportunities for improved outcomes and a better integrated healthcare delivery system.

[2] Veroff D, Marr A, Wennberg D, *Enhanced Support For Shared Decision Making Reduced Costs Of Care For Patients With Preference-Sensitive Conditions,* [Internet]. *Health Aff (Millwood).* February 2013 32:2285-293; doi:10.1377/hlthaff.2011.0941

The Client Access Portal project proposed in this plan relates to community needs CN.1, CN.16, and CN.17.

This client health information access portal would be a new service for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Hiring a project manager to coordinate the project, train staff and clients, and be the webmaster

- Developing the project plan
- Contracting with outside consultants for website development and hardware installation
- Purchasing equipment for staff and clients to check out; equipment remains the property of Spindletop and will be tracked and have programmed limitations to ensure appropriate usage.
- Training staff and clients on the use of the new tablets to access the client portal, to setup and use email accounts, and on basic use of the internet.
- For ongoing quality improvement, Spindletop will conduct client satisfaction surveys routinely and publish the results utilizing an industry standard electronic survey tool. Comments will be reviewed and used to improve the quality of site content and client satisfaction.

For demonstration year 2, the process milestone is to hire the project manager, purchase initial hardware and software, and contract with various professional vendors to install and deploy hardware and software for the client access portal. In demonstration year 3, the process milestone will be to continue development of the portal and purchase additional equipment. Once the site is operational, the project manager will organize a pilot group of staff and clients to help test all equipment, create training materials, and develop portal content.

In DY 4, the improvement milestones will be to train 600 of Spindletop's behavioral health outpatient client to access healthcare information on the client portal. In DY 5, the improvement milestone will be a reduction in ED visits for the clients who have been trained to use the client portal in DY3-4; the baseline for the ED visits will be established in DY4. This improvement milestone was selected since the goal of the project is to improve the health of the clients and reduce healthcare costs. Spindletop will continue to train additional clients in DY5.**Related Category 3 Outcome Measure:**

Spindletop has selected improvement outcome measure IT-6.1.1, percent improvement over baseline of patient satisfaction scores, patients getting timely health information. One of the purposes of this project is for clients to have access to their healthcare information and learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment. For DY2, the process milestone is developing the plan; for DY3 the process milestone is establishing the baseline for the satisfaction survey scores.

Relationship to Other Projects and Measures:

This project relates to Spindletop's projects to integrate primary care with behavioral health #096166602.2.1 as physical health information would be available to clients on the web portal; to enhance behavioral health training #096166602.2.3 as providers are trained on using the client portal to support health care; and to utilize peer-to-peer support services #096166602.2.7 as group discussions related to health care are developed. This project's focus on using information technology for behavioral health treatment and emphasis on peer support services ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.6, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, , 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on the expansion and enhancement of telemedicine services in our region for psychitraic, behavioral, and neurological support. The following Category 1 projects in our RHP are related: 136367307.1.2- Introduce, Expand, or Enhance Telemedicine/Telehealth; 112706003.1.1- Introduce, Expand, or Enhance Telemedicine/Telehealth; and 096166602.1.11- Introduce, Expand or Enhance Telemedicine/Telehealth

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

096166602.1.5	1.11.3	1.11.3	Client Health Information Access Portal	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.9**	**OD-6 IT-6.1 (1)**	**Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Hire project manager; contract with consultants; purchase initial equipment Metric 1 P-X.1: Goal: Hire project manager, contract with consultants, purchase initial equipment Data Source: Payroll records, consultant agreements, purchase records Milestone 1 Estimated Incentive Payment *:* $695,893	**Milestone 2** P-X: Develop client portal; purchase additional equipment; and train test group Metric 1 P-X.1: Baseline/Goal: Develop client portal; purchase additional equipment; train test group of 50 clients Data Source: Program documentation, purchase records Milestone 2 Estimated Incentive Payment: $763,171		**Milestone 3** I-X: Train clients on client portal Metric 1 I-X.1: Baseline/Goal: 600 MH outpatient clients receiving training Data Source: Training documentation Milestone 3 Estimated Incentive Payment: $815,812	**Milestone 4** I-X: Reduce ED visits for clients trained on client portal in DY3-4 Metric 1 I-X.1: Baseline/Goal: 5% reduction in ED visits for clients receiving training; baseline to be established in DY4 Data Source: Hospital ED admissions Milestone 4 Estimated Incentive Payment: $788,437
Year 2 Estimated Milestone Bundle Amount: $695,893	Year 3 Estimated Milestone Bundle Amount: $763,171		Year 4 Estimated Milestone Bundle Amount: $815,812	Year 5 Estimated Milestone Bundle Amount: $788,436
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,063,312				

PROJECT OPTION: 1.12.4 Enhance Service Availability of appropriate levels of behavioral health care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136367307.1.1

PERFORMING PROVIDER NAME/TPI: The Burke Center/136367307

Title of Project: Enhance Service Availability of appropriate levels of behavioral health care
Provider: Under Texas statutes, the Burke Center is designated as a Community Mental Health and Mental Retardation Center. Burke Center provides community-based behavioral health, early intervention and intellectual disability services to persons living in a twelve county catchment area. Ten of these counties (Angelina, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler) are contained in RHP 2. The remaining two (Houston and Trinity) are contained in RHP 1. This service area stretches over 10,000 square miles and contains 370,000 persons. It has been designated a mental health professional shortage area.
Project: This project will expand the capacity of the Burke Center to serve more children and adults with mental illness. We will provide outpatient psychiatric care, therapy, medication services and patient education as needed.
Need for the Project: With current funding, services are limited to a stringent "priority population" as defined by DSHS and there is a waiting list of eligible persons. Many others with serious mental illness seek care but are denied access as they do not meet the target population criteria. With this project, we will expand our capacity by 1200 persons per year over baseline by DY5 to address the needs of those with serious mental illness.
Target Population: The target population for this project will be persons on the wait list for care and others with a significant mental illness not meeting current eligibility criteria. The vast majority will be Medicaid or medically indigent.
Category 1 patient benefits: Service volume will increase over baseline by 10% (400 individuals) in DY 3, 20% (800 individuals) in DY 4 and 30% by DY 5. This will reflect the fact that more people get timely care.
Category 3 outcomes: IT-6.1.1 improved access to care will be reflected in improved patient satisfaction in receiving timely care, appointments, and information. The Center will participate in a statewide learning collaborative to identify and implement other relevant measures and strategies for data collection through HIEs or other sources.

PROJECTION DESCRIPTION:
This project will expand the capacity of primary behavioral health care to better accommodate the needs of the regional patient population and community, so that patients have enhanced access to services allowing them to receive the right care at the right time in the right setting. This project will expand and enhance system access points in a rural medically underserved area. This project will provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and substance use issues in order to meet this population's complex behavioral health needs.

Project Goals:

1.) Provide services to more patients
2.) Expand, enhance and improve access points
3.) Decrease travel distance for patients

Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. However, many Texans are unable to access either routine services or needed care in a timely manner either because they lack transportation or because they are unable to schedule an appointment due to work scheduling conflicts (or school scheduling conflicts in the case of children) or because they have obligations to provide care for children or elderly relatives . While such barriers to access can compromise anyone's ability to make or keep scheduled appointments, individuals with behavioral health needs may be especially negatively affected. Many individual with behavioral health needs are reticent to seek treatment in the first place and such barriers may be sufficient to prevent access entirely. Others may be easily discouraged by such barriers and may drop out of treatment. Any such delay in accessing services or any break or disruption in services may result in functional loss and the worsening of symptoms. These negative health outcomes come at great personal cost to the individual and also result in increased costs to payers when care is finally obtained.

In order to mitigate the effects of these barriers to accessing care, Burke Center proposes to take specific steps to broaden access to care that will include an expansion of operating hours in a select number of clinics.

Anticipated Challenges:

Challenges include having a limited number of specialized providers to serve a growing population of medically indigent individuals and having a limited array of treatment modalities and resources for which to meet the needs of individuals with multiple concomitant issues. This often results in services not being offered to those in need as evidenced by the large waiting list for services and even larger number of individuals who simply are turned away to seek services elsewhere. This project addresses these challenges by creating positions and appointment availability to meet these needs. Psychiatrists, mid-level practitioners, therapists, substance abuse specialists (via Alcohol and Drug Abuse Council of Deep East Texas), and support staff will provide fundamental specialized services to cover the needs of these individuals.

The 5-Year expected outcomes:

The expected 5-year outcome is the expansion of the number of patients served by 30% and an improvement of their satisfaction with access to and provided services. This project relates to regional mission by improving access to care and health outcomes. IT 6.1. will be used to show percent improvement in access so individuals receive timely care, appointments, and information.

Regional goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

STARTING POINT/BASELINE:

Burke Center services are limited by contractual agreement with the Department of State Health Services (DSHS) to persons in crisis or those meeting "priority population" or the more stringent "target population" diagnoses, per DSHS. Target Population diagnoses include individuals with schizophrenic disorders (32% of population served), bi-polar disorders (42%), and major depressive disorder (26%) with a global assessment of functioning below 50 in our adult population. There is a waiting list for adult outpatient services and large a number of individuals are referred to already strained and limited community resources. Resources are inadequate to provide care for persons with significant mental illnesses outside the "priority population" definitions. Most of the individuals referred or placed on the waiting list have limited funds to pay for services in the community. By opening up capacity individuals placed on the waitlist, those referred out for services, and other community members seeking help outside the target population will have the opportunity to receive behavioral health services. We are currently providing services to approximately 4000 individuals each year. By the end of DY 5, we anticipate that we will have expanded our capacity by 30%, serving 1200 additional persons each year.

RATIONALE:

Relationship Between Project Options and Community Needs

The selected project is 1.12 Enhance Service Availability of appropriate levels of behavioral health care and the project option is 1.12.4 "Other" project option.

Individuals may experience barriers in accessing primary behavioral health care services secondary to lack of transportation, lack of financial resources, 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 behavioral health care setting. By enhancing access points, available appointment times, individual's awareness of available services and overall primary care capacity, patients and their families will align themselves with the behavioral health care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced expense to patients.

Core options include expanding behavioral health care clinic location, expand primary behavioral health clinic hours, and expand primary behavioral health care clinic staffing. As mentioned earlier we have a high level of need in our service area as evidenced by the number of individuals who are currently on a waitlist as well as the high number of individuals referred for services who do not meet our target diagnostic population. We also have individuals in the

community who do not seek our services simply because they know they will not meet our criterion for services.

Several DY 2 and DY 3 Process Metrics & Milestones will be chosen to show the breadth and depth of the program. Our Process Milestones include the expansion of primary clinics and the number of providers at these expanded and extended clinics. Milestone P-6 establishes behavioral health services in new community-based settings in underserved areas. The Process Metric P-6.1 expands the number of additional clinics. The proposed process includes the addition of one clinic in a community that does not currently have a primary behavioral health care office. This provides opportunities to those with limited means of transportation and increases the chances for them to actually receive this needed service.

Process Milestone P-5 will be used to expand hours at two satellite clinics and Process Millstone P-4 to train/hire additional specialty providers and staff to provide services to this non/under-served population. Process Metric P-5.1 will be used to establish the most efficacious and client friendly number of hours of operation for the expanded hours. Process Metric P-4.1 will be used to establish the number of staff/providers to hire and train to serve this population. Services to individuals with behavioral health problems as well as those with severe mental illness require specialized providers in the provision of this service. Psychiatrists, mid-level prescribers and licensed professionals of the healing arts as well as support staff for these individuals are required.

Improvement Milestone I-X will be used to increase primary behavioral health care clinic volume of visits and evidence of improved access for individuals seeking services. Improvement Metric I-X.1 will document the number of increased visits and demonstrate improvement over the reporting period. The customized milestone was determined to be the best option to allow us to focus on the improvement most necessary in this community, that of improved access to service as evidenced by the number of individuals using the service.

Unique Community Need Identification numbers:

CN.1
CN.5
CN.6

Expansion or Enhancement:

This project will allow the Center to serve significantly more individuals and to serve individuals who are currently ineligible for our services due to not meeting priority population as per DSHS. It will also allow us to provide services in rural areas not currently served, thus increasing access. Currently no state or federals dollars are being spent on this initiative.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Our primary outcome is OD-6 Patient Satisfaction. The expansion of primary services via expanded clinic hours and increased number of providers will significantly improve the quality

of life of the individuals served. Baseline satisfaction scores will be collected as the standalone measure. IT 6.1. will be used to show percent improvement in access so individuals receive timely care, appointments, and information. The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and continually improve services.

It is well known the national supply of behavioral healthcare does not meet the mental health services . for the Medicaid and indigent population. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHPs are in real need of expanding behavioral health care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients, and to assure these services are provided in a manner that meets patient satisfaction.

RELATIONSHIP TO OTHER PROJECTS:

This project is related to Category 2.18 Recruit, Train, and Support consumers of mental health services to provide peer support services and to Category 1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth. Both of these projects will be focusing on the expansion of service delivery in the medically underserved service area; one in the form of identifying individuals with health risks who need peer services and the other to provide required modality of reaching clients in satellite locations. The increase in service expansion through the addition of extended/expanded hours and specialized staff will open the door for more people who need peer services and Telehealth/telemedicine is an essential conduit to reach these individuals in their own communities. Having expanded hours as well as specialized staff is crucial to these projects. This project's focus on expanding the capacity of primary behavioral health and emphasis on increasing access to services and receiving care in the right setting ties to these Category 1 and 2 projects in our RHP : 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 284333601.1.1, 261955689.1.1, 136367307.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary behavioral health care to better accommodate the needs of the regional patient population and community. There are no other related Category 1 similar projects in our RHP. This project focuses on the expansion of primary behavioral health care to better accommodate the needs of the regional patient population and community. There are no other related Category 1 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the

region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

The need for strategies to improve access to care via expanded service times as well as specialized providers is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality, overuse of emergency departments, and poor health outcomes as severity of behavioral health disorders increase.

The target population for all services is largely uninsured individuals or those with Medicaid/Medicare for whom local specialty providers are not available.

One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness. We are anticipating increasing our total number served through our Expansion of Behavioral Healthcare project. Individuals having a medical need for behavioral health services will receive targeted support services from specialized service providers.

136367307.1.1	1.12	1.12.4	ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE	
The Burke Center				136367307
Related Category 3 Outcome Measure(s): OD-6	136367307.3.1	IT-6.1.1	Percent Improvement Over Baseline of Patient Satisfaction Scores. Timely Care, Appointments and Information	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 **P-6:** Establish behavioral health services in new community-based settings in underserved areas. Metric 1 P-6.1. Number of new community-based settings where services are delivered. Baseline/Goal: The number of current locations and the number of patients served. Goal: Add one additional service site and increase the number of patients served. Data Source: Internal count of operating hours and number of patients served. Milestone Estimated Incentive Payment (maximum amount): $928,842 Milestone P-5: Establish extended hours. Metric 1 P-5.1. Number of areas prioritized for intervention with	**Milestone 2** **P-4**: Hire and train staff to operate and manage projects selected. Metric P-4.1 Number of staff secured and trained. Baseline/Goal: The number of current providers and staff. Goal: At least one additional prescriber, one support staff, one therapist, and one case worker will be hired. Data Source: Internal count of current staff allocation. Milestone Estimated Incentive Payment (maximum amount): $1,026,358 **Milestone I-X:** Increase primary care clinic volume of visits and evidence of improved access for individuals seeking service. Metric I-X.1: Documentation of Increased number of visits. Demonstrate improvement over prior		**Milestone I-X:** Increase primary care clinic volume of visits and evidence of improved access for individuals seeking service. Metric I-X.1: Documentation of Increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase the number of visits over the baseline reporting period by 20%. (800 individuals) Data Source: Information pulled from agencies EHR. Milestone Estimated Incentive Payment (maximum amount): $2,180,436	Milestone I-X: Increase primary care clinic volume of visits and evidence of improved access for individuals seeking service. Metric I-X.1: Documentation of Increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase the number of visits over the baseline reporting period by 30% (1200 individuals). Data Source: Information pulled from agencies EHR. Milestone Estimated Incentive Payment (maximum amount): $2,190,011

136367307.1.1	1.12	1.12.4	ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE	
The Burke Center				136367307
Related Category 3 Outcome Measure(s): OD-6	136367307.3.1	IT-6.1.1	Percent Improvement Over Baseline of Patient Satisfaction Scores. Timely Care, Appointments and Information	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
options in operation. Baseline/Goal: The number of current hours of service for these locations. Goal: Add an additional 12-14 hours of operation in existing sites Data Source: Internal count of operating hours. Milestone Estimated Incentive Payment (maximum amount): $928,842	reporting period. Goal: Increase the number of visits over the baseline reporting period by 10% (400 individuals). Data Source: Information pulled from agencies EHR. Milestone Estimated Incentive Payment (maximum amount): $1,026,358			
Year 2 Estimated Milestone Bundle Amount: $1,857,684	Year 3 Estimated Milestone Bundle Amount: $2,052,716		Year 4 Estimated Milestone Bundle Amount: $2,180,436	Year 5 Estimated Milestone Bundle Amount: $2,190,011
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIO:: $8,280,847				

PROJECT OPTION: 1.7.1 Introduce, Expand, or Enhance Telemedicine/Telehealth

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136367307.1.2

PERFORMING PROVIDER NAME/TPI: The Burke Center/136367307

Provider: Under Texas statutes, the Burke Center is designated as a Community Mental Health and Mental Retardation Center. Burke Center provides community-based behavioral health, early intervention and intellectual disability services to persons living in a twelve county catchment area. Ten of these counties (Angelina, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler) are contained in RHP 2. The remaining two (Houston and Trinity) are contained in RHP 1. This service area stretches over 10,000 square miles and contains 370,000 persons. It has been designated a mental health professional shortage area.

Project: Improve access to psychiatric care by enhancing and expanding the current telemedicine infrastructure. We will upgrade connectivity at one site and add two more remote sites to make care more accessible in rural locations.

Need for the Project: Broadband width and internet connectivity is a challenge in our rural area and a barrier to expanding our current telemedicine network. Many of the persons we serve must travel over 50 miles to reach an outpatient clinic. This project will allow us to add sites and the capacity to expand telemedicine to serve more patients.

Target Population: The target population for this project is persons with significant mental illness who have been unable to access care due to distance or lack of clinic capacity. The vast majority of these persons are medically indigent or Medicaid eligible.

Category 1 patient benefits: Service volume will increase over baseline by 20% in DY 4 and 30% by DY 5. This project will allow the Center to serve an additional 275 Medicaid and uninsured consumers This will reflect the fact that more people get timely access to care.

Category 3 outcomes: IT-6.1.1 improved access to care will be reflected in improved patient satisfaction in receiving timely care, appointments, and information.

PROJECTION DESCRIPTION:

The Burke Center has been using telemedicine over 10 years to provide psychiatric service to our patients. We will expand and enhance telemedicine (psychiatric) services in our region by adding additional broadband and internet capabilities; purchasing necessary equipment to allow for the expanded use of telemedicine in existing sites; and adding this capability in one or more new locations. Expanding and/or enhancing telemedicine services will allow for additional capacity for our Center and to meet our project goals outlined below. Our core project components are to provide patient services by psychiatrists using telecommunications and to ensure quality improvement is met by identifying the project impacts; identifying 'lessons learned'; determining when to scale the project to a broader population; identifying key challenges associated with expansion; and determining solutions to the challenges identified.

Project Goals:

4.) increase patients' timely access to psychiatric care and reduce geographic barriers;

5.) create the ability for psychiatrist to provide direct patient consults to patients based at rural clinics;
6.) Provide services in HPSAs.

Provide electronic health care services to increase patient access to health care. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, remote monitoring of vital signs with a focus on the specialty care access challenges in rural communities, and continuing medical education are all considered part of telemedicine and telehealth.26 Telehealth is the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.27

Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states can choose to cover under Medicaid. This definition is modeled on Medicare's definition of telehealth services (42 CFR 410.78). Note that the federal Medicaid statute does not recognize telemedicine as a distinct service.28 Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding required for billing of remote services. Telemedicine encompasses different types of programs and services provided for the patient. Each component involves different providers and consumers.29

Anticipated Challenges:

Broadband width and internet connectivity is a challenge in our rural areas. Developing an optimal system to allow the dependable use of equipment is our primary challenge. It is also costly. DSRIP funds will allow the funding to run fiber connections and pay for increased broadband width.

The 5-Year expected outcomes:

Our expected outcomes are to increase capacity by increasing the number of telemedicine psychiatric services provided to patients and expanding by adding one or more additional sites, while affording patient satisfaction with timeliness and accessibility of services. **Outcome Improvement Target** IT-6.1.1: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: TBD% improvement over baseline satisfaction scores Data Source: Patient Survey

Regional goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

STARTING POINT/BASELINE:

The Burke Center currently serves 20% of our consumers in our five (5) outpatient clinics via telemedicine .for a baseline of 550 consumers serviced annually.

26 http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333

27 http://www.hrsa.gov/ruralhealth/about/telehealth/

28 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

29 http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333

RATIONALE:

Relationship between Project Option and Community Needs

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

Investments in technology are the foundation for implementing many of our delivery system transformations. The Center currently uses technology at five (5) worksites; however, connectivity issues continue to prevent some of these worksites from fully utilizing available options.

In Texas, and in our rural area, communities are struggling to care for an increasing number of underserved, disadvantaged, and at-risk populations. In most communities, especially in rural areas, care is not organized to promote prevention and early intervention, coordinate services, or monitor access to and quality of care. Moreover, public and private funding to subsidize care remains inadequate, despite growing community needs associated with increases in the uninsured and aging populations. Consequently, many people are left to seek care in emergency rooms, often as a last resort, in an unmanaged and episodic manner. The costs of such care are borne by care-giving institutions, local governments, and, ultimately, taxpayers, many of whom are already burdened with the costs of meeting health-related costs of their own.

Given the various benefits observed through the provision of health care via telemedicine, there is a tremendous amount of momentum toward increasing access to care through the use of health information technologies, thereby creating an exciting and central role for innovation and implementation of new and advanced platforms for service delivery. Two such platforms include the use of wireless and telemonitoring technologies. It is our belief that healthcare delivery is about to make a significant leap forward. The development and installation of high-speed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients without bringing them into a

hospital or a specialty care center. This real/near-time monitoring and interacting could enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectations of our healthcare system.

The Burke Center coverage area is approximately 10,000 square miles. As previously mentioned, we have three (3) major service sites within this plan's service region and two (2) satellite sites within this plans service area. Currently residents in five of our twelve counties must travel 50 miles or more to receive face-to-face services with a Psychiatrist. Residents in three of our twelve counties must travel 30 to 49 miles to receive a face-to-face Psychiatric service. There is no public transportation in ten (10) of our counties; and only limited public transportation in the other two (2).

A vital component of our service delivery system is psychiatric services. With the shortage of psychiatrists, we are utilizing telemedicine services for our psychiatric needs. Our current limitations in connectivity and equipment are stretching our system to its limits. We currently provide telemedicine in our three (3) satellite offices but our limitations due to infrastructure limit the number of concurrent sessions we can have and travel to these sites for our consumers is also a limitation. For example, our Polk County clinic has a t-1 line connection and this smaller connection prevents this clinic from fully utilizing telemedicine options. Fiber options are available but current cost of running fiber to this clinic is prohibitive within our current financial budget. We must ensure each site has the bandwidth connectivity to allow for multiple video sessions as well as necessary equipment to expand needed psychiatric services.

We are also planning to expand our services by adding up to three (3) additional satellite offices within our region to not only allow us to expand the number of consumers we serve but to reduce travel times for those consumers who are currently travelling large distances to receive services.

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

Required core project components:

a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications

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

Our Process Milestone is P-4: Implement or expand telemedicine program for targeted health services, (Psychiatry) based upon regional and community need. Our implementation plan will include Metric P-4.1 which is identifying highest potential for impact to consumers and then identifying broadband connection issues by areas served and procuring the equipment necessary to provide these services. This will occur in Year 2. We will then proceed to Metric P-4.2 which we document the number of services delivered via telemedicine for psychiatric services. This will occur in Year 3. We conduct our quality improvement activity in year three by using P-11. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least

twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. P-11.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.

Our first Improvement Milestone to occur in Year 2 will be I-16: Expand telemedicine program to additional clinic. Metric I-16.1 will be will met by expanding telemedicine to one or more sites. Our second Improvement Milestone to occur in Year 4 is I-12 to increase number of telemedicine visits for psychiatric services. Our required quality improvement component will be addressed with P-11. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-11.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Unique Community Need Identification numbers:

CN.1
CN.5
CN.6

Expansion or Enhancement:

This project will allow the Center to significantly enhance our telemedicine services. We currently have some technology but the cost to increase broadband width and purchase additional equipment necessary to expand telemedicine has proved prohibitive within our current funding streams.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Our primary outcome is OD-6 Patient Satisfaction. We have chosen IT6.1.1 to improve patients' satisfaction in receiving timely care, appointments, and information. The expansion and enhance of telemedicine must go hand in hand with satisfaction. If we are unable to provide dependable connectivity that will allow for a clear picture between patient and doctor, optimal service will not occur. In addition, the telemedicine will allow our patients to receive timely care and appointments and reduce our waiting list if not eliminate it altogether. Telemedicine will also allow our HPSA to contract with psychiatrists in other areas to provide this service. The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and test and execute the plan.

RELATIONSHIP TO OTHER PROJECTS:

This project's entire designed is to support the success of our project 1.12: expand behavioral healthcare services.

This project's focus on telemedicine and emphasis on psychiatric services ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2,

081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion and enhancement of telemedicine services in our region for psychitraic, behavioral, and neurological support. The following Category 1 projects in our RHP are related: 136367307.1.2- Introduce, Expand, or Enhance Telemedicine/Telehealth; 112706003.1.1- Introduce, Expand, or Enhance Telemedicine/Telehealth; and 096166602.1.5- Introduce, Expand or Enhance Telemedicine/Telehealth

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness and can be considered as population affected.

The needs assessment morbidity data indicates there is a 76.8% gap in our area based on shortage of mental health providers. Expanding telemedicine will reduce this gap by allowing our Center to access psychiatrists from other regions.

This project costs has a long-term results that will continually reduce costs per person with time. Expansion and enhancing equipment, broadband options has upfront costs to establish an infrastructure. Once this infrastructure is built, on-going maintenance costs are less significant.

The community benefit of this project is that is improves access; reduces burdens on patients in rural areas; and is transformative.

136367307.1.2	1.7	1.7.1 E, F	EXPAND AND ENHANCE TELEMEDICINE
The Burke Center			136367307
Related Category 3 Outcome Measure(s):	136367307.3.2	IT-6.1.1	Percent Improvement over baseline satisfaction scores. Timely Care, Appointments and Information

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-4 Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 4.1 Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Baseline/Goal: Submission of implementation documentation. Data Source: Program Materials Milestone 1 Estimated Incentive Payment (maximum amount): $143,972 **Milestone 2.** I-16 Expand telemedicine program to additional clinics. Metric 1-1.16.1 New telemedicine-enhanced clinics. Baseline/Goal: Goal is to add telemedicine options to one (1) additional clinic. Data Source: Log of teleservices by location. Milestone 2: Estimated Incentive Payment (maximum amount): $85,736	**Milestone 3** P-4 Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 4.2 Documentation of the quantity of actual telehealth services delivered after implementation. Baseline/Goal: Number of telemedicine sessions provided via video-conferencing to ensure actual implementation occurred. Data Source: Log of teleservices by type of health care professionals and type of service Milestone 3 Estimated Incentive Payment (maximum amount): $114,087.50 **Milestone 4** P-11. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects P-11.1. Metric: Participate in semi-annual face-to-face	**Milestone 5.** I-12 Increase number of telemedicine visits identified as high need. Metric 1-12.1 Number of telemedicine visits. Baseline/Goal: Baseline TBD/Goal is to increase 20% over baseline (110 consumers) by demonstrating increase in access due to teleservices. Data Source: EHR; encounter records from telemedicine program. Milestone 5: Estimated Incentive Payment (maximum amount): $277,386	**Milestone 6 (repeat).** I-12 Increase number of telemedicine visits identified as high need. Metric 1-12.1 Number of telemedicine visits. Baseline/Goal: Baseline TBD/Goal is to increase 30% over baseline (165 consumers) by demonstrating increase in access due to teleservices. Data Source: EHR; encounter records from telemedicine program. Milestone 6: Estimated Incentive Payment (maximum amount): $204,639

136367307.1.2	1.7	1.7.1 E, F	EXPAND AND ENHANCE TELEMEDICINE	
The Burke Center				136367307
Related Category 3 Outcome Measure(s):	136367307.3.2	IT-6.1.1	Percent Improvement over baseline satisfaction scores. Timely Care, Appointments and Information	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
		meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 4 Estimated Incentive Payment (maximum amount): $114,087.50		
Year 2 Estimated Milestone Bundle Amount: $171,472		Year 3 Estimated Milestone Bundle Amount: $228,175	Year 4 Estimated Milestone Bundle Amount: $227,386	Year 5 Estimated Milestone Bundle Amount: $204,639
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $881,672				

PROJECT OPTION: 1.9.2 Improve access to specialty (psychiatric) care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 081844501.1.1

PERFORMING PROVIDER/TPI: Tri-County Services/081844501

DSRIP Category/Project Area: 1.9: Expand Specialty Care Capacity
Project Title: Expanded Psychiatry Delivery Program

Provider: Tri-County Services is a Community Center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended. Tri-County is sponsored by the Commissioners Courts of Montgomery, Walker and Liberty Counties and is designated as a unit of local government. Tri-County contracts with the Texas Department of State Health Services (DSHS) and the Texas Department of Aging and Disability Services (DADS) among others to provide services to persons with mental illnesses and/or developmental disabilities. Tri-County has primary service locations in Conroe, Huntsville, Cleveland and Liberty Texas. Tri-County has approximately 320 fulltime equivalent employees, including 7 prescribing staff.
Interventions(s): With this Region 2 Expanded Psychiatric Delivery Program, Tri-County proposes to provide specialty psychiatric services to persons who are otherwise unable to receive necessary psychiatric care in Liberty County. The primary intervention will be the provision of medication and case coordination to persons with diagnoses which do not meet DSHS contract requirements.
Need for project: As stated below, both our experience and the statistical data support the need for additional mental health services in Liberty County. These additional services should result in cost savings for the community by providing appropriate treatment alternatives to local emergency departments, hospitals, psychiatric hospitals or criminal justice systems.
Target population: The target population for this project is persons with psychiatric conditions which are interfering with the individual's global functioning. The project, at the end of DY 5, will serve over 75 unique individuals per year with 250 scheduled appointments available for care and follow-up. Based on our experience as a provider, it is likely that most of these individuals will be indigent. However, the changes associated with the Patient Protection and Affordable Care Act may result in persons being served with newly acquired health insurance. Regardless of changes in health insurance coverage however, individuals served will probably not have many options for psychiatric care in Liberty County without this program due to the shortage of providers in this county.
Cat 1 or 2 expected patient benefits: We believe these individuals will benefit from this service. Liberty County is a medically underserved portion of our service area and very limited

psychiatric care is available. Category 2 milestone relate to designing an appropriately placed service to meet the needs of these individuals.

Category 3 outcomes: For Category 3, we have chosen to measure perceived quality of life with the expectation that individuals with higher quality of life will: 1) be more likely to improve their ability to cope with life circumstances appropriately; and, 2) be less likely to use inappropriate types of care (e.g. the Emergency Department).

PROJECT DESCRIPTION:

Goal: The goal of this project is to provide specialty psychiatric services to persons who are otherwise unable to receive necessary psychiatric care in Liberty County. There is a high demand for psychiatric care. With regard to the specialty areas with greatest need, the Committee on Physician Distribution and Health Care Access cites psychiatry where ratios per 100,000 in population are 56.7% of the US ratios.

Description: This proposed program will provide basic services requested and needed by these individuals in Liberty County to reduce inappropriate care. This program will admit and serve these individuals in medication services and care coordination to meet the primary treatment needs as requested. We would contract with medical staff and hire staff to deliver these services, and would also expand hours of service availability as needed. Although Tri-County has extensive experience serving individuals with Severe and Persistent Mental Illnesses, Tri-County is unable to serve many of the individuals that present themselves at clinic locations for non-priority psychiatric disorders. Individuals will receive proactive care that keeps them healthy and empowers them to self-manage their conditions in order to avoid their mental health worsening and needing ED or inpatient care at general hospitals, admissions to psychiatric facilities or involvement with law enforcement.

Challenges:

Historically it has been quite challenging to recruit prescribing staff. Space in existing clinics or new space will have to be identified for the provision of these services. An assessment of geographic areas in Liberty County who lack access to psychiatry will be performed and attempts will be made to locate clinics in areas of highest proportional need. To address the issue of recruiting psychiatric prescribing staff, the Center will consider contracting with our regional behavioral health provider (East Texas Behavioral Health Network) to provide psychiatric services via telemedicine.

Outcomes: Tri-County will expand the availability of psychiatric services which can be provided in the community by the end of DY 5 as evidenced by the number of appointments available, number of persons seen and number of unique persons served by this program.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of the region by expanding and coordinating access to specialty care services and chronic disease management. This project will address CN.5-mental/behavioral health provider shortage and CN.10-high emergency department usage by providing access to specialty care psychiatry providers in Liberty County.

STARTING POINT/BASELINE:

There are currently 32 persons with Severe and Persistent Mental Illness (SPMI) on Tri-County's adult waiting list in Liberty County. On average 10.5% of the persons on Tri-County's waiting list have required crisis services since the list began in 2008. In addition, a large number of individuals have their first contact with Tri-County during a crisis episode. Tri-County also assesses over 500 persons a year that are not eligible for adult mental health services funded by DSHS. In FY 2010, the last year where jail matching data was completed through the Center, an average of 128 inmates per quarter were incarcerated in Liberty County jails with a SPMI diagnosis that would qualify them for DSHS-funded treatment. In addition to these 128 per quarter that have SPMI diagnosis matches, nearly 240 inmates per quarter had been in seen by a mental health service provider in Texas at some time prior to incarceration. It is not surprising that this number of inmates have mental health treatment issues, because as Health Management Associates (HMA) noted in their 2011 analysis of the Impact of Proposed Budget Cuts to the Community Mental Health Services in Texas, there is a "strong correlation between the amount of money a state spends on mental health services and the size of jail and prison populations" (Health, P. 9).

According to published prevalence data statistics, it is estimated that there are between 6.2% (Kessler, et. al P. 987) and 8.2% (Bijl, et. al P.127) of the general population or approximately 5,200 to 7,000 persons in Liberty County which have SPMI. In addition, it is estimated that an additional 7% (Bijl, et. al P.127) or 6000 persons in Liberty County has a moderate level of mental illness.

In short, both our experience and the statistical data support the need for additional mental health services in Liberty County. These additional services should result in cost savings for the community by providing appropriate treatment alternatives to local emergency departments, hospitals, psychiatric hospitals or criminal justice systems.

In a Mental Health Local Planning survey by Tri-County in 2010, stakeholders were asked to rank services that Tri-County needs to expand further, and Medication Services for adults was the most frequently requested service by these stakeholders.

RATIONALE:

This project will address Community Needs CN.5-mental/behavioral health provider shortage and CN.10-high emergency department usage by providing access to specialty care psychiatry providers in Liberty County.

Tri-County has long been aware of the need to increase the capacity to provide psychiatric services so the individuals in our communities have increased access to these services. For individuals who are indigent, there are very few options for psychiatric care in Liberty County. Though medically indigent, these individuals may work or have other responsibilities which would make expanded service hours helpful. Due the unavailability of indigent psychiatric care in Liberty County, care for these disorders is typically provided in inappropriate care settings (including emergency departments and jails).

Tri-County proposes to improve the access to specialty psychiatric care for individuals who are in need for psychiatric care, but who are otherwise unable to be served by the current service system. We will increase service availability with extended hours as needed, increase the number of psychiatric clinic options for the medically indigent, will implement standardized referrals to appropriate services, and will conduct quality improvement for the project using rapid cycle improvement.

This project represents a new initiative for Tri-County. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Facilities will be determined for provision of this service.
- Appropriate prescribing and service staffs will be hired/contracted with to administer the program.
- The program will be advertised in the community.
- Protocols will be established for service provision and scheduling.
- A system of reporting utilization and outcomes will be developed.
- Ongoing assessments will be done to provide feedback for impact and improvements.

This project will focus on improving access to specialty care (1.9.2) by increasing service availability with extended hours (a), increasing the number of specialty clinic locations (b) and by conducting quality improvement for the project (d). Continuous Quality Improvement activities will include evaluations of services provided, effectiveness of services provided and impact of services on use of the current service system. We will seek to make incremental improvements in the performance of the program throughout the project award. An effort will be made to make referrals which are standardized across the system, but there are limited providers in Liberty County who may take these referrals, especially for indigent consumers.

For demonstration year 2, the process milestone is to identify components needed to implement and operate the expanded psychiatry delivery program and develop an appropriate project plan.

For demonstration year 3, the process milestones will be to develop administrative protocols and clinical guidelines for our project and to hire or contract and train staff to operate and manage the expanded psychiatry project.

In demonstration years 4-5, the process milestone will focus on identifying barriers persons receiving specialty care so that operating hours and locations can be customized for the program. The improvement milestones will measure the number of appointments available, number of appointments kept and the number of unique persons served. By the end of demonstration year 5, 250 visits will be available for individuals who are seeking behavioral

healthcare services, 125 appointments will be completed and over 75 unique individuals will be served.

The target population for this project is persons with psychiatric conditions which are interfering with the individual's global functioning. The project, at the end of DY 5, will serve over 75 unique individuals per year with 250 scheduled appointments available for care and follow-up. Based on our experience as a provider, it is likely that 80% or more of these individuals will be indigent or Medicaid recipients. However, the changes associated with the Patient Protection and Affordable Care Act may result in persons being served with newly acquired health insurance or Medicaid. Regardless of changes in health insurance coverage however, individuals served will probably not have many options for psychiatric care in Liberty County without this program due to the shortage of providers in this service area.

We believe individuals outside of the DSHS Priority Population will benefit from this service. Large portions of Liberty County are medically underserved and very limited psychiatric care is available.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Tri-County has selected improvement outcome measure IT-10.1, Percent improvement over baseline of Quality of Life scores. Since the goal of this project is to provide expanded psychiatric care in our community, measuring the impact of this service on individuals' quality of life is important. Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. In short, effective quality improvement focuses on patient outcomes. Ultimately, uncompensated care is impacted by services which improve the overall quality of life of the individual.

RELATIONSHIP TO OTHER PROJECTS AND MEASURES:

This project relates to Tri-County's Region 17 Intensive Evaluation and Diversion program, # 081844501.1.1, and Region 17 Intellectual and Developmental Disability Assertive Community Treatment program, #081844501.1.2, which could generate referrals for this program after crises are resolved by the respective intervention. This project's focus on expanding psychiatric services and emphasis on Liberty County, care coordination and hiring staff to expand hours ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS AND MEASURES:

This project focuses on the improvement of access to specialty care along with these other Category 1 projects in our RHP:0818444501.1.1 - Expanded psychiatry delivery program; 109372601.1.1-Expand specialty Brazoria County and 131030203.1.4- Improve Access to Specialty Care.

PROJECT VALUATION:

Tri-County considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for mental illnesses. Improving the behavioral health individuals should reduce the number of ED visits and the occurrences of hospitalizations.

According to internal data, approximately 10.5% of individuals on the Mental Health Waiting list have needed crisis services. These crisis interventions may not have been required if such individuals had been admitted into some level of service. According to a report issued by HMA in 2011, "patients with mental illness overuse emergency rooms when appropriate mental health care is not available. Additionally, individuals with mental illness remain in the emergency room longer, decreasing the access of others with medical emergencies" (Health, 2011, P. 4). The report further indicates that "police officers are reporting longer waits in emergency rooms for individuals that they have brought in for care [with a mental illness]…" (Health, 2011, P. 5) In contrast, of those who receive Community Center care, 97% avoid a crisis episode, 98% have avoided multiple hospital readmissions, [and] 84% of adults have improved employment…" (Health, 2011, P. 6). The average cost for an adult with SPMI to receive treatment from a community center is "12 dollars a day" (Health, 2011, P. 8) or $360 a month. By contrast, the cost of an average State Mental Health Hospital stay is $11,629 for 29 days of care; a 30-day stay in jail costs an average of $4,110; and one visit to the emergency room costs $986 (Health, 2011, P. 8). In addition, many of these individuals are likely treated through multiple of these interventions in a given year (seen in the ER with police supervision and then taken a State Hospital, etc.). The Expanded Service and Delivery Program will provide an appropriate intervention for these individuals, prior to needing crisis services, accessing the emergency department or being incarcerated.

- *Another valuation factor used for this project is the monetary value for behavioral health interventions as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the mental health intervention. Programs that improve their mental health should increase both the length and quality of their lives.*

- ***Sources:***

Bijl, R. V., Graaf, R., Hiripi, E., Kessler, R. C., Kohn, R., Offord, D., & Ustun, T. B. (2003). The prevalence of

treated and untreated mental disorders in five countries [Electronic version]. *Health Affairs*, *22*(3), 122-133. doi:10.1377/hlthaff.22.3.122

Health Management Associates: Impact of Proposed Budget Cuts to Community-Based Mental health Services. (2011, March). http://www.txcouncil.com/userfiles/file/Impact%20of%20Budget%20Cuts%20to%20Community-based%20Mental%20Health%20Services%20Final%203%209%2011.pdf. Retrieved August 24, 2012

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J., Laska, E. M., Leaf, P. J., & Manderscheid, R. W. (2001, December). The prevalence and correlates of untreated serious mental illness [Electronic version]. *Health Services Research*, *36*(6), 997-1007.

081844501.1.1	1.9.2	1.9.2 A, B,D	Expanded Psychiatry Delivery Program	
Tri-County Services				0181844501
Related Category 3 Outcome Measure(s):	081844501.3.1	IT 10.1	Quality of Life	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-X: Identify components needed to implement and operate option selected. Metric 1 P-X.1: Create Project Plan Goal: Complete a project plan for the Expanded Psychiatry program which details administrative protocols and guidelines, required training, and identifies appropriate clinic locations. Baseline/Goal: Completed project plan. Data Source: Project Plan **Milestone 1 Estimated Incentive Payment *:* $95,456**	**Milestone 2** [P-X.2] : Develop administrative protocols and clinical guidelines for project selected Metric 1 [P-X.2.1] Manual of operation for the project detailing administrative protocols and clinical guidelines. **Milestone 2 Estimated Incentive Payment: $92,297** **Milestone 3** [P-X.1]: Hire/contract and train staff to operate and manage project. Metric 1 [P-X.3.1]: Number of staff secured and trained Goal: Appropriate providers are available to provide services to persons in the expanded services program. Data Source: HR or Contracting records, training records **Milestone 3 Estimated Incentive Payment: $92,297**	**Milestone 4** [P-X.4]: Identify areas which lack sufficient transportation to appointments and operating hours Metric 1 [P-X.4.1]: Assessment of gaps in accessibility to establish/prioritize geographic areas for intervention Data Source: Survey of providers, key stakeholders, records regarding kept and missed appointments **Milestone 4 Estimated Incentive Payment: $143,375** **Milestone 5** I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased volume of visits. Demonstrate improvement over DY 2. Baseline/Goal: 125appointments available, 70 visits Data Source: Electronic Health record. Metric 2 [I-23.2]: Documentation of increased number of unique patients encountered by the program.	**Milestone 6** [I-X.6]: Use of Emergency Department Care by individuals with mental illness or substance use disorders Metric 1 [I-X.6.1]: X% decrease over baseline in inappropriate utilization of the Emergency Department by persons served by this program. Data Source: Questionnaires from clients receiving services during the first 6 months of the DY in comparison with the baseline period. Baseline: 10% decrease over baseline in ED use for behavioral health care. **Milestone 6 Estimated Incentive Payment: $153,970** **Milestone 4** I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased volume of visits. Demonstrate improvement over DY 2. Baseline/Goal: 250 total appointments available, 125 visits Data Source: Electronic Health

081844501.1.1	1.9.2	1.9.2 A, B,D	Expanded Psychiatry Delivery Program	
Tri-County Services				0181844501
Related Category 3 Outcome Measure(s):	081844501.3.1	IT 10.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Demonstrate improvement over prior reporting period Baseline/Goal: 25 Unique patients Data Source: Electronic Health record. **Milestone 5 Estimated Incentive Payment:** $143,375	record. Metric 2 [I-23.2]: Documentation of increased number of unique patients encountered by the program. Demonstrate improvement over prior reporting period Baseline/Goal: 75 additional unique patients over previous reporting period Data Source: Electronic Health record. **Milestone 7 Estimated Incentive Payment:** $153,970
Year 2 Estimated Milestone Bundle Amount: $95,456	Year 2 Estimated Milestone Bundle Amount: $184,594		Year 4 Estimated Milestone Bundle Amount: $286,750	Year 5 Estimated Milestone Bundle Amount: $307,940
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $874,740				

PROJECT OPTION: 1.1.2 Expand Primary Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136381405.1.1
PERFORMING PROVIDER/TPI: Tyler County Hospital District / 136381405

Title of project: To Expand Primary Care in Tyler County
Provider: Tyler County Hospital District consist of a 49 acute care bed hospital, 5 practitioner rural health clinic, school of vocational nursing and a 501(c)(3) Foundation located in a rural East Texas Community. Woodville has a population of 2,100 and a county population of 21,766 serving 935.7 square miles. There are no specialists living in the community. There are five school districts in Tyler County. Twenty percent live at or below the poverty level with an additional 9% unemployed.
Intervention(s): This project will expand access to primary care by adding a physician and LVN to our Rural Health Clinic and expand operating hours at the clinic to 8:00am to 7:00pm Monday to Thursday, 8:00am to 5:00pm Friday, and 8:00am to 12:00pm Saturday. We will have 1 physician, 1 LVN and 1 clerical staff member working during expanded hours. Also, we plan to provide primary care and chronic disease management to RHC patients and reduce the number and/or proportion of patients with HbA1c>9%.
Need for project: We currently only have 2 doctors and one nurse practitioner accepting new patients. Appointments may take up to one week to schedule. It is difficult for patients to get a primary care appointment in a timely manner or even get a follow-up visit. First, recruitment and retention of new care providers can be difficult, and take significant time and effort, for a rural community such as ours, due to the lack of local amenities (such as shopping centers or other leisure activities), quality of schools, and other expectations of providers and their families. Therefore, we plan to utilize a professional agency to recruit new caregivers, and to offer an aggressive compensation package.
Target Population: The largest population is our patients that have been receiving serves in urgent and emergency care settings: 26% of the community is uninsured Medicaid clients, and 19.26% of the diabetics do not get an HbA1c screening.
Category 1 patient benefits: The project seeks to add 1 physician and 1 nurse to a health professional shortage area and a medically underserved area. Hours of operation will be expanded to 8-7 Monday to Thursday, 8-5 Friday and 8-12 Saturday. Base line will be set in Year 4 with 600 visit increase in Year 5. Our Chronic Disease Management program will integrate the program into routine patient visits rather than requiring separate scheduling, whenever possible, and we will provide information on where patients might secure support for purchasing medicines, affordable transportation, and how to prepare diabetic meals. We will also seek resources to support low income patients in obtaining medicines, transportation, and appropriate foods.
Category 3 outcome: IT-1.10 our goal is to train 75% of staff in a chronic disease management program for diabetes, who then will teach patients 18 to 75 years of age with an HbA1c>9% to manage their diabetes. Our second goal is to reduce the number of diabetes patients RHC with HbA1c > 9% over 4 years. Year 4 and 5 goal TBD based on baseline rates established in DY3.

Currently, 19.26% of patients with diabetes in Tyler County do not get an HbA1c screening. There is a 27.5 per 100,000 diabetes mortality rate in Tyler County. Morbidity for Diabetes Mellitus is 11.4 per 100,000. The 30 day readmission rate for medical discharges, a measure of quality of care, was higher than both the Texas and U.S. rates. Shifting our focus for diabetes care from treatment to a disease management model will allow us to transform care from being reactive to being proactive. We will then be able to stay focused on keeping our patients healthy and out of the hospital. The Chronic Disease Management Program for diabetes will be developed for providers to use with patients.

Provider: Tyler County Hospital District consist of a 49 acute care bed hospital, 5 practitioner rural health clinic, school of vocational nursing and a 501(c)(3) Foundation located in a rural East Texas Community. Woodville has a population of 2,100 and a county population of 21,766 serving 935.7 square miles. There are no specialists living in the community. There are five school districts in Tyler County. Twenty percent live at or below the poverty level with an additional 9% unemployed.

Intervention(s): This project will expand access to primary care by adding a physician and LVN to our Rural Health Clinic and expand operating hours at the clinic to 8:00am to 7:00pm Monday to Thursday, 8:00am to 5:00pm Friday, and 8:00am to 12:00pm Saturday. We will have 1 physician, 1 LVN and 1 clerical staff member working during expanded hours. Also, we plan to provide primary care and chronic disease management to RHC patients and reduce the number and/or proportion of patients with HbA1c>9%.

Need for project: We currently only have 2 doctors and one nurse practitioner accepting new patients. Appointments may take up to one week to schedule. It is difficult for patients to get a primary care appointment in a timely manner or even get a follow-up visit. First, recruitment and retention of new care providers can be difficult, and take significant time and effort, for a rural community such as ours, due to the lack of local amenities (such as shopping centers or other leisure activities), quality of schools, and other expectations of providers and their families. Therefore, we plan to utilize a professional agency to recruit new caregivers, and to offer an aggressive compensation package.

Target Population: The largest population is our patients that have been receiving serves in urgent and emergency care settings: 26% of the community is uninsured Medicaid clients, and 19.26% of the diabetics do not get an HbA1c screening.

Category 1 patient benefits: The project seeks to add 1 physician and 1 nurse to a health professional shortage area and a medically underserved area. Hours of operation will be expanded to 8-7 Monday to Thursday, 8-5 Friday and 8-12 Saturday. Base line will be set in Year 4 with 600 visit increase in Year 5. Our Chronic Disease Management program will integrate the program into routine patient visits rather than requiring separate scheduling, whenever possible, and we will provide information on where patients might secure support for purchasing medicines, affordable transportation, and how to prepare diabetic meals. We will also seek resources to support low income patients in obtaining medicines, transportation, and appropriate foods.

Category 3 outcome: IT-1.10 our goal is to train 75% of staff in a chronic disease management program for diabetes, who then will teach patients 18 to 75 years of age with an HbA1c>9% to

manage their diabetes. Our second goal is to reduce the number of diabetes patients RHC with HbA1c > 9% over 4 years. Year 4 and 5 goal TBD based on baseline rates established in DY3. Currently, 19.26% of patients with diabetes in Tyler County do not get an HbA1c screening. There is a 27.5 per 100,000 diabetes mortality rate in Tyler County. Morbidity for Diabetes Mellitus is 11.4 per 100,000. The 30 day readmission rate for medical discharges, a measure of quality of care, was higher than both the Texas and U.S. rates. Shifting our focus for diabetes care from treatment to a disease management model will allow us to transform care from being reactive to being proactive. We will then be able to stay focused on keeping our patients healthy and out of the hospital. The Chronic Disease Management Program for diabetes will be developed for providers to use with patients.

PROJECT DESCRIPTION:

Tyler County Hospital Family Medical Clinic currently has four physicians and one Nurse Practitioner as well as five LVNs, but only two physicians and one nurse practitioner are accepting new patients for a county with a population over 21,000. Additionally, Tyler County expects a population increase, due to a recently approved a bio mass plant and German Pellet Plant with construction beginning soon, which are expected to bring an additional 200 employees and their families to our community. Even with the current population level, it is difficult for patients to get a primary care appointment in a timely manner or even get a follow-up visit. Appointments may take up to one week to schedule.

Our existing RHC building was designed to hold six practitioners, so we will redesign our office structure to achieve efficiency and maximize the capacity to add a physician and LVN. We propose to add a physician and an LVN to decrease waiting time and increase capacity to deliver care.

We also want to increase our operating hours. Current operating hours are from 8am to 5pm Monday – Friday. Proposed hours are 8am to 7pm Monday – Thursday, 8am to 5pm Friday, and 8am to 12pm Saturday. We will have 1 physician, 1 LVN and 1 clerical staff member working during expanded hours.

All RHC providers will be trained in Chronic Disease Management for Diabetes. This will improve access to care to accommodate the needs of a growing community with a particular need for chronic disease management.

Project goal:

We plan to expand access to primary care by adding a physician and LVN to our Rural Health Clinic (RHC) and expand operating hours of the clinic. Also, we plan to provide primary care and chronic disease management to RHC patients, and reduce the number and/or proportion of patients with HbA1c >9%.

Anticipated challenges:

We anticipate a number of challenges with this program. First, recruitment and retention of new care providers can be difficult, and take significant time and effort, for a rural community such as ours, due to the lack of local amenities (such as shopping centers or other leisure activities), quality of schools, and other expectations of providers and their families. Therefore, we plan to utilize a professional agency to recruit new caregivers, and to offer an aggressive compensation package.

Second, we plan to ensure that the public is aware of newly expanded hours at the clinic with advertisements in the newspaper and on the local radio station, distribution of flyers to

churches and other community organizations, and announcements at public meetings and speaker bureau events.

Third, ensuring that patients actively and effectively participate in Chronic Disease Management programs can be a challenge because of low health literacy, low locus of control and motivation, failure to keep follow up visits due to transportation and other reasons, lack of financial resources to purchase medicines and testing supplies, and difficulty in adhering to a diabetic diet and exercise regime, among others. Our Chronic Disease Management program will integrate the program into routine patient visits rather than requiring separate scheduling, whenever possible, and we will provide information on where patients might secure support for purchasing medicines, affordable transportation, and how to prepare diabetic meals. We will also seek resources to support low income patients in obtaining medicines, transportation, and appropriate foods.

Fourth, we recognize that new primary care providers may need training to ensure cultural competency relevant to our patient population, e.g. in relation to the levels of poverty, unemployment, low educational attainment, and lack of health insurance; issues related to the Native American population located on the nearby Alabama Coushatta Reservation; and low level of health literacy. Therefore, we will provide specific training on these issues, and intentionally discuss the impact of the issues on patient care in our local context. We will introduce providers to Elders on the Reservation, and create opportunities for the community to meet the new providers in public, social settings.

Finally, because we have not previously developed a Chronic Disease Management Program, we will need support in responding to issues such as training of providers as well as requirements related to resources and personnel. Therefore, we will actively collaborate with other successful programs in the Region to learn their lessons and adapt elements of their program for our local context.

The 5-year expected outcome(s):

A Primary Care Physician and LVN will be added to the clinic staff to provide a Diabetic Management Program and increase access to care. Hours will be more flexible; increase in number of patients seen. Disease management Program will be implemented. The number of clinic patients with HbA1c >9% by DY5: specific reduction goal to be determined based on baseline information from DY3.

Regional goals:

This project supports at least 2 of Region 2 goals, including:

1. Improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.
2. Improve the health of our region by expanding coordinating access to specialty care services and chronic disease management.

STARTING POINT/BASELINE:

1. Current number of providers: 4 physicians, 1 nurse practitioner.
Proposed: 5 physicians, 1 nurse practitioner 6 LVNs (increase of 1 physician and 1 LVN).
2. Current hours of operation are 8am to 5pm Monday – Friday.

Proposed: 8am to 7pm Monday – Thursday, 8am to 5pm on Friday and 8am to 12pm on Saturday.

3. Number of patients with HbA1c >9% to be reduced by DY5 (Specific reduction goal to be determined by DY3).

RATIONALE:

***R*elation between Project Choices and Community Needs:**

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.

A community health assessment was completed for Tyler County August 2012. Two areas reflected a need for addition healthcare providers. The Community's Access to Health Services shows that Tyler County's rate of uninsured is almost double the United States rate for those 19 years of age, and more than 10 percentage points higher for the population under 65. Tyler County is federally designated as a medically underserved area. Also, high rates of visits to the emergency department indicate lack of access to primary care or inappropriate utilization. The rate of ED visits for Tyler County was among the worst in Texas which is in the bottom 25% all counties.

The Community's Health Service Resources presents Tyler County as a federally designated Health Professional Shortage Area for primary care and mental health providers. The rates of providers per 100,000 population are also low for specialists, mid-level providers, dentists, and pharmacists. Also, there are no licenses psychiatric care beds and there are no facilities that provide substance abuse treatment, or detox. The 30 day readmission rate for medical discharges, a measure of quality of care, was higher than both the Texas and U.S. rates.

The Community Health Assessment clearly demonstrates the need to recruit additional health care providers which will enhance the quality of care the patients receive, reduce patient wait time and improve case management of patients with chronic disease in the community.

1. We currently have 26% of the community uninsured.
    a. The diabetes mellitus mortality rate is 27.5 per 100,000 in Tyler County.
    b. We are currently in the bottom 25% of all counties in Texas for heart disease.
    c. Twenty percent of the community smokes
    d. Thirty percent of Tyler County doesn't perform physical activity.
2. Need more appointment slots
    a. Currently takes up to 1 week to get appointments.
3. Chronic Diagnoses are increasing, and the population of the county is expected to increase with new economic development taking place.

We chose our milestones and metric based on our community needs assessment. We want to train and hire an additional Primary Care Provider and LVN to increase the number of providers which will improve the access to primary care. Our second milestone will be to expand the hours of our clinic including evening and weekends. Expanding hours not only allows for more patients to be seen, but also provides more choice for patients.

The project choice is a direct reflection of Tyler County's community needs. The project focuses on increasing access to care, and on improving management of chronic diseases.

In relation to access to care, the Tyler County Community Needs Assessment shows a strong need for improved access to care, including adding care providers and extending hours of operation to accommodate schedules of working people, especially the working poor. The County has 19.9% living at or below the poverty line as opposed to 17.5% in Texas and 15.3% in US. Disability is 21.5% for Tyler County, 11.5% for Texas and 12% for US. Poor physical health days average are 5.7% for Tyler County, 3.6% for Texas and 3.5% for the US. PCP's are 45/100,000 for Tyler County, 69.5/100,000 for Texas and 91/100,000 for the US.

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million American have diabetes and half of these cases are undiagnosed. Complications from the disease cost the United States nearly $100 billion annually. 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 citizens of Tyler County and save valuable healthcare dollars.

We chose Diabetes Care due to the overwhelming need in Tyler County. Tyler County has a Mortality Rate of 27.5 per 100,000 for Diabetes, which is higher than Texas at 26 per 100,000 and US at 20.9 per 100,000. Morbidity for Diabetes Mellitus is 11.4% in Tyler County, 9% in Texas, and 10.9% in the US. Also, 19.26% of patients with diabetes in Tyler County do not receive Hb1Ac screening.

In relation to chronic disease management, the Assessment identified that local diabetes screening, prevalence, morbidity and mortality are at or above state averages, and above national averages. There are 19.26% Diabetics who are not receiving HbA1c screening while the Texas average is 19% and the US average is 17%. Diabetes Mellitus mortality rates are 27.5/100,000 in Tyler County as opposed to 26/100,000 in Texas and 20.9/100,000 in the US. Diabetes Mellitus Morbidity is 11.4% in Tyler County, 9% in Texas and 10.9% in the US.

Unique Community Need Identification Numbers:

CN.1 Access Barriers: Lack of Personal Resources
CN.3 Primary Care Physician Shortage
CN.12 Chronic Diseases: Diabetes

Expansion or enhancement:

This project will both expand and enhance current services. Expansion will be accomplished by increasing primary care access through expanded hours and increasing the number of providers at the RHC. Enhancements will include development and implementation of a Chronic Disease Management Program.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Category 3 Outcome Measures include to engage stakeholders, identify current capacity and needed resources, determine timelines, and implement a Disease Management Program. We will instruct patients with HbA1c >9% on Disease Management. Our goal is to establish baseline for HbA1c >9% in DY3 and to reduce HbA1c >9% (goal to be determined) in years 4 and 5.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding primary care access and emphasis on chronic disease in a rural clinic setting ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 284333601.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

Chronic Disease Management Programs, expansion of primary care projects. This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

PROJECT VALUATION:

Table A Expand Primary Care in Tyler County by adding a Primary Care Physician and LVN.

Table B Development and Implementation of a Chronic Disease Management Program.

A. Population Affected-

- The community needs assessment identified a significant amount (11.4%) of the population who were affected by diabetes, 19.6% of the population that did not receive HbA1c screening and 19.9% living at or below the poverty line in Tyler County. Those living at or below the poverty line averages are above the state and United States average. Tyler County Population is 21,766 so we estimate about 2,481 are affected by diabetes. Currently there are only 2 Physicians and 1 Nurse

Practitioner in our Clinic accepting new patients. Adding a Primary Care Physician will greatly enhance access to care.

- Score: 5 points awarded because population is affected and there is a high percentage of uninsured population.

B. Severity-

- There is a need in Tyler County to reduce the Diabetes mortality of 27.5 per 100,000 which is significantly higher than 20.9 per 100,000 for the United States. Diabetes is one of the most costly of chronic diseases which leads to many complications if untreated. There is also a need to add a Primary Care Physician because we are a Health Professional Shortage Area and a Medically Underserved Area.
- Score: 5 points awarded for severity because it is higher than State and US average.

C. Cost effectiveness –

- Measure: The estimated cost of the project is $1,003,549 over 4 years. The expected number of people reached is to be determined by DY3. There will be a reduction in need for long term care for chronic patients and Emergency Department Services.
- Score: 5 points awarded

D. Community Benefit-

- Adding a Physician will benefit the entire community since we are a Medically Underserved Area. It will improve access, quality, and reduce cost for diabetes as well as other chronic disease. We are the bottom 10% of all Texas Counties for Varicella, Respiratory and Lung Morbidity. We are at the bottom 25% of all Texas counties for Prostate, Skin and Pertussis Morbidity. Tyler County is at the bottom 25% of all Texas Counties for Chronic Lower Respiratory Disease and Diseases of the Heart.
- The US benchmark of PCP's is 10/1,000. Tyler County only has 4 physicians full-time, (2 Emergency Department full-time), 1 physician in private clinic and 5 nurse practitioners to cover a population of 21,766. Tyler County only has enough PCP's to cover 1,000 people and the population affected is 20,000.
- Score: 5 points

Total Score: 20 points

136381405.1.1	1.1	1.1.2 (a –c)	EXPAND PRIMARY CARE IN TYLER COUNTY	
Tyler County Hospital District				136371405
Related Category 3 Outcome Measure(s):	136381405.3.1	IT 1.10	Diabetes Care: HbA1c Poor Control (>9.0%)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-5. Train/hire additional Primary Care Provider and staff and/or increase the number of Primary Care Clinic's for existing providers. P-5.1 Metric 1 Documentation of increased number of providers (hire 1 physician) Baseline: 4 doctors in 2012 Goal: Hire 1 physician Data Source: Signed Rural Health Physician Agreement (Contract) Rationale: Increased number of PCPs will allow increased patient access Milestone 1 Estimated Incentive Payment $ 224,588 (90%)	Milestone 2 P-4. Expand the hours of primary care clinic including evening and/or weekend hours. P-4.1 Metric: Increased number of hours at primary clinic over baseline. Baseline – hours are 8:00 am to 5:00pm Monday thru Friday. Goal: Increase hours 8:00am to 7:00pm Monday thru Thursday, 8:00am to 5:00pm Friday and 8:00am to 12:00pm Saturday. Data Source Clinic Documentation Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients. Milestone 1 Estimated Incentive Payment $ 200,000 Milestone 3 P-5. Train/hire additional primary care providers and staff and/or increase the number of Primary Care Clinics for existing providers.	**Milestone 4** I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1 Improvement Metric: Documentation of increased number of visits. Baseline: Total number of visits prior reporting period. Goal: Improvement over prior reporting period (over baseline from DY3). Data Source: Registry, EHR, Claims, Clinic or other performing provider source Appointment Analysis Rationale: measuring the increased volume of visits demonstrates increased capacity to provide care. Milestone 4 Estimated Incentive Payment $ 263,017	**Milestone 5** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1 Improvement Metric: Documentation of increased number of visits. Baseline: Total number of visits prior reporting period. Goal: Improvement over prior reporting period DY4 with 600 visit increase. Data Source: Registry, EHR, Claims, Clinic or other performing provider source Appointment Analysis Rationale: measuring the increased volume of visits demonstrates increased capacity to provide care. Milestone 5 Estimated Incentive Payment $ 225,347

136381405.1.1	1.1	1.1.2 (a –c)	EXPAND PRIMARY CARE IN TYLER COUNTY	
Tyler County Hospital District				136371405
Related Category 3 Outcome Measure(s):	136381405.3.1	IT 1.10	Diabetes Care: HbA1c Poor Control (>9.0%)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	P-5.1 Metric 1 Documentation of increased number of providers and staff and/or clinic sites Baseline: 5 LVN's in 2012 Goal: Hire 1 staff LVN Data Source: Personnel File Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Milestone 3 Estimated Incentive Payment $60,326			
Year 2 Estimated Milestone Bundle Amount $ 224,588	Year 3 Estimated Milestone Bundle Amount $260,326		Year 4 Estimated Milestone Bundle Amount $263,017	Year 5 Estimated Milestone Bundle Amount $225,347
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $973,278				

PROJECT OPTION 1.1.2 - Expand Primary Care Access in Galveston and Brazoria Counties

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.1
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will expand primary care capacity for Galveston and Brazoria Counties by adding 8 primary care providers to meet the needs of the community for primary care services including chronic disease management and prevention.
NEED FOR THE PROJECT: Both Brazoria and Galveston counties have low ratios of primary care providers (PCPs) per 100'000 population compared to the rest of the state, resulting in a shortage of primary care access.

Primary Care Physician Statistics:

- Brazoria County 44. 2 PCPs per 100,000
- Galveston County 55.6 PCPs per 100,000
- State of Texas 69.5 PCPs per 100,000

TARGET POPULATION: Our target population is the medically underserved areas with in Galveston and Brazoria counties. Within Galveston County, there are 8 census tracts that are federally designated as Medically Underserved Areas and in Brazoria County there are 6 large areas designated as Medically Underserved Areas.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project aims to increase primary care access for patients and improve their ability to manage and prevent chronic disease. Across DY 2 - DY 5, the goal is to increase community based clinic total visit volume by just less than 10% from the baseline. With goal of increasing volume by 3% in each DY over the previous fiscal year's visit volume, we estimate that the patient impact of the project will be growth form 106,675 CBC visits in FY12 to 109,875 CBC visits in FY 13 (DY3), 113,171 CBC visits in FY14 (DY4) and 116,566 CBC visits in FY15 (DY5).
CATEGORY 3 OUTCOME: I.T-1.7 Our goal is to improve high blood pressure control among our target population.
PROJECT DESCRIPTION:
This project plans to increase primary care capacity and access for Galveston and Brazoria counties within UTMB's Community Based Clinics while focusing on controlling high blood pressure of patients. This will include the hiring of primary care providers, while focusing on controlling high blood pressure in our current patients and as well as new patients brought in through this project.
Project goal(s):
To expand the capacity of primary care by hiring 8 primary care providers over DY2-5 to better accommodate the needs of Galveston and Brazoria patient populations and community so that patients have enhanced access to services, allowing them to receive the right care at the right

time in the right setting. We will provide and expand or enhance primary care services by hiring additional primary care providers while focusing on controlling high blood pressure resulting in creating better care for individuals, better health for the community, and improved outcomes with lower overall costs.

Our project is focusing on the primary care services the Community Based Clinics (CBC) provides in Galveston and Brazoria counties. In Texas fiscal year 2012 the CBCs provided a total of 106,675 visit volume. Medicaid was approximately 15,916 visits resulting in approximately 14.92 percentage of the total visit volume.

Per the Texas Health and Human Services Commission website, the February, 2013 Point in Time Count – Medicaid Enrollment identified 30,329 "Total Enrollment" for Galveston County and 28,077 "Total Enrollment" for Brazoria County for a grand total of 58,406 "Total Enrollment" for both counties (website accessed February 7, 2013 http://www.hhsc.state.tx.us/research/MedicaidEnrollment/PIT/201302.html).

Our project goal is to increase primary care services by adding needed primary care providers in our CBCs to increase the available primary care services for our population. We expect the Medicaid visit proportion to increase equitably in our total visit increases due to the increased capacity we provide with additional providers.

Required Core Project Components:

This project will not specifically address expanding additional clinic space. We will possibly expand hours by looking at expanding available primary care clinics. Our primary focus is to provide more primary care providers to address the need of primary care access in Galveston and Brazoria counties.

Anticipated challenges:

We anticipate several overarching challenges including: (1) finding and hiring suitable primary care providers in this tight PCP market, (2) ensuring we engage the patients appropriately in managing their own health care and (3) specific community barriers for each county.

The 5-year expected outcome(s):

Hire 8 primary care providers and increase access to care for patients during DY2-5. Additionally, we plan to improve blood pressure control in the patients cared for in our primary care clinics so as to decrease the incidence of myocardial infarction, stroke, and chronic renal insufficiency. Decreasing the incidence of these significant health problems will improve the quality of life of our patients and decrease morbidity/mortality.

Regional goals:

To create a coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.

This project meets the following Region 2 goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

The baseline of the Community Based Clinics was 23.6 clinical FTE's of primary care providers on September 30, 2012.

RATIONALE:

Brazoria and Galveston County both report having lower rates of Primary Care Physicians compared to the rest of the state and thus a shortage of primary care access. As a result, 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 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 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.

Primary Care Physicians Statistics:

- Brazoria County 44.2 Primary Care Physicians per 100,000
- Galveston County 55.6 Primary Care Physicians per 100,000
- State of Texas 69.5 Primary Care Physicians per 100,000

Galveston County:

Galveston has 8 census tracts that are federally designated as Medically Underserved Areas. The number of people that reported not being able to see a doctor due to cost concerns was lower than the Texas rate, but higher than the US rate. The rate of preventable hospital stays—an indicator of lack of access to primary care—for the county is higher than the Texas rate.

The community reported the barriers to being healthy into 7 categories: *access* (insurance, resources, geographic location, and closed systems), *education* (about disease, medicine, and available resources), *environment* (access to healthy foods, recreation, and transportation), *lifestyle* (poor choices and attitudes), *population characteristics* (age, chronic diseases, obesity), *quality of care* (continuity, poly-pharmacy), *resource utilization* (inappropriate use of the emergency department, overuse by those who are well-insured). The community had several suggestions for improving health that included community based educational/support resources, increasing available hours (later and on weekends) for primary and preventive health

services, increasing the number of places to get mental health services and affordable healthy foods, providing access to weight management programs, and better transportation options.

Brazoria County:

Texas has a very high rate of uninsured, compared to the US, and although Brazoria County has a lower rate of uninsured people than Texas, it is still almost double the US rate for those under 19 years of age, and 7 percentage points higher for the population under 65. Brazoria has a lower percentage of Medicaid clients than the Texas average, but has 6 large areas that are federally designated as Medically Underserved Areas. The number of people that reported not being able to see a doctor due to cost was lower than both the Texas and US rates. The rate of preventable hospital stays—an indicator of lack of access to primary care—for the county is slightly less than the Texas rate.

The community reported the barriers to being healthy into 7 categories : *access* (insurance, resources, and closed systems), *education* (about disease, medicine, and available resources), *environment* (access to healthy foods, recreation, and transportation), *lifestyle* (poor choices and attitudes), *population characteristics* (age, chronic diseases, obesity), *quality of care* (continuity, poly-pharmacy), *resource utilization* (inappropriate use of the emergency department, overuse by those who are well-insured). The community had several suggestions for improving health that included increasing access to transportation, increasing charity care, education and support for prevention and chronic disease management, increasing access to primary and specialty care, and increasing mental health services. Other ideas for improving health included increasing wellness and exercise access, increasing services to address addiction issues, assistance navigating the system, and expanded medication assistance program.

Our project focuses on the quality outcome of controlling high blood pressure that will have a large impact on our population as we expand primary care access by increasing the number of primary care providers. Controlling high blood pressure was chosen as a focus because approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive, which are more likely to have heart failure.

Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Increasing the number of primary care providers will substantially increase primary care access for the Galveston and Brazoria counties populations.

Unique Community Need Identification numbers:

- CN.3 - Primary Care Physician Shortage
- CN.8 – Lack of Mid-Level Provider Shortage
- CN.10 – High ED Utilization Rates
- CN.11 – 30 Day Readmission Rates

Expansion or enhancement:
This project is an expansion of our current primary care services by adding additional primary care providers in both Galveston and Brazoria Counties.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD-1 Primary Care and Chronic Disease Management:
IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)[228]. (Standalone measure).

Reasons/rationale for selecting the outcome measure:
Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive, which are more likely to have heart failure. Yearly goals will be established according to national benchmark goals.
We are focusing on Controlling High Blood Pressure in order to impact a large part of our population. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.
In order to increase the population we serve we are looking at increasing access to our primary care providers as access to health care providers is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have higher satisfaction, will likely return to work sooner, and may well have better medical outcomes.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding primary care access In Galveston and Brazoria Counties and emphasis on controlling high blood pressure ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 284333601.1.1, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-

Expand Existing OB/GYN Primary Care Capacity; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity.**PLAN FOR LEARNING COLLABORATIVE:**

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.1	1.1.2	1.1.2 (A-C)	EXPAND PRIMARY CARE ACCESS IN GALVESTON AND BRAZORIA COUNTIES	
The University of Texas Medical Branch at Galveston				TPI - 094092602
Related Category 3 Outcome Measure(s):	094092602.3.1	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinics. Goal: Train/hire 2 additional primary care providers in DY2. Baseline: 23.6 clinical FTE's of primary care providers on September 30, 2012. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. Milestone 1 Estimated Incentive Payment: $1,681,336	**Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinics. Goal: Train/hire 2 additional primary care providers in DY3. 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: $1,489,677 **Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-12.1]: Documentation of increased number of visits (excluding providers who are not seeing patients	**Milestone 4[**P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 2 [P-5.1]: Documentation of increased number of providers and staff and/or clinics. Goal: Train/hire 2 additional primary care providers in DY4. 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 4 Estimated Incentive Payment: $2,317,608 **Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-12.1]: Documentation of increased number of visits (excluding providers who are not seeing patients	**Milestone 6 [**P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 2 [P-5.1]: Documentation of increased number of providers and staff and/or clinics. Goal: Train/hire 2 additional primary care providers in DY5. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. Milestone 6 Estimated Incentive Payment: $ 2,321,029 **Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-12.1]: Documentation of increased number of visits (excluding providers who are not seeing patients

094092602.1.1	1.1.2	1.1.2 (A-C)	EXPAND PRIMARY CARE ACCESS IN GALVESTON AND BRAZORIA COUNTIES	
The University of Texas Medical Branch at Galveston				TPI - 094092602
Related Category 3 Outcome Measure(s):	094092602.3.1	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	due to maternity, surgery, or FMLA). Demonstrate improvement over prior reporting period. Goal: Increase Community Based Clinic (CBC) Total Visit volume by 3% for the period DY3 from baseline. Baseline: CBC Total Visit volume during FY12. Data Source: Registry, EHR, claims or other Performing Provider source. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Milestone 3 Estimated Incentive Payment: $1,489,677		due to maternity, surgery, or FMLA). Demonstrate improvement over prior reporting period. Goal: Increase Community Based Clinic (CBC) Total Visit volume by 3% for the period DY4 from baseline. Baseline: CBC Total Visit volume during FY13. Data Source: Registry, EHR, claims or other Performing Provider source. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Milestone 5 Estimated Incentive Payment: $2,317,608	due to maternity, surgery, or FMLA). Demonstrate improvement over prior reporting period. Goal: Increase Community Based Clinic (CBC) Total Visit volume by 3% for the period DY2-DY5 from baseline. Baseline: CBC Total Visit volume during FY 14. Data Source: Registry, EHR, claims or other Performing Provider source. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Milestone 7 Estimated Incentive Payment: $2,321,029
Year 2 Estimated Milestone Bundle Amount: $1,681,336	Year 3 Estimated Milestone Bundle Amount: $2,979,354		Year 4 Estimated Milestone Bundle Amount: $4,365,217	Year 5 Estimated Milestone Bundle Amount: $4,642,059
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,667,966				

PROJECT OPTION*:* 1.1.2 Expand Primary Care Capacity

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.2
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/094092602

Title of Project: 1.1 **-** Expand Primary Care Capacity - Pediatric Urgent Care Clinic Expansion
PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will expand primary care capacity for the pediatric population on Galveston Island and reduce inappropriate use of the emergency department by expanding the pediatric urgent care clinic including physical expansion, as well as, increases in staffing and clinic hours.
NEED FOR THE PROJECT: One third (28.3%) of the total Galveston County population falls under the age of 19 and, within Galveston County, there are 63% less primary care physicians than the United States and 25% less than the rest of the state of Texas. Currently the urgent care clinic is operating above capacity and is unable to meet the primary care needs of the pediatric population leading to increased utilization of the emergency department.
TARGET POPULATION: Our target population is the pediatric population on Galveston Island who are currently unable to or have difficulty in accessing pediatric primary care servicesThere is an estimated 9200 children living on Galveston Island (2011) and more than 38% of these children are on Medicaid. (~3500 children on Medicaid). Expansion of the pediatric urgent care clinic will better allow us to provide primary care services to this demographic.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project aims to increase access to primary care and ensure our pediatric patients are receiving the right level of care at the right time and in the right acuity setting, by expansion of the pediatric urgent care clinic staffing, space, and hours. This project is also seeks to improve patient satisfaction with primary care services.
CATEGORY 3 OUTCOME: I.T-6.1 Our goal is to increase patient satisfaction by increasing access to primary care through the expansion of our pediatric urgent care clinic.
PROJECT DESCRIPTION
This project includes an expansion of our current pediatric after hours urgent care clinic to better meet the needs of our pediatric population on Galveston Island.
Core Components:

a) Expand primary care clinic space-- plan is to expand pediatric primary care space for Urgent Care Clinic from 1,800 sq ft to 7,000 sq.ft.
b) Expand primary care clinic hours—the Urgent Care Clinic will be open after hours and on weekends. We will extend hours by at least one hour per day.
c) Expand primary clinic staffing-- additional healthcare providers will be added to use the expanded space (12 additional exam rooms) and to cover the additional hours.

Project goal(s)
To provide the right level of care to our pediatric patients, at the right time in the right acuity setting by offering greater access to pediatric urgent care on Galveston Island and thus reducing the inappropriate use of our emergency department .

Anticipated challenges:
The first challenge associated with this project includes securing a suitable location for the clinic expansion that is on 61st in Galveston, TX, a high traffic area with easy access for our patients. The new space needs to provide adequate access, parking and signage. Build out and construction adds an increased complexity to our project timeline. Space options are currently being assessed. Communication to patients regarding the new services will be paramount in making this a successful project. Marketing tools with expansion details and location change will be developed to inform the community of these beneficial changes.

The 5-year expected outcome(s):
The goal and expected outcome of this project is to provide the right level of care to our pediatric patients, at the right time in the right acuity setting by offering greater access to pediatric after hours urgent care on Galveston Island and thus reducing the inappropriate use of our emergency department. We will specifically increase access for patients in this community by expanding the time available for obtaining care in the most appropriate setting. This will decrease the need for inappropriate Emergency Room visits. By year 5 we expect to increase patient access by 15% over baseline (increase from 7311 to 8407 visits).
Our Improvement Targets (Its) both are related to Patient Satisfaction. We are specifically concerned with patient satisfaction related to obtaining timely care, immediate appointments, and information. Secondly, we plan to measure how well doctors communicate with patients. Both of these Improvement Targets will support the overall project mission of providing the right level of care in the proper acuity setting with the best communication between the patient and the provider.

Regional goals:
1. Improve the health of our region by expanding and coordinating access to patient centered primary care and behavioral healthcare services that includes health promotion and disease prevention.
2. Grow the health system resources in our region by expanding and enhancing training of the healthcare work force.

STARTING POINT/BASELINE
In FY2011 the 61st Urgent Care Clinic had 7,311patient visits. This will be used as the baseline for our expansion project.

RATIONALE

Relation between Project Choices and Community Needs:
Category 1 Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. We will offer expanded access to pediatric urgent care in order to reduce the number of pediatric emergency department visits for non-emergent conditions. Caring for patients in a closely linked primary care/urgent care model maximizes the use of a shared electronic medical record, provides

expanded access to pediatricians, and promotes care in the most appropriate and economical setting.
It is well known that the current national supply of primary care providers does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHPs must expand primary care capacity in order to implement the health care delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

Galveston County has a population of 291,309. Nearly one third (28.3%) of that population falls under the age of 19. According the Community Health Needs Assessment for Region 2, Galveston County currently has a rate (per 100,000) of primary care physicians of 55.6, compared to 69.5 in the state of Texas, and 91.0 in the United States. These numbers show that Galveston County has 25% less primary care physicians that the rest of the state of Texas, and 63% less than the United States average. This is a significant difference and we believe our project will assist in reducing this gap and expand the preventive care and urgent care we are able to provide, thus reducing inappropriate emergency department admissions. Children comprise a significant portion of our population, and the ability to meet their health care needs is essential to the growth and sustainability of a healthy community.

In our current system, pediatric patients often receive services in the emergency room setting for conditions that could be managed in a more coordinated manner, if provided in the urgent 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 be seen 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.

Patient satisfaction with primary care services is largely related to utilization of primary care services. Understanding strengths, needs and receiving patient feedback allows for providers and staff to better understand how to tailor care delivery to meet their patients' needs.

Unique Community Need Identification numbers:

CN.3 PRIMARY PHYSICIAN SHORTAGE

CN.10 HIGH ED UTILIZATION RATES

Expansion or enhancement*:*

This project greatly enhances service availability for the children in our community. The clinic is currently over capacity and unable to meet the needs of our patient population. Expanding from 4 to 9 exam rooms gives a much greater ability to meet these needs. The current clinics

capacity issues and lack of the necessary radiology capabilities, often requires patients to be seen in the emergency department for these services. Space is needed to add providers and support staff in order to accommodate additional patients. The first process measure for this project is to engage the clinic staff and the community in communications regarding the construction phase of this project and the plans for expansion. Having the staff engaged in the project is key to successfully expanding the care delivery team. Having the community engaged in the project will be key to a smooth transition to the newly expanded clinic and realizing improved access to pediatric primary care.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

IT-6.1 Patient Satisfaction

This improvement targets selected is key to the success of this project. The improvement in patient satisfaction scores is a tool to validate that our goals in this project are being met. Patient satisfaction with primary care services is largely related to utilization of primary care services. Understanding strengths, needs and receiving patient feedback allows for providers and staff to better understand how to tailor care delivery to meet their patients' needs. By selecting outcome improvement measures related to patient satisfaction aimed at improvement above the national average, the project will have solid data to justify success in increasing timely care and improving communication between doctors and patients. We anticipate improving our patient satisfaction scores by 2% over the 5 year project period. Baseline for patient satisfaction score will be set during DY3.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding urgent care and emphasis on pediatrics in Galveston County ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the

region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.2	1.1.2	1.1.2 (A-C)	EXPAND PRIMARY CARE CAPACITY - PEDIATRIC URGENT CARE CLINIC EXPANSION	
The University of Texas Medical Branch at Galveston				TPI - 094092602
Related Category 3 Outcome Measure(s):	094092602.3.2	IT-6.1	Percent Improvement over baseline of patient satisfaction scores.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: [P-8 **Milestone 1: [P-X] Engage the community and staff in plans to expand the Pediatric Urgent Care Clinic** **Metric:** Develop community outreach and marketing materials and staff training to assure clear communications on urgent clinic construction phase and clinic expansion initiative. **Data Source:** Documentation of plan for staff and community engagement. Materials developed to support engagement activities. **Baseline:** No communication has taken place regarding plans to expand the Pediatric Urgent Care Clinic: **Rationale:** Involving staff in the planning for the clinic expansion is key to effectively expanding the care delivery team in the expanded space and additional hours. Having knowledgeable staff will improve communications with patients regarding upcoming changes. Likewise engaging the community is key to assuring a smooth transition to the newly expanded space and extended hours. Milestone 1 Estimated Incentive	**Milestone 2: [**P-1] Expand existing and relocate existing pediatric urgent care clinic located on 61st in Galveston, Texas to a new location. Metric 1: [P-1.1] Expanded hours or space documented by detailed expansion plan. Data Source: Project documentation of expanded space. Baseline: current space is 1,800 sq ft Milestone 2 Estimated Incentive Payment (maximum amount): $163,362 **Milestone 3: [**P-4] Expand the hours of the Pediatric Urgent Care Clinic including weekend, evening and holiday hours. Metric 1: [P-4.1] Increased number of hours at Pediatric Urgent Care Clinic over baseline. Baseline: The current hours of operation are 5:30pm-10:00pm M-F, 10am-8pm Sat, Sun and Holidays.		**Milestone 4**: [**I.12]** Increase urgent care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1:[I.12.1] Documentation of increased number of visits. Demonstrate improvement over reporting period. Goal: Increase total number of visits over baseline (7311 visits) by 7.5%.(increase to 7860 visits) Data Source; Electronic Medical Record; EPIC. Milestone 4 Estimated Incentive Payment: $508,249	**Milestone 5**: [**I.12]** Increase urgent care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1:[I.12.1] Documentation of increased number of visits. Demonstrate improvement over reporting period. Goal: Increase total number of visits over baseline by 15% (increase to 8407 visits). Data Source; Electronic Medical Record; EPIC. Milestone 5 Estimated Incentive Payment: $351,645

094092602.1.2	1.1.2	1.1.2 (A-C)	EXPAND PRIMARY CARE CAPACITY - PEDIATRIC URGENT CARE CLINIC EXPANSION	
The University of Texas Medical Branch at Galveston				TPI - 094092602
Related Category 3 Outcome Measure(s):	094092602.3.2	IT-6.1	Percent Improvement over baseline of patient satisfaction scores.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment (maximum amount): $194,705	Goal: To increase hours of operation on weekdays from 5:00pm – 10:30pm, and on the weekends/holidays from 9:00am-8:00pm; or as demand allows. Data Source: Clinic documentation of increased hours of operation increase and volumes. Milestone 3 Estimated Incentive Payment: $163,363			
Year 2 Estimated Milestone Bundle Amount: $194,705	Year 3 Estimated Milestone Bundle Amount: $326,725		Year 4 Estimated Milestone Bundle Amount: $508,249	Year 5 Estimated Milestone Bundle Amount: $351,645
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,381,324				

PROJECT OPTION: 1.1.2 Expand Primary Care Capacity

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.3
PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

Title of Project: 1.1.2 Expansion of Alvin Primary Care Clinic to Include Adult Care

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will use Alvin Primary Care Clinic to expand primary care capacity for the pediatric and adult population within Brazoria County by expanding existing primary care services to include adult services and relocating the clinic to a more accessible area. Primary care access will also be improved through the development of a Patient Centered Medical Home and expanding clinic hours and staffing. We currently have over 15,000 pediatric clinic visits a year; we are targeting an addition of 5,000 adult primary care visits in DY3. Adopting the Patient Centered Medical Home model will focus on team-based care, prevention and management of chronic disease.
NEED FOR THE PROJECT: Brazoria County is a historically underserved population, with a percentage of primary care providers per 100,000 residents that falls below both state and national averages. The current clinic schedules just below 15,000 visits annually and is in a location that will not allow for future growth nor meet the needs of the growing patient base.
TARGET POPULATION: The target population is the pediatric and adult population within Brazoria County who has trouble accessing much needed primary care and prevention services and lacks a coordinated care continuum. The current pediatric patient population is 68% Medicaid, with the expansion of Medicaid eligibility and the adult clinic, it is expected that the percentage of government payors (Medicaid and Medicare) will remain around 70% for this clinic location.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project seeks to improve access to primary care physicians and services by relocating the clinic to a more accessible and visible area, while focusing on patient and family centered care. By improving access, clinic visits are expected to increase in DY4 and DY5 by 5% over the prior reporting period.
CATEGORY 3 OUTCOME:

- I.T-1.1 The goal is to decrease the number of days to the third next available appointment for primary care to zero.

I.T-6.1 Another goal of the project is to increase patient satisfaction by improving access to primary care through the expansion of the Alvin Clinic to include adult services.

PROJECT DESCRIPTION:

UTMB Health plans to expand primary care for both adults and children in Brazoria County, a historically underserved population. The expansion will increase existing pediatric primary care

services with the addition of adult care. This expansion will require identifying and equipping appropriate facilities to co-locate the existing pediatric clinic with the proposed adult care clinic. The current facility that houses the pediatric clinic is landlocked, and is not in a location that provides good visibility or ease of access.

The project will improve access in an underserved area and provide a medical home that will promote wellness and coordinate care across the continuum, including tertiary and quaternary care when necessary. The medical home will capitalize on the shared EMR and MyChart communication tools. UTMB Health Ambulatory Operations, in conjunction with Faculty Group Practice, will staff the new expanded clinic. In early demonstration years, focus will be placed on building the practice by encouraging primary care access to individuals without a medical home. In later demonstration years, the clinic will continue to expand adult services in order to meet the needs of the growing Brazoria population.

Project Goals:

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

Anticipated Challenges:

The current clinic is in a location that cannot provide future growth and is not easily accessible for the geographic area to be served. In addition, growing the patient base and improving self-care education in a population that historically has not embraced preventive care. This project will address these challenges by first identifying an appropriate facility to for the existing pediatric practice and allow for implementation of the adult primary care clinic. The facility will be in a location that is visible and accessible from major highways, and provides ample off street parking. Co-locating the pediatric and adult primary care clinics will meet the UTMB objective to provide family centered care. The design will incorporate adult and pediatric (well and sick) waiting areas, and space to provide patient resource materials.

To address the community health goals, the clinics will become Patient Centered Medical Home (PCMH) sites, and will focus on prevention, health self-management and chronic disease management. This underserved area will require PCMH resources and support to develop a partnership role with the provider in their care; the model will include a team approach by the clinic, with the Health Coach playing a key role. Implementation of the PCMH model will be in parallel with the relocation of pediatrics and initiation of adult primary care.

5 year Expected Outcomes:

After appropriate planning and data systems development, The 5 year outcomes expected for the expansion of primary care are patient access to services, as measured by the Third Next Available Appointment (IT – 1.1) and an a percent increase in patient satisfaction scores (IT-6). Using the third next available appointment as a measure to determine appropriate access to primary care services, at the end of the five year period to goals is to have 0 days to third

available appointment. These goals were chosen to represent the objective of the Patient Centered Medical Home, providing access to team care for patients. The third available appointment will measure access, and the overall patient satisfaction measure will determine whether we have achieved the objectives in the patient's opinion

Regional Goals:

Improve the health of our region by expanding and coordinating access to patient centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

The pediatric clinic currently sees just fewer than 15,000 visits annually, based on the population and demographics; we are expecting about 5000 adult patient visits in year 3, with an annual incremental growth of . 1,500 patients in each of the years 4 and 5. An additional annual incremental growth of 5% for pediatric patients is also anticipated.

RATIONALE:

Relationship between Project choices and Community Needs:

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.

Category Project Area: 1.1.2 Expansion of Alvin Primary Care Clinic to Include Adult Care includes the following required core project components:

a) Expand primary care clinic space – currently working with UTMB real estate office to identify locations and developers to plan for the expanded and relocated family health clinics. A location has been identified, and approved by UTMB Facilities Steering Committee, and will be on the May 2013 agenda for the UT System Board of Regents.
b) Expand primary care clinic hours - Alvin pediatrics currently has one evening a week of extended hours for patient appointments, Saturday hours and same day appointments are being evaluated.
c) Expand primary care clinic staffing – The business plan identifies the additional staffing that will required to implement the adult primary care clinic, co-locating the adult and pediatric clinics will result in some economies of scale for support staff.

To do this we will use the following process and improvement milestones:
Year 2
P-1 Establish additional /expand existing/relocate primary care clinics P-1.1. Metric: Number of additional clinics or expanded hours or space a. Documentation of detailed expansion plans b. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. c. Rational: The shortage for adult primary care for adults is well known. Baseline/Goal: Expand space by at least 6 exam rooms.
Year 3
P-5.1 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.
Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation Rational: Additional staff for adult primary care is necessary.
P-4 Expand the hours of primary care clinic, including evening and/or weekends Metric 1: P4.1 – Expand hours for evening clinics Data Source: Posted clinic hour schedule Rationale: Improved access and patient choices.
Years 4 and 5
I.12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. P.12.1 Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Baseline/goal: Total number of visits for reporting period at least 5% per year. b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale: demonstrates ability of provider to increase capacity

Unique Community Need Identification Numbers:

CN.1, CN.3, CN.10

Expansion/Enhancement:

Provides primary care in an underserved area, and builds on an existing successful pediatric clinic serving adults. The pediatric clinic in Alvin currently sees approximately 15,000 visits annually. Projections based on the community needs assessment estimate that the pediatric volume will increase by 5% and the incremental volume of adult patient visits will be just under 5,500 in milestone year three, and will continue to increase by a similar percentage in milestone year 4. There is no state or federal fund currently be used for this project.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

To implement category three measures we will implement three process measures:
P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Data source: Business Plan Rationale: New project startup. Goal: Document implementation plan. Determine timeline.**P-2:** Establish baseline rates Data source: Epic Goal: Initiate registry Rationale: New project startup; and **P-3:** Develop and test data systems Data source: Epic Reports/Patient Registries Goal: Implement new registry. Rationale: New project start up.

Outcome targets for this project are selected from two domains.
OD 1 Primary Care Expansion
OD-6 Patient Satisfaction

IT-1.1 Third next available appointment [217,218]: (Non- standalone measure)
Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. b. Denominator: This measure applies to providers within a reported clinic and/or Department Inclusions: This measure applies to providers* within a reported clinic and/or department**
*Providers: A. All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week. 1. Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice). 2. When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA).
Overarching Goals: Decrease number of days to third next available appointment to zero Days (same day) for Primary Care.
 Data Collection: Sample all physicians on team the same day of the week, once a week. Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Report the average number of days for all physicians sampled. Note: Count Calendar days (e.g. include weekends) and days off. Do not count any saved appointments for urgent visits (since they are "blocked off" on the schedule.) The data collection can be done manually or electronically. Manual collection means looking in the schedule book and counting from the "index" (day when the "dummy" appointment is requested) to the day of the third available appointment. Some electronic scheduling systems can be programmed to compute the number of days automatically.
217 http://www.ihi.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx
218 http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918

IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure***)*** Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) Are getting timely care, appointments, and information; (**Standalone measure)**

a Numerator: percent improvement in satisfaction in targeted patient satisfaction domain
b Data Source: Patient survey c Denominator: Number of patients who were administered the survey
d Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on

care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding primary care and emphasis on adults and children in Brazoria County ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 121805903.1.3, 284333601.1.1, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of primary care capacity along with these other Category 1 projects in our RHP: 121805903.1.1-Establish More Primary Clinics-Pediatrics; 121805903.1.2 - Establish More Primary Care Clinics-Primary Care;112671602.1.1-Expand Existing Primary Care Capacity; 1328296208.1.1-Establish More Primary Care Clinics; 019053001.1.1-Expand Existing Primary Capacity; 139172412.1.1-Expand Primary Care Capacity;131030203.1.1-Expand Primary Care Capacity; 131030203.1.2-Expand Primary Care Capacity-Perinatal Care; 1363814405.1.1-Expand Primary Care; 094092602.1.1-Expand Primary Care Access in Galveston & Brazoria Counties; 094092602.1.2-Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion; 094092602.1.3-Expansion of Alvin Primary Care Clinic to include Adult Care; 121805903.1.3-Expand Existing OB/GYN Primary Care Capacity; ; 284333601.1.1- Expand Existing Primary Care; 261955689.1.1 Expand Existing Primary Care Capacity

PLAN FOR LEARNING COLLABORATION:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning

collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.3	1.1.2	1.1.2 (A-C)	EXPANSION OF ALVIN PRIMARY CARE CLINIC TO INCLUDE ADULT CARE
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	**094092602.3.4** **094092602.3.3**	**IT-1.1** **IT-6.1**	**IT-1.1 Third next available appointment** **IT-6.1 Percent improvement over baseline of patient satisfaction**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1. Establish additional /expand existing/relocate primary care clinics P-1.1. Metric: Number of additional clinics or expanded hours or space a. Documentation of detailed expansion plans b. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. c. Rational: The shortage for adult primary care for adults is well known. Baseline/Goal: Expand space by at least 6 exam rooms. Milestone 1 Estimated Incentive Payment): $5,532,921	**Milestone 2** P-5.1 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation Rational: Additional staff for adult primary care is necessary. Milestone 2 Estimated Incentive Payment: $2,038,309 **Milestone 3** P-4 Expand the hours of primary care clinic, including evening and/or weekends Metric 1: P4.1 – Expand hours for evening clinics a. Data Source: Posted clinic hour schedule b. Rationale: Improved access and patient choices.	**Milestone 4** I.12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. P.12.1 Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Baseline/goal: Total number of visits for reporting period at least 5% per year. b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale: demonstrates ability of provider to increase capacity Milestone 4 Estimated Incentive Payment: $2,771,179	**Milestone 5** I.12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. P.12.1 Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Baseline/goal: Total number of visits for reporting period at least 5% per year. b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale: demonstrates ability of provider to increase capacity Milestone 5 Estimated Incentive Payment: $2,266,200

094092602.1.3	1.1.2	1.1.2 (A-C)	EXPANSION OF ALVIN PRIMARY CARE CLINIC TO INCLUDE ADULT CARE	
The University of Texas Medical Branch at Galveston				**094092602**
Related Category 3 Outcome Measure(s):	**094092602.3.4** **094092602.3.3**	**IT-1.1** **IT-6.1**	**IT-1.1 Third next available appointment** **IT-6.1 Percent improvement over baseline of patient satisfaction**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 Estimated Incentive Payment: $2,038,309			
Year 2 Estimated Milestone Bundle Amount:): $5,532,921	Year 3 Estimated Milestone Bundle Amount: $4,076,617		Year 4 Estimated Milestone Bundle Amount: $2,771,179	Year 5 Estimated Milestone Bundle Amount: $2,266,200
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $14,646,917				

PROJECT OPTION: 1.3.1 Implement and use chronic disease management registry

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.4
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/094092602

Title of project: Chronic Disease Management Registry
PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured. UTMB is home to the Texas Transplant Center which provides transplant programs in kidney, pancreas, heart, lung, and liver as well as a hepatobiliary program and pancreatic islet program.
INTERVENTIONS: This project will establish a patient registry that will improve chronic disease tracking and management within patient populations diagnosed with chronic diseases/ end stage organ failure that may benefit from transplantation across Texas and neighboring states. The registry will provide a way to streamline documentation and manage, evaluate, and treat patients' chronic diseases by tracking key patient information, helping to identify gaps in patient treatment, and improve rates of preventative care. Additionally this project will improve waitlist compliance monitoring, decrease time from referral to listing of renal patients, and reduce the readmission rate for patients receiving ventricular assist devices.
NEED FOR THE PROJECT: Within RHP 2, a significant portion of the population has been diagnosed with chronic diseases that can lead to end-state organ failures. We need to promote early enrollment of patients experiencing end-state organ failure to ensure waitlist compliance monitoring.
Within RHP 2:

- Diabetes prevalence ranges 9.3 to 13.4%
- Diseases of heart mortality prevalence ranges 201.5-295.2 per 100,000
- Pulmonary disease prevalence is 6.9-13.1 per 100,000

TARGET POPULATION: The target populations are patient populations diagnosed with chronic diseases and end stage organ failure that may benefit from transplantation across communities in Texas and neighboring states. The baseline for this project is the 200 with end stage organ disease currently on our organ transplant waitlist.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project seeks to improve the health of the region by expanding and coordinating access to specialty care services, chronic disease management and improved end-stage organ failure patient management. Patients will receive improved rates of preventative and maintenance care and see increased communication with their care team to address their individual needs.
CATEGORY 3 OUTCOME:
Outcome measures for this project includes a stand-alone measure from OD-3, Potentially Preventable Re-Admissions- 30 Day Readmissions Rate (PPRs), IT-3.12 Other-Readmission Rate (Venticular Assist Devices-- VAD) combined with 2 additional non-standalone measures taken

from OD-1, Primary Care and Chronic Disease Management: I.T-1.20 (a) Improved waitlist compliance monitoring and I.T-1.20 (b) Decrease time from referral to listing of renal patients.

These measures were chosen for this project because 1) VAD represent a sub-population that receive their pre-treatment and hospitalization/intervention here at UTMB so can be tracked through their hospital care and post discharge follow-up care; 2) tracking patients on the waitlist to facilitate medical management and monitoring of patients with chronic disease resulting in organ failure to ensure continued suitability for organ transplantation as a potential treatment option for patients with chronic disease, as required by federal regulation improves patient outcomes, and 3) decreasing the time from referral to listing on the transplant waitlist for patients with end stage renal would decrease the time a patient is on dialysis waiting for a suitable organ resulting in a reduction in costs (dialysis) and potential improved quality of life.

PROJECT DESCRIPTION:

Develop and implement an electronic patient registry that facilitates and tracks the medical management, evaluation and treatment of patients with chronic disease/end stage organ failure that may benefit from transplantation. The population served is primarily focused on patients in communities throughout Texas but also includes those in neighboring states. The certified Epic EMR (currently installed at UTMB and already in use by the transplant service), meets meaningful use standards, and was subject to HITECH incentive funds, but is only designed to electronically support discrete patient encounters. The transplant registry proposed here provides the capability to follow transplant patient population longitudinally and receives no HITECH support.

CORE COMPONENTS:

a) Enter patient data into unique chronic disease registry –allows for transition of data from multiple sources to include local databases, excel spreadsheets, paper documents, EMR, and external federal registries to one unique registry for potential transplant candidates with end stage organ failure/disease and organ donors to allow for more efficient tracking, early identification of co-morbidity development and improved communication with referring providers.

b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need - allows for tracking and follow-up of patients throughout the continuum of care from referral for end stage disease management or treatment through transplantation or donation.

c) Use registry reports to develop and implement targeted QI plan – allows for tracking of key performance indicators required by regulation and/or as necessary to ensure the delivery of quality patient care identified in our existing quality assurance and performance improvement 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 – A project implementation plan will be adhered to which outlines an initial scope and goals for the successful implementation of the database registry including periodic quality reviews and course corrections.. The project plan takes into consideration project impacts, and the potential to utilize the registry for tracking of an increased number of patients.

Project goal(s):

Implement a disease management registry for patient populations diagnosed with a selected chronic disease –end stage organ failure. By tracking key patient information, a disease registry can help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions:

- Prompt the multidisciplinary team to conduct appropriate testing and follow-up based on presence of co-morbidities and diagnosis'.
- Promote early identification and treatment of issues that may result in increased readmission rates.
- Identify patients who are due for testing and evaluation procedures based on patient need and regulatory requirements.
- Provide reports to identify compliance with patient management recommendations and regulatory requirements by individual care teams and providers in the delivery of recommended care to patients with chronic disease/end stage organ failure.

PROJECT BASELINE:

The baseline for this project is the 200 with end stage organ disease currently on our organ transplant waitlist. The current 30 day readmission rate for patients receiving VADs is 38%. There are currently 0 patients in the chronic disease registry being monitored and medically managed to ensure continued suitability for organ transplantation. The current median time from referral to listing of patients with end-stage renal disease is 229 days.

Anticipated challenges*:*

- Interface of existing data that is stored in multiple locations to include spreadsheets, access and oracle databases into the new registry. The steering committee will determine the scope of the project and dedicated IT and staff will collaborate to build the appropriate interfaces to ensure continuity of patient care.
- Staff training on utilization of a new registry (learning curve). Training will be provided to staff in multiple venues to include teleconference, hands on training and distribution of training documents to serve as an ongoing education resource. In addition, IT and the department will identify super users that will be available to staff to answer questions and provide additional training, as needed. One of the benefits of this registry is that the developer allows for customization at the institutional level. In order to effectively utilize the registry this customization must be prioritized to meet the needs of this challenging patient population while having the ability to quickly respond to changes in regulatory requirements. We have collaborated with an alpha site for the registry to serve as a

resource as we identify the customization needs for our program and develop a timeline for implementation.

The 5-year expected outcome(s):

The five year expected outcome for this project are to reduce the VAD readmission rate by 6% (from baseline of 38% to 36%; to have 100% waitlist compliance monitoring for all 200 baseline patients; and to decrease the time for median days from referral to listing for end stage renal failure patients by 20% (from 229 days to 183 days.)

Regional goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.

e)

RATIONALE:

Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the registry will include clinician prompts and reminders, which should improve rates of preventive care.

Milestones for this project include: (P-2) an assessment of current capabilities against current and future needs. It is necessary to understand what we need from the registry to set appropriate goals for optimal care management. This will assist us to develop an accurate timeline, create an education plan and to develop resources to support our other milestone (P-6) focusing on initial and ongoing staff training to ensure optimization of registry capabilities. Other improvement milestones include (I-15) progressive increase of patients enrolled in the registry, and (I-18) evaluation of effectiveness of the registry through monitoring of patient compliance and adherence to follow-up visits, tests and procedures, which is currently an inefficient, unreliable manual process. Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care and communication with referring providers internally and externally. A recent abstract presented at the United Network Of Organ Sharing (2012): WAITLIST MANAGEMENT IN KIDNEY TRANSPLANT PROGRAMS: A PRACTICE REVIEW by Xiaohua "Sarah" Wu, MSN, FNP-BC, Vanderbilt Transplant Center, concluded that 80% of transplant programs re-evaluate their patients on a regular time interval and those with effectively manage their waitlist have a lower death (mortality rate) than those who have not implemented this position and/or practice.

To promote continuous quality and process improvement efforts we have selected an additional milestone (P-14) that includes participation in meetings with other providers and the RHP to meet and share ideas and "raise the floor". Through this investment we have the opportunity to share ideas, learn from others and to participate in activities to collectively "raise the bar" of performance internally and externally.

Unique Community Need Identification numbers:
CN.12, CN.14, CN.15
Expansion or enhancement:
We are not currently receiving state or federal funding for this project.
RELATED CATEGORY 3 OUTCOME MEASURE(S):
P-3 Develop and Test Data Systems – to ensure accuracy and effectiveness of the system, we will periodically run monthly reports to verify status on enrollment of patients into the registry and accuracy of reminders. Through ongoing testing of the system, we can identify and address issues in a timely and efficient manner.
IT 3.12 Lower PPR for VAD) Decrease readmission rates in the Ventricular Assist Device population (VAD) as the registry allows for more effective patient tracking pre transplant/VAD implantation procedure to ensure that patients are compliant; post procedure which allows for early identification and treatment of factors that may influence readmission, such as non-compliance with the medical regimen. One goal is to decrease VAD readmission rates within 30 days of discharge from implantation by 3% initially and 5% over baseline by year 5 .Baseline readmission is 38% within 30 days of VAD procedure in FY12. A ventricular assist device (VAD) is a technological advance that artificially assists the heart thus controlling the signs and symptoms of heart failure. Through the utilization of this technology readmission rates are expected to decrease. This also provides a means for patients with end stage cardiovascular disease to survive until cardiac transplantation is a viable option.
IT-1.20 (a) Other Improvement Targets – are monitoring of compliance with the medical regimen follow-up schedule for patients with end stage organ failure currently on the organ transplant waitlist. The baseline for this target is 0/200 currently waitlisted patients, as the current process for monitoring is manual and very labor intensive. This population will grow over time with program growth. Our goal is to effectively monitor 100/200 patients to be enrolled in the registry with progression to 200/200 of patients enrolled by year 5. IT 1-20 (b) Decrease time from referral to listing on the transplant waitlist. The registry allows for tracking of progress of patients toward listing. The goal would be to decrease from the baseline of 229 days by 3% and 5% respectively by year 5 which results in a decrease in dialysis days and potential for improved quality of life for patients currently suffering from end stage organ disease.
Overall effectiveness of the registry is measured by the ability to accurately track patient's due dates for follow-up visits and, testing and compliance with the health maintenance schedule throughout all phases of patient care for this high risk population. CMS Conditions of Participation (CMS CoP 482.94) for Transplant Centers and the United Network for Organ Sharing (UNOS) require evaluation testing for patients with end stage organ failure, as well as, continued testing and monitoring to treat the chronic condition through transplantation. The registry provides an effective tool to track patient data in one central location to improve communication with the primary/referring community physician throughout all phases of transplantation from referral to post-transplant. The registry allows for patient data to be maintained in a single repository. This registry allows for streamlining of shared information to primary care providers and referring physicians. As reported in "Ending the Document Game" one of every seven primary care visits is affected by missing medical information. A single repository for patient information minimizes this risk and allows for the opportunity to

communicate and/or access a complete patient record electronically to promote collaboration with the over 50% of primary care physicians currently utilizing an electronic format for medical records (as published in Information Week HealthCare July 13, 2010). Additional benefits of this patient registry is that it provides a repository for patient data improving the ability to track patients and their progress toward listing which allows for a reduction in the time from referral to listing and early identification and treatment of issues that may increase readmission rates, such as, non-compliance with follow-up. As continuous monitoring and collaboration with primary care providers is essential throughout all phases of transplantation from referral to post-transplant, this registry provides a means of effective management of this chronic and challenging patient population improving communication, and through patient tracking of due dates for testing; ensures early identification and treatment of infection and/or rejection to ensure optimal medical management and health status for the waitlisted patient as well as decreasing the risk of organ failure and return to end stage organ disease for the post transplant patient.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on implementing a patient registry and emphasis on transplantation and end stage organ failure ties to these Category 1 and 2 projects in our RHP: 131030203.1.3, 094092602.1.4, 094092602.1.5, 138296208.2.1, 094092602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of chronic disease registry along with these other Category 1 projects in our RHP:131030203.1.3 - Implement a chronic disease management registry; 094092602.1.4 - Transplantation chronic disease management registry; 094092602.1.5-Implement and utilize disease management registry.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.4	1.3.1	1.3.1 (A-D)	IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY
The University of Texas Medical Branch at Galveston			TPI: 094092602
Related Category 3 Outcome Measure(s):	094092602.3.5	IT-1.20	1.20 Other Outcome Improvement Target

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-2 Review current registry capabilities and assess future needs. (Core component B) Metric 1 P-2.1 Documentation of review of current registry capability and assessment of future registry needs. Baseline/Goal: We do not currently have a database that captures all of this data. Numerator: number entered into registry (0) Denominator: total number of patients with the targeted condition to initially be entered into the database = 200 baselines. Data Source: EMR, existing excel spreadsheets populated with manually collected data. Rationale/Evidence: Necessity to track ongoing health status of patients with end stage organ disease to promote optimal care management. Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,370,969	**Milestone 2** P-6 Conduct staff training on populating and using registry functions. (Core component c) Metric 1 P-6.1 documentation of staff training programs and a list of staff members trained. Baseline/Goal: No staff is currently trained in utilization of the patient registry. 6 staff members will be trained initially, during this time period. Data Source: Staff training materials. Rationale/Evidence: Staff training on appropriate use of the registry functions to optimize use and efficiency. Milestone 2 Estimated Incentive Payment: $251,228 **Milestone 3 P-1** Identify target population with chronic disease end stage organ failure (Core component A) Metric: Numerator: = 200 current waitlist Denominator= 200 waitlisted Data source: EHR and other spreadsheets and ad hoc lists	**Milestone 5** I-15 Increase percentage of patients enrolled in the registry. Metric 1 I-15.1Increase percentage of patients enrolled in the registry Goal: Increase percentage of patients enrolled in the registry by 10% over baseline (220 patients entered into registry). Numerator: number patients entered into registry Denominator: total number of patients with the targeted condition200 baseline. Data Source: EMR, existing excel spreadsheets populated with manually collected data. . Data Source: EMR, existing excel spreadsheets populated with manually collected data Milestone 5 Estimated Incentive Payment: $353,290 **Milestone 6:** P-14 Participate in face to face learning at least twice per year with other providers in the RHP to promote collaborative learning surrounding chronic disease	**Milestone 7** : I-18 Perform routine follow-up monitoring to ensure adherence to the disease management program. Metric 1 : I-18.1 Measured by the number of patients adhering to the recommended regimen as compared to the total number of patients following a program regimen. Goal: provide a means of monitoring patients with end stage organ failure (chronic disease) during the process of evaluation and listing to ensure early intervention and treatment of additional co-morbidities/diseases that may develop. Data Source: EMR/registry Milestone 7 Estimated Incentive payment: $134,250 **Milestone 8**: I-15 Increase percentage of patients enrolled in the registry. Metric 1: I-15.1 Increase percentage of patients enrolled in the registry. Goal: Increase patients enrolled in registry by 40% over baseline during this time period (280 patient entered into registry)

094092602.1.4	1.3.1	1.3.1 (A-D)	IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY	
The University of Texas Medical Branch at Galveston				TPI: 094092602
Related Category 3 Outcome Measure(s):	094092602.3.5	IT-1.20	1.20 Other Outcome Improvement Target	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Rationale: Entering all baseline patients into registry will allo focus on clinical outcomes and quality improvements. Milestone 3: Estimated Percentage: $251,228 **Milestone** 4]: P-14 Participate in face to face learning at least twice per year with other providers in the RHP to promote collaborative learning surrounding chronic disease management and use of chronic disease registries. At each meeting all providers should identify and agree upon several improvements each participating provider should publicly commit to implementing these improvements. (Core component D) Metric 1 P-14.1 Participate in semi-annual face to face meetings or seminars organized by the RHP. Goal: Meet and share ideas to promote improvements to "raise the floor" at least semi-annually. Data Source: Documentation of meetings including agendas/slides		management and use of chronic disease registries. At each meeting all providers should identify and agree upon several improvements each participating provider should publicly commit to implementing these improvements. Metric 2: P-14.1 Participate in semi-annual face to face meetings or seminars organized by the RHP. Goal: Meet and share ideas to promote improvements to "raise the floor" at least semi-annually. Data Source: Documentation of meetings including agendas/slides from presentations and/or meeting notes. Rational/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality healthcare systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 6 Estimated Incentive payment: $353,290	Numerator: number of patients entered into registry Denominator: 200 baseline patients entered into registry Data Source: EMR/registry/national database Milestone 8: Estimated Incentive Payment: $134,250

094092602.1.4	1.3.1	1.3.1 (A-D)	IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY	
The University of Texas Medical Branch at Galveston				TPI: 094092602
Related Category 3 Outcome Measure(s):	094092602.3.5	IT-1.20	1.20 Other Outcome Improvement Target	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	from presentations and/or meeting notes. Rational/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality healthcare systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 4 Estimated Incentive Payment: $251,229			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,370,970	Year 3 Estimated Milestone Bundle Amount: $753,685		Year 4 Estimated Milestone Bundle Amount: $706,580	Year 5 Estimated Milestone Bundle Amount: $268,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $4,099,735				

PROJECT OPTION*:* 1.3.1 Implement a Chronic Disease Management Registry

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.5
PERFORMING PROVIDER NAME/TPI The University of Texas Medical Branch at Galveston/ 094092602

Title of project: Implement Chronic Disease Management Registries

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.

INTERVENTIONS: The project will allow UTMB to implement and utilize chronic disease registries within the UTMB EMR, which will improve patient outcomes by tracking information within diabetes, CHF, asthma, hypertension, and COPD registries. UTMB's EHR dash boarding tool, RADAR, will also be utilized to improve chronic disease management by allowing providers to create patient specific interventions.

NEED FOR THE PROJECT: Within RHP 2, a significant portion of the population has been diagnosed with chronic diseases that could be managed more appropriately with the chronic disease registry. Streamlining the registries with the EMR will allow us to effectively reach patients in real time and reduce additional illness and increased cost in the population.

TARGET POPULATION: The target population is the patient population diagnosed with chronic diseases that primarily receive services in Galveston County. Specifically focusing on diabetes in our region, prevalence ranges from 9.3-13.4%. In the 12 months ending Sept 2012 there were 10,196 primary care visits with a Medicaid payer source, that were Medicaid eligible, or who were uninsured. Of these, there were 1,964 patient visits in our primary care clinics alone (excluding specialty Endocrinology or other visits) in which diabetes was a documented problem during the same period. These are conservative estimates of impact because we estimated only a modest 2.5% growth in visits and since the chronic disease registry model will be extended to other chronic diseases highlighted above.

Medicaid / Uninsured	DY1	DY2	DY3	DY4	DY5
Primary Care Visits	10,196	10,451	10,712	10,980	11,254
Diabetes on Prob List	1,964	2,013	2,063	2,115	2,168

CATEGORY 1 EXPECTED PATIENT BENEFITS: This project seeks to improve the health outcomes of patients by integrating disease registries with the UTMB EMR and utilizing RADAR to ensure providers receive relevant, accurate, and timely data. By DY5, patients listed within the diabetes registry should experience a 7 percentage point drop in their HbA1c control.

CATEGORY 3 OUTCOME:

I.T-1.10 The outcome measure is to lower HbA1c levels that are under poor control from 2 -7 percentage points from the baselines across DY3, DY4, and DY5.

PROJECT DESCRIPTION:

We will implement and utilize chronic disease registries in the UTMB Electronic Medical Record (EMR) to improve patient outcomes by providing relevant, accurate and timely data to caregivers capable of introducing interventions targeted to individual patients serviced primarily in Galveston County. The chronic disease registries will be diabetes, CHF, asthma, hypertension and COPD. In addition to the registries, the EHR's dash boarding tool, RADAR, will be implemented that will enable providers to view performance at a glance and target patients requiring specific interventions.

Project goal(s):

Implement a disease management registry for one or more patient populations diagnosed with a selected chronic disease(s) or with Multiple Chronic Conditions (MCCs). By tracking key patient information, a disease registry can help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions. A disease registry can assist physicians in one or more key processes for managing patients with a chronic disease, including:

- Prompt physicians and their teams to conduct appropriate assessments and deliver condition-specific recommended care;
- Identify patients who have missed appointments, are overdue for care, or are not meeting care management goals;
- Provide reports about how well individual care teams and overall provider organizations are doing in delivering recommended care to specific patient populations;
- Stratify patients into risk categories in order to target interventions toward patients with highest needs.

1.31 Implement/enhance and use chronic disease management registry functionalities

Core project components and project milestones:

P-3 Develop cross-functional team to evaluate registry program.

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.

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

c) Use registry reports to develop and implement targeted QI plan

P-4 Implement/expand a functional disease management registry.

I-20 Generate registry-based reports for each provider/care team for the care delivered outside the office visit, which may include historical and peer comparisons to help providers see how well they are managing their patients chronic health needs compared to other doctors in the hospital/clinic 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.

I-23 Interventions to implement a chronic disease management registry.

Anticipated challenges:

Building the Radar reporting tool into the workflows of clinicians will be the most effective way of assuring their use, but will be difficult because of the differing work styles of various clinicians (e.g. primary care, specialty care, procedurists, etc.). We routinely use a change management process that will help us anticipate such a challenge.

We have been unable to implement such decision support and data presentation solutions because our scarce information technology (IT) resources have been devoted to completing EMR implementation in all settings where patients are served (competing priorities). We have recently augmented the clinical IT team and affirm priorities at intervals. A new position, focused on registry implementation will be required to complete this effort.

Existing measures of ambulatory performance, including facets of the ambulatory care guidelines, are not widely shared or utilized, and may not be well understood. During the instruction of the use of registry tools, we will ask our physician champions to assist with explaining the underlying evidence justifying the measures. The UTMB Clinical Practice Council, along with the Primary Care service line, will be asked to review and endorse the selection of preventive health guidelines.

Not all stakeholders are adequately prepared for the distribution of the data that may reflect a need for performance improvement. We will look to the quality leads in each clinical department, along with corresponding department chairs, to reinforce the importance of individual, team, and group performance in enhancing population health.

The 5-year expected outcome(s):

By the end of the five year period, we expect the EMR chronic disease registries and Radar dashboard to be implemented with accurate, relevant and timely data. Providers will be accustomed to using the registry data with Radar to confidently implement improvement interventions and track the results of those interventions for patients identified in one of the registries. In 2011, among the 534 Medicare patients sampled in the CMS GPRO initiative, 93% received HgbA1c tests according to guidelines. We will establish the Medicare rate in DY2 and expect to see a 5% increase in appropriate testing by DY5. At the end of the 5 year period, we should see a 7 percentage point drop in HbA1c poor control. Success with this outcome measure will have instigated the adoption of other outcome measures with anticipated success.

Regional goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

STARTING POINT/BASELINE:

Epic Care Ambulatory is already implemented in all primary care settings. About 20,000 patients are using the patient web portal and have identified their preference for e-communications. The Epic scheduling system will be implemented in April, 2013, making the

integration of these workflows even better.
The US Preventive Services Task Force recommendations/guidelines – have been evaluated and prioritized by Clinical Practice Council / Primary Care service line for first two topics.
EpicCare Ambulatory EMR has been completely implemented in Primary Care. The Health Maintenance and registry modules are not part of the core EMR delivered, and have not been implemented in any setting at UTMB. The Reporting Workbench tool set has only been used for targeting Meaningful Use measures and we are now ready to apply the tool to meaningful clinical decision support. The focus of this initial implementation will be primary care – to facilitate population health management.

RATIONALE

Relation between Project Choices and Community Needs:

Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care.

Delays to effective preventive health care result in additional illness burden and cost in a population. Under accountable care reforms, for the populations we serve, we must improve our ability to maintain health and guard against preventable illness using known evidence.
This solution actualizes decision support, allowing us to effectively reach patients in real-time. The clinical user is enabled to take action, within the EMR at the moment of recognition of a need rather than stopping to open another application or delay and hand off a task.

This project engages care delivery reforms along with infrastructure development. Today, when an individual's care is provided in multiple settings, there is no comprehensive record of status of preventive care measures. The Epic system will allow us to maintain a centralized record and share it. Automating the process of reminders also frees up clinicians to do work that requires their skills and knowledge.

Unique Community Need Identification numbers:

CN.12 Chronic Diseases: Diabetes

Expansion or enhancement:

Implementing Radar reporting, a provider portal within the Epic application proper, will provide clinicians with real-time data about patients who need their attention (based on rules triggers), and provide performance data about their achievement of population goals and care team performance. Because the dashboard sits resident in the EMR, it will allow the provider the ability to take immediate action to resolve issues and for office staff to directly schedule preventive health visits convenient to the patient based on organizational protocols.
Implementation of the Health Maintenance functionality in the Epic EMR can be extended to facilitate all preventive health care and evidence-driven health maintenance reminders (e.g. to include pediatric and adult immunizations) and the Radar dashboard can be enhanced by the addition of efficiency and other measures as they are developed.
Radar provides a centralized place that allows users to access all types of reports within the active Epic workspace, so users don't have to search. Radar offers reporting dashboards with convenient access to up-to-date, actionable information – if a patient needs some action, the user can launch from the report directly into the patients active record to execute the action.

From a personalized Radar reporting home page, a user can review key metrics, access favorite reports, and view links to other important resources. Reporting users can personalize their dashboards and the sections on their dashboards, giving them some control over the content and appearance.

Users can also receive automatic updates of new content with topic-based sections, which add reports tagged with a particular topic as soon as the report is available. Report writers can also tag new reports with standard or custom topics, so those reports are immediately available to the users who need them.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan
- Establish baseline rates
- Develop and test data systems
- Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- Disseminate findings, including lessons learned and best practices, to stakeholders
- Improvement Target: Diabetes care: HbA1c poor control (>9.0%)

The importance of glycemic control as part of the comprehensive management of diabetes is well documented, and HbA1c testing is a well-established strategy to monitor glycemic control in patients with diabetes. Unfortunately, NCQA data from 2007(6) reveals that between 13 and 22 percent of patients with diabetes do not get regular HbA1c testing. When tested, significant numbers of patients are in poor control with HbA1c values of 9 percent or greater: 29.6 percent of commercial populations, 27.3 percent for Medicare, and 48.7 percent of Medicaid populations. Systematic approaches are necessary to achieve improvements in the quality of care delivery and health care outcomes for patients.[1hrsa.gov/quality/toolbox/measures/diabetes/index.html]

Putting systems in place to track HbA1c testing frequency and HbA1c values enables an organization to better understand how effectively it is able to care for its patients with diabetes. Identifying adult patients aged 18 through 75 years with HbA1c values greater than 9 percent provides an opportunity for an organization to focus attention and services on those patients who are in poor control and at highest risk. These same tracking systems can facilitate appropriate management and follow-up for patients providing critical steps to help them attain and maintain their established glycemic goals.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on implementing and utilizing a chronic disease management registry and emphasis on diabetes, CHF, asthma, hypertension and COPD ties to these Category 1 and 2 projects in our RHP: 131030203.1.3, 094092602.1.4, 094092602.1.5, 138296208.2.1, 094092602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of chronic disease registry along with these other Category 1 projects in our RHP:131030203.1.3 - Implement a chronic disease management

registry; 094092602.1.4 - Transplantation chronic disease management registry; 094092602.1.5-Implement and utilize disease management registry.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.5	1.3	1.3.1	IMPLEMENT CHRONIC DISEASE MANAGEMENT REGISTRIES	
The University of Texas Medical Branch at Galveston				*094092602*
Related Category 3 Outcome Measure(s):	**094092602.3.6**	**IT-1.10**	**Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1[P-3] Develop cross-functional team to evaluate registry program. Metric 1[P-3.1] Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program Baseline/Goal: There are currently no personnel assigned to team. Numerator: number of personnel assigned to enter the registry; Denominator: total number of EMR personnel Goal: include representative participation from providers that treat targeted patient populations Data source: Team roster and minutes from team meetings Milestone 1 Estimated Incentive Payment *(maximum amount):* $800,791	**Milestone 2** [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 Metric [P-8.1] Submitted protocols for the specified conditions and health indicators Numerator: Number of preventive services approved and implemented protocols; Denominator: Total number of potential health maintenance protocols Baseline: No protocols finally approved for UTMB use as yet. Goal: Starting with US Preventive Services Task Force, three protocols will have been approved and implemented by end of DY3. Data Source: Protocols Milestone 3 Estimated Incentive Payment: $1,156,800	**Milestone 3** [P-4] Implement/expand a functional disease management registry. Metric 1 [P-4.1] Registry functionality available in the Primary Care sites for Diabetes. Numerator: number of Primary Care Sites with Diabetes registry functionality live; Denominator: total number of Primary Care sites Baseline: We have approximately 630 physicians participating among 185 clinics. Currently, no registries are available in any clinics. Goal: . Registry functionality is available in 65% (6 sites) of the Primary Care sites for Diabetes. Data source: Documentation of adoption, installation, upgrade, interface or similar documentation Milestone 3 Estimated Incentive Payment: $176,645 **Milestone 4 [**I-20] Generate registry-based reports for each provider/care team for the care delivered outside the office visit, which may include	**Milestone 5** [I-23] Interventions to implement a chronic disease management registry. Metric: [I-23.2] Increased utilization of targeted recommended service(s). Numerator: Number of patients that are up to date on targeted service (e.g. HgbA1c testing every 6 months, LDL checked annually, etc.) Denominator: total number of patients eligible for that service. Data Source: Registry, EHR, claims or other Performing Provider source Goal: HbA1c rate of testing for Family Medicine and General Internal Medicine improved 5% over DY2 baseline for the > 13,000 patients with diabetes. Rationale/Evidence: Measures the increased compliance with care recommendations Milestone 5 Estimated Incentive Payment: $929,510

094092602.1.5	1.3	1.3.1	IMPLEMENT CHRONIC DISEASE MANAGEMENT REGISTRIES	
The University of Texas Medical Branch at Galveston				*094092602*
Related Category 3 Outcome Measure(s):	**094092602.3.6**	**IT-1.10**	**Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			historical and peer comparisons to help providers see how well they are managing their patients chronic health needs compared to other doctors in the hospital/clinic system. Metric 2[I-20.1] Increase or achieve number or reports sent out to a number or percent of primary care providers over the 12-month period. Numerator: number of provider based diabetes reports ; Denominator: total number of Primary Care Providers Goal: All active Family Medicine and General Internal Medicine physicians receive at least one quarterly panel report. Metric: Number of unique reports provided during the reporting period. Data Source: Registry and/or EHR. Rationale: Registry reports will alert providers to any variations in care across historical trends and peer comparisons Milestone 4 Estimated Incentive Payment: $176,645	
Year 2 Estimated Milestone Bundle Amount*:* $800,791	Year 3 Estimated Milestone Bundle Amount: $1,156,800		Year 4 Estimated Milestone Bundle Amount: $353,290	Year 5 Estimated Milestone Bundle Amount: $929,510

094092602.1.5	1.3	1.3.1	IMPLEMENT CHRONIC DISEASE MANAGEMENT REGISTRIES	
The University of Texas Medical Branch at Galveston				*094092602*
Related Category 3 Outcome Measure(s):	094092602.3.6	IT-1.10	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $3,240,391				

PROJECT OPTION: 1.6.2 Establish/Expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER*:* 094092602.1.6
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/094092602

Title of project: Enhancing Urgent Medical advice: Texas Regional Health Line
PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: The project is designed to improve access to primary care advice and triage to urgent services by expanding the current nurse advice line, a service that is currently provided to all patients of UTMB and expanding to a subset population within Region 2 on a community by community basis and creating a Texas Regional Health Line. The project will also improve care coordination and reduce ED utilization.
NEED FOR THE PROJECT: In Region 2, there are 9 Primary Care Health Professional Shortage Areas and between 896.6-2459.1 preventable hospital admissions. The population of the region is highly diverse and includes many rural areas without access to medical advice, which leads to increased ED visits.
TARGET POPULATION: The target population is the entire patient population within Region 2 counties who do not currently have adequate access to primary care services or urgent medical advice. For purposes of this project, we will target two of our highest need areas in our region with a total population of 241,285. Of this population, 40% (97,276) are Medicaid or Uninsured patients.

- Nacogdoches County total population = 66,773 Medicaid=9,203 Uninsured=32,355

- Angleton-Danbury Health District = 70,000 Medicaid=6762 and Uninsured=17,933. This is a subset of the overall Brazoria County population based on pulling certain zip codes that represent the service area of the hospital.

CATEGORY 1 EXPECTED PATIENT BENEFITS: This project seeks to provide improved access to primary care resources, as well as, culturally appropriate advice across the region by operating a 24 hour Nurse Hotline for medical advice. This will result in more informed and educated patients with a goal in DY2 of informing 25% of targeted patients about the advice line and a goal in DY5 of reducing ED utilization by 15% of established base line of patients utilizing the nurse advice line.
CATEGORY 3 OUTCOME:
I.T-9.2 The outcome measure is to lower inappropriate utilization of the ED by reducing all emergency room visits by improving the awareness and education of patients.
PROJECT DESCRIPTION:

UTMB Health has over fifteen years experience in providing a nurse advice line that provides urgent medical advice by highly trained registered nurses telephonically. This service is offered to all patients of the UTMB health system and has proven most effective in reducing the number of avoidable ED visits, directing patients to the appropriate source of care, and raising patient satisfaction with the health system. Using the nationally recognized triage guidelines from McKesson this service allows for assessment, planning, and interventions that are specific to the patient's needs. Additionally this service is supported by bilingual nurses and full access to the language interpretation line. There is follow-up on every call to the triage line with the patient's local provider.

This project is designed to expand the nurse advice line service throughout Region 2 on a community by community basis in order to improve access to primary care advice and triage to urgent services. This will be patient centered care and provide the patient with home care measures or appropriate disposition to a high level of care. There is follow-up on the incoming calls with the local community providers thus increasing the coordination of care. The Texas Regional Health Line will not schedule the appointments for the patients but will provide the appropriate referral information in the community as is contained in the community-specific repository that has been created in collaboration with the local providers.

Core Components –

a) Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.
b) Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.
c) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. Call Center quality analysis will include monthly chart reviews and quarterly statistical analysis of call comparison between call center and participating Emergency Department visits. Learning collaborative will be an increased working relationship between the participants and the after-hours call service to reduce unnecessary ED visits and improve overall health care within the region. Continuing collaborations will include educational material to target population and providing a continuity of care between after hours service and participating providers.

Project Goals:

The goals for this project are the following:

- Increase access to evidenced-based, quality medical advice
- Guide consumers to appropriate community resources
- Improve the patient experience by providing easy access to after-hours medical advice

- Lower health care costs by reducing unnecessary visits to the ER
- Promote equity and reduce disparities by providing culturally competent advice
- Create a learning collaborative for participating providers to identify lessons learned and opportunities to further enrich and improve the hotline service and to evaluate the impact of the project

RATIONALE:

RHP2 is a highly diverse and dispersed population with many of the residents living in rural areas and/or Health Professional Shortage Areas. Currently there is no good, reliable system for providing after- hours access to medical advice. Patients who have questions and concerns often end up in the emergency rooms because they have nowhere else to go. This problem is also a barrier to recruitment of physicians to communities because the physician has no back-up coverage and do not want to be responsible for being on call 24/7. Our experience with the nurse advice line has demonstrated that having access to a nurse for medical advice reduces unnecessary trips to the ER and improves the callers peace of mind with regards to their question or concern. Providing the Texas Regional Health Line throughout a subset of the region addresses many of the concerns in our region's community needs assessment:

- Texas Regional Health Line will be available to all members of the community regardless of their insurance status or personal resources (CN.1; CN.2)
- Texas Regional Health Line can be used as a recruitment tool for primary care physicians in rural areas (CN.3)
- Texas Regional Health Line uses technology to provide services to a larger population lessening the provider shortage (CN.8)
- c Texas Regional Health Line an help reduce inappropriate ED utilization (CN.10)
- c Texas Regional Health Line can be useful as diverting hospital readmissions by directing the patient to local resources in a timely manner (CN.11)
- Texas Regional Health Line can be a useful tool in helping patients with questions regarding management of chronic disease (CN.12, CN.13, CN.14, CN.15)
- Texas Regional Health Line directs patients with mental/behavioral health issues to the appropriate resource call center for assistance (CN.5, CN.16, CN.17)

The Texas Regional Health Line is a vital tool that aids coordination of care by helping the patient find the right level of care at the right time and place. To make this resource available across the region with a community-specific focus will be transformational for the region by improving the patient experience and making better use of available resources. This project directly supports our regional goals to improve the health of our region by expanding and coordinating access to patient centered primary care and improving the quality of patient care through data collection, analysis, reporting and continuous improvement.

Anticipated Challenges:

Expanding the nurse advice line to the Texas Regional Health Line throughout region 2 presents some formidable challenges:

- Establishing good communication processes with local providers

- Building and maintaining a quality repository of community resources and contact information
- Developing community specific linkages for available resources
- Defining the appropriate follow-up pathway for each community
- Creating appropriate "branding" of the Texas Regional Health Line in each community
- Educating the community of the availability of the Texas Regional Health Line, how to access it and the benefits
- Determining an equitable shared financing model for service

We will address these challenges through intense collaboration with our regional partners and through our learning community. As we build trust and demonstrate success in serving our pilot communities we anticipate that other communities throughout the region will want to take advantage of this most valuable resource.

The 5-year expected outcome(s):

- DY 3 Expected patient outcome is to educate 25% of the targeted populations.
- DY 4 Expected patient outcome is to enhance services by Increase number of patients using the nurse advice line by 5% over baseline established in DY 3, estimated at 3,016 to show an increase in callers.
- DY 5 Expand nurse advice lines an additional 10% of callers 3,332.

By the end of year 5 we anticipate transforming the health care system in Region 2 by providing a Texas Regional Health Line service that provides urgent medical advice throughout our targeted areas of the region. This service developed through collaboration with providers in the community will offer community specific, culturally appropriate advice available to all citizens of our region. This will improve the coordination of care throughout the region and reduce unnecessary utilization of our participating community emergency departments.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD – 9 Right Care, Right Setting

IT-9.2 ED appropriate utilization (Standalone measure)

Reduce all Emergency Department visits (including ambulatory care sensitive conditions). The exact measure has yet to be determined pending establishment of a baseline.

Process Milestones include-**P-2: Collect baseline data and develop metrics specific to the nurse advice line to track access to specific patient populations** Project Planning in year one will include determination of medical advice line needs including populations to be covered and development of tracking metrics that allow providers to determine efficacy in reaching target populations; and, **P-5 Inform and educate patients on the nurse advice line** Informing the public about the availability of the nurse advice line and how to use it means that the patients are less likely to seek care for non-emergent conditions in the Emergency Department. Baseline data will be determined in DY2 and DY3 will include continuous data gathering to meet outcome measures of improved access of urgent medical advice to the community though nurse triage. This data will be collected with simple, interim measurement systems and based on self-reported data and sampling that is sufficient for the purposes of improvement.

The milestone Improvement Target is **1-13 Increase in the number of patients that accessed the nurse advice line** Targeted patients that access and utilize a nurse advice line are less likely to seek care for non-emergent conditions in the Emergency Department.

STARTING POINT/BASELINE:

This project is an implementation/expansion of a program into new service areas that do not currently have access to this service so the baseline is zero. Our starting point is to add an expanded service in two new areas that covers a population of 2136,773. Baseline will be established for the metrics and for utilization of the nurse advice line.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding access to care through a nurse advice call line and emphasis on providing urgent medical advice to callers from all Region 2 counties ties to these Category 1 and 2 projects in our RHP: 112671602.1.1, 094092602.1.2, 094092602.1.6. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of a nurse advice call center for participating counties in region 2. There are no other related Category 1 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2 we will develop learning collaboratives that are based on similar health or system delivery challenges and that focus on sharing knowledge, experience, and expertise. These learning collaborative will establish their own meeting venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish their own schedule for meeting frequency with a minimum of meeting quarterly. Guidance in setting up the learning collaboratives will be facilitated by our regional anchor. The learning collaboratives will use data driven analysis to drive performance improvement.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.6	1.6	1.6.2	ENHANCING URGENT MEDICAL ADVICE/DEVELOPING A CALL CENTER FOR REGION 2 (TEXAS REGIONAL HEALTH LINE)
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.7	IT-9.2	ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-2]**.** Collect baseline data and develop metrics specifically to tract access to specified patient populations Baseline: Track telephone calls by participating providers and determine percentile of patient population served. This percentage will be compared to participating provider emergency department for reduced ED visit analysis. Goal for this Milestone/Metric: Identify metrics and develop baseline assessment and number of targeted patients by community. Data source : Call Center reports Rationale: This describes the target populations and service areas to be provided. Metrics will be used to determine efficacy for region target population. **Milestone 1** Estimated Incentive Payment (maximum amount): $1,046,054	**Milestone 2** [P-6]. Inform and educate patients on the nurse advice line. Goal for this milestone/metric: 25% of target patient population informed/educated on the nurse advice line. (Nacogdoches and Angleton-Danbury Hospital Disrict tot).al target population of 136,773). Goal is to achieve 25% = 34,100 Data source: documentation of promotion efforts/materials, , flyers, pamphlets, and other promotional/educational material Rationale: Patients must be informed and educated that the nurse advice line is available and how to use it. **Milestone 2** Estimated Incentive Payment: $1,726,171 **Milestone 3** [P-4] Establish nurse advice line based on baseline data to increase access to patients based on need within RHP.	**Milestone 4** [I-13]. Increase in the number of patients that accessed the nurse advice line Goal for this milestone/metric: Increase number of patients using the nurse advice line by 5% over baseline established in DY3. Data source: Call Center reports Rationale: Patients who are aware the nurse advice line is available will use this service when undecided about the appropriateness of visiting the Emergency Department. Milestone 4 Estimated Incentive Payment: $5,105,115	**Milestone 5** : [I-13] Increase in the number of patients that accessed the nurse advice line Goal: Increase number of patients using the advice line by 10% over metric established in DY4 Data source: Call Center reports Rationale: Patients who are aware the nurse advice line is available will use this service when undecided about the appropriateness of visiting the Emergency Department. Milestone 5 Estimated Incentive Payment: $3,470,104

094092602.1.6	1.6	1.6.2	ENHANCING URGENT MEDICAL ADVICE/DEVELOPING A CALL CENTER FOR REGION 2 (TEXAS REGIONAL HEALTH LINE)
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**094092602.3.7**	**IT-9.2**	**ED appropriate utilization**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Numerator = number of nurses staffing nurse advice line per shift Denominator = number of calls per shift. Data Source: Documentation of nurse advice line staffing levels and call volume reports. Rationale/Evidence: Patients will experience expanded access to medical advice line and direction to the appropriate level of care as a result of a higher ratio of nurses to patient calls. **Milestone 3** Estimated Incentive Payment: $1,726,172		
Year 2 Estimated Milestone Bundle Amount:: $1,046,054	Year 3 Estimated Milestone Bundle Amount: $3,452,343	Year 4 Estimated Milestone Bundle Amount: $5,105,115	Year 5 Estimated Milestone Bundle Amount: $3,470,104
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,073,616			

PROJECT OPTION: 1.10.2 - Enhance Performance Improvement and Reporting Capacity

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.7
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.

INTERVENTIONS: The project is aimed at expanding our quality improvement reporting capacity by improving our utilization of people, processes, and specifically technology, with a goal of reducing readmissions. Quality improvement capacity will be enhanced by developing a collaborative forum for RHP 2 representatives to share best practices, providing education and training to clinical and administrative staff, and designing more timely and efficient data collection systems.

NEED FOR THE PROJECT: In Region 2, there are several hospitals that patients can be readmitted to including 1 academic medical center, 5 public hospital, and 16 private hospitals. Other stakeholders include 5 FQHCs, 8 hospital districts, 7 public health districts, 4 mental health authorities, and 16 county indigent care programs. This collaborative will allow for coordination of care across RHP 2 providers and improve access to patient centered primary, behavioral, and specialty care, which will reduce hospital readmissions.

TARGET POPULATION: All RHP 2 hospitals and stakeholders will take part in this collaborative forum. The target population is the entire patient population within Region 2 counties who do not currently have access to primary care services, experience barriers in obtaining specialty or behavioral services, and suffer from unmanaged chronic diseases. Within RHP 2:

- Number of Primary Care HPSAs: 9
- Preventable Hospital Admissions: 896.6-2459.130
- Day Readmission Rate: Medical: 16.0-18.3

The number of readmissions for 13 of the 16 RHP 2 hospitals (critical access hospitals not reporting) during last HospitalCompare reporting period included 1,302 patients for Heart Attack (AMI); 3,784 for Heart Failure (CHF); and 3,458 for Pneumonia (CAP) (see Figure 1 below).

CATEGORY 1 EXPECTED PATIENT BENEFITS: This project seeks to improve access to primary care resources, as well as, enhance the quality of care received by our patients. Patients will receive patient centered, timely and appropriate care across RHP 2, which will decrease unnecessary hospital days and readmissions for our population. By DY4 and DY5 the region's goal is to reduce hospital readmissions below the baseline rates of hospital readmissions for DY2.

CATEGORY 3 OUTCOME:

I.T-3.1 All cause 30 day readmission rates is the best measure that reflects the overall regional improvement area identified.

Project Goal: To expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.

Project Option/Project Component:
1.10.2 Enhance improvement capacity through technology
PROJECT DESCRIPTION:
The improvement collaborative we establish will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement from subject matter experts, from project staff coaches and from each other. The RHP2 Executive Steering Committee will assist in the selection of improvement topics/targets, monitor the progress of teams and assist in enabling required changes for sustainable improvement. As an anchor, UTMB will
Core Project Components and Milestones:

a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.

We will launch the effort by first establishing a performance improvement office (**P-1)**, and hiring quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (**P-6**). We will allocate a dedicated improvement project manager, data analyst, project coaches and administrative support personnel to support the establishment of a Region 2 Performance Improvement office infrastructure.
To facilitate learning and collaboration we will implement quality improvement data systems, collection, and reporting capabilities (**I-7**), including a web-based groupware tool for use in supporting the Improvement Collaborative projects and membership to host file-sharing (e.g. best practices, project progress reports), project management, threaded conversations among participants, etc.
We will utilize eSurvey results from RHP2 hospitals to identify performance improvement priorities, existing data-sharing initiatives, best practices, and potential resources. We will obtain data-sharing agreements from RHP members to authorize use of Medicaid Potentially Preventable Readmission and Potentially Preventable Complication data through TX HHSC.
We will recruit faculty and subject matter experts who have applied best practices with demonstrated breakthrough performance in their own practice/settings; develop content for the Collaborative; provide faculty leadership and an Improvement Advisor that teaches and coaches teams on improvement methods and how to apply them in local settings.
Project staff will prepare for each collaborative by assisting subject matter experts in preparing a Change Package and enable access via the collaborative groupware workspace to high yield changes most effective in producing results, along with project timelines and materials. A preparatory conference call will clarify the processes, roles, and expectations and launch pre-work for teams. For each targeted improvement collaborative, we will conduct three face-to-face Learning Sessions, bringing together multidisciplinary teams from each organization and the expert faculty to exchange ideas, seed the opportunities, and prompt action.

At *Learning Session One*, a subject matter expert will present a vision for idealized care in the topic area and the Change Package, which will significantly improve local system performance. Teams learn, just in time, from an Improvement Advisor, how to conduct rapid cycle tests of change/key elements of successful process improvement (e.g. specific/measurable aims, measuring for improvement over time, and iterative learning and testing) (P6, P-6.1). At *Learning Sessions Two and Three*, team members report out and learn from one another practically as they report on successes, barriers, and lessons via storyboard presentations, informal dialogue and exchange.

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.

There will be a formal mechanism via facilitated bi-weekly conference calls (**P-7**) and the groupware.

c) Design data collection systems to collect real-time data that is used to drive continuous quality improvement (e.g. weekly run charts or monthly dashboards)

During *Action Periods* between the Learning Sessions, teams test and implement changes in their local settings—and collect data to measure the impact of the changes (I-7.1, I-7.2). Various strategies will be used to maintain member team focus, pace, and peer pressure (and support) and ongoing learning:

- Monthly targets for team progress and the submission of monthly progress reports,
- Conference calls to share single-page storyboard summaries of team progress,
- Peer site visits, and web-based discussions that enable dialogue with experts and each other.

Proceedings, Measurement, Evaluation and Sustainability:

Once the Collaborative is complete, the work is documented and teams present their results and lessons learned to RHP leadership, and to others in RHP who elected not to participate in that round of effort. All team results will be archived on web-enabled groupware for wide availability. While the collaborative is running, key faculty members will review each team's monthly report to assess the overall progress of the Collaborative. These run charts of system measures over time are designed to be continued within sites, and a mechanism for tracking via the groupware site will be used to review continued sustainability by the Steering Committee.

Anticipated challenges:

As a newly forming Regional Healthcare Partnership (RHP), each member has variable infrastructure for data management and performance improvement. In our rapid cycle improvement training, we will emphasize real-time, paper-based tools for collecting data for improvement. For tracking and collaboration, we will be using only web-delivered electronic tools that require a browser and simple office spreadsheet tools.

Since success of projects depends on engaged leadership and organizational readiness, the project team will enroll RHP member teams using target conditions for success, including the active presence of senior leaders who will be expected to guide, support, and encourage the improvement teams, and to bear responsibility for sustainability – helping successful changes become standard practices. Interest without organizational readiness will prompt project staff

conversations with applicants' leaders. Pre-launch homework and coached use of the tools along the way will assure understanding and proper usage. Participants will also receive coaching in communicating effectively with their senior leaders and scheduled interim reporting that 1) engages senior leaders of member organizations locally to eliminate barriers teams were facing institutionally, and 2) communicated work in progress to the RHP Steering Committee.

We also anticipate that population challenges (described in community needs below) and variable data resources and process improvement skills will make some organizations' work harder and these issues will be embedded in our approach to the collaborative.

5-year expected outcome(s):

By providing a collaborative for member representative interdisciplinary teams to learn and take action in real-time, we will expand the use and improvement of published best practices, increase the number of member organization staff proficient in applying basic performance skills, and reduce avoidable readmissions of hospitalized adults. We will have established a regional infrastructure; achieved active participation of especially hospital-based teams in all readmission efforts; evaluated the effectiveness of our approach to skill-building to inform subsequent collaboratives and; ultimately, have improved hospital readmission rates in DY4 and DY 5 of the cycle when compared to baseline rates of hospital readmission in DY2.

Regional goals:

The work of this collaborative directly supports Region 2-wide goals

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement – *through regional capability-building*
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention– *by identifying and eliminating/reducing common barriers to effective patient self-management after discharge*
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management– *by decreasing unnecessary hospital days and over usage*

STARTING POINT/BASELINE:

RHP 2 hospitals include 1 academic health center, 5 public hospitals, 16 private hospitals where patients may be readmitted. Regional partners with a stake in the solutions, include our 5 FQHCs, 8 hospital districts, 7 public health districts, 4 mental health authorities, and 16 county indigent care programs. Not having collectively worked on regional improvement priorities in this way before, we will have to learn and build on the assets and gaps among the regional members.

Each member participant will bring to the collaborative their unique prior experience and development in formal and informal performance improvement training. UTMB, the anchor for RHP 2, hosts a 10 session interdisciplinary team-based quality improvement course and during

FY 2012 trained over 50 leaders in quality improvement; building system capability with valuable skills and tools both about rapid cycle improvement and structured interdisciplinary team-based change. The course is a hands-on, project-based approach that emphasizes immediate, practical application of principles and methods under the guidance of a coach who assists with immediate application of concepts and tools just in targeted organizational projects.

RATIONALE:

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[1] Hospitals' avoidable readmission rates have come under close scrutiny by payers and policymakers because of the potential of high savings associated with them. According to a recent study, unplanned readmissions cost Medicare $17.4 billion in 2004.[2] The study found that 20 percent of Medicare fee-for-service patients were readmitted within 30 days of discharge. In addition to having financial implications, avoidable readmissions are increasingly viewed as a quality issue by payers, health care organizations, and patients, with some research showing that readmission rates may be correlated with quality of care.[3] There are a number of evidence-based interventions that target controllable practices in hospitals that have been shown to have an impact on

Relation between Project Choices and Community Needs:

Our region has a high incidence of chronic disease and some of the highest healthcare costs in the US. Hospital readmission has been shown to be related to chronic illness self-management efficacy (including mental health and substance use issues), patient resources, access to primary and specialty care.

Unique Community Need Identification numbers:

CN.1	Access Barriers: Lack of Personal Resources
CN.2	Access Barriers: Lack of Insurance
CN.3	Primary Care Physician Shortage
CN.5	Mental/Behavioral Health Provider Shortage
CN.11	30 Day Readmission Rates
CN.12	Chronic Diseases: Diabetes
CN.13	Chronic Diseases: Obesity
CN.14	Chronic Diseases: Heart & Vascular Related Diseases & Disorders
CN.15	Chronic Diseases: Pulmonary Diseases
CN.17	Mental/Behavioral Health Related Morbidity

Expansion or enhancement:

After the infrastructure for this learning collaborative is installed and initial successes with Hospital Readmission Reduction are achieved and being sustained,

---

[1] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75-91.

[2] Jencks, Stephen F., Williams, Mark V., and Coleman, Eric A. 2009. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *N Engl J Med* 360 (14):1418-1428.

[3] Benbassat, J., Taragin, M. 2000. Hospital readmissions as a measure of quality of health care: advantages and limitations. *Archives of Internal Medicine* 160 (8):1074-1081.

- with HSSC support, the collaborative could be opened to other Waiver regions or replicated by them;
- we anticipate that Region 2 will be able to extend the same approach to Potentially Preventable Complications and Healthcare Acquired Conditions (OD-4).

Related Category 3 Outcome Measure(s):

OD-3 – Potentially Preventable Re-Admissions – 30 Day Readmission Rates (PPRs)

IT-3.1 All cause 30 day readmission rate – NQF 1789 [250] (standalone measure)

RELATIONSHIP TO OTHER PROJECTS:

As the learning collaborative, this project related to and ties together all projects in the region.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' IN THE RHP:

This project establishes an improvement collaborative that will serve as a forum for RHP2 participants to learn both about content and about rapid cycle improvement. There are no other related Category 1 similar projects in our RHP as this project includes all providers in Region 2.

Reason/rationale for selecting outcome measure:

IT-3.1 All cause 30 day readmission rates is the best measure that reflects the overall regional improvement area identified.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.7	1.10.2	1.10.2 (A – C)	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.8	IT-3.1	All cause 30 day readmission rate- NQF 1789 (Standard Measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Establish a performance improvement office. Metric 1 [P-1.1] Documentation of the establishment of performance improvement office Baseline: None available Goal: Dedicated RHP Improvement Project Manager 1 FTE and & coach resources (3200 hrs); Establishment of web-based collaborative groupware. Data source: Anchor HR documents & job descriptions, Communications with members, office policies and procedures, productivity logs Milestone 1 Estimated Incentive Payment (maximum amount): $612,026 **Milestone 2** [P-6]: Hire quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes.	**Milestone 3** [P-7]: Facilitate at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that providers participate in. Baseline: None available Goal: 50% of collaborative members represented on 75% of collaborative calls. Data source: Documentation of bi-weekly conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 3 Estimated Incentive Payment: $576,024 **Milestone 4** [P-6] Train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such	**Milestone 5** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities. (incl. 1.10.2.c) Design data collection systems to collect real-time data that is used to drive continuous quality improvement (e.g. weekly run charts or monthly dashboards and 1.10.2.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.) Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Baseline: None available Goal: 50% of active members will set and demonstrate an increase in usage of quality data systems Data source: Members Quality improvement data systems Milestone 5 Estimated Incentive Payment: $1,080,045	**Milestone 6** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities. Metric 1 [I-7.2] Demonstrate how quality reports are used to drive rapid-cycle performance improvement. Baseline: None Available Goal: Quarterly accountability reports for Potentially Preventable Readmissions and Potentially Preventable Complications published to complement collaborative real-time data collection for Rapic Cycle tests of change. Data source: Documentation from member quality improvement offices Milestone 6 Estimated Incentive Payment: $820,834

094092602.1.7	1.10.2	1.10.2 (A – C)	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.8	IT-3.1	All cause 30 day readmission rate- NQF 1789 (Standard 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)**
Metric 1 [P-6.2] Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement. Baseline: None Available Goal: Dedicated RHP data analyst (1 FTE) and MEDPAR data contract analysis (1000 hrs). Data source: Anchor HR documents & job descriptions, Communications with members Milestone 2 Estimated Incentive Payment (maximum amount): $612,026	as rapid cycle improvement and/or data and analytics staff for reporting purposes. (1.10.2.a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.) Metric 1 [P-6.1] : Increase number of staff trained in quality and efficiency improvement principles Baseline: None available Goal: 100% of collaborative initiatives include improvement methods instruction and coaching Data source: Collaborative meeting Agendas & Content; Participation logs & annual summary reports to Executive Steering Committee. Milestone 4 Estimated Incentive Payment: $576,024			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,224,051	Year 3 Estimated Milestone Bundle Amount: $1,152,048		Year 4 Estimated Milestone Bundle Amount: $1,080,045	Year 5 Estimated Milestone Bundle Amount: $820,834
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4 ,276,980				

PROJECT OPTION: 1.4.1 Enhance Interpretation Services and Culturally Competent Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.8 – Pass 2
PERFORMING PROVIDER NAME/TPI: University of Texas Medical Branch at Galveston/094092602

Title of project: "Strengthening the UTMB health information system to Reduce Health Disparities".
Project Area: 1.4 Enhance Interpretation Services and Culturally Competent Care
PROVIDER: UTMB is an academic health center comprised of a 475 bed acute care hospital, Level 1 Trauma Center, 44 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will expand UTMB's current and future interpretation services through technology, additional personnel and training. This will lead to improved access, improved quality of care and patient satisfaction for our patients and their families.
NEED FOR THE PROJECT: Forty percent of the region is ethnically non-white and English is a second language (or, "not-proficient in English") in 8.6% of the homes in the region. 6.9% of Galveston County population reports speaking English less than "very well." On average, UTMB Health provides ASL interpreting services 58 times per month with the average encounter lasting 3.5 hours. These key indicators support the need for bridging the gap between cultural competencies and educating our staff and the community on the importance of and accessibility to qualified medical interpreters.
TARGET POPULATION: Our target population is the general population on Galveston Island and surrounding region who are currently unable to or have difficulty in accessing care due to language and cultural challenges. It is most likely that this population will be reflective of, or exceed the percentage of patients who are covered by Medicaid and other private and public programs. Approximately 30% of UTMB patients (of the total 26,545 admissions and 681,100 visits in 2012) have Limited English Proficiency (LEP) or are hearing impaired, and approximately half of those patients served have Medicaid coverage or are uninsured. Across UTMB, including our Regional Maternal Child Health locations which are heavily used by Medicaid subscribers, there were over 12,000 telephone based medical language interpretations in 2012 (Dec 2012 annualized) between our UTMB and contracted outside vendor interpreters. In 2012, there were 753 deaf patients served via contracted sign interpreters (Sep-Dec 2-12 annualized). These data do not include the many visits that were interpreted using "proficient" Spanish language staff or in person. UTMB data shows a steady increase in the usage of medical language interpreters in the last two years (Figure 1 below).
CATEGORY 1 EXPECTED PATIENT BENEFITS: To help our caregivers attain clinical cultural competence, to: (1) be made aware of the impact of social and cultural factors on health beliefs and behaviors; (2) be equipped with the tools and skills to manage these factors appropriately through training and education; and (3) empower their patients to be more of an active partner in the medical management.

CATEGORY 3 OUTCOME: OD 3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
IT – 3.1 percent decrease on All cause 30 day readmission rate – NQF 1789 in targeted population. **.**
In DY2, we selected P-1, Project Planning, including engaging stakeholders, identify current capacity and needed resources; determine timelines and document implementation plan, because this is a major expansion that will require planning and coordination. This will allow us to properly plan ahead for the next four years.

Project Description: Over the course of this project, the UTMB Health Language Services will be able to expand its current and future interpretation services through technology, additional personnel and training which will lead to improved access, improved quality of care and patient satisfaction for our patients and their families. The technology will allow UTMB Health to provide remote video interpreting services both for foreign languages and sign language interpreting. Additional staff resources will allow UTMB to educate both patients and our staff on how to effectively use interpreters, provide additional training inside the UTMB community and the community at large on cultural competencies to bridge the communication gap between the community and the health care providers. All cause 30 day readmission rates – NQF 1789 for the targeted population will be the quality improvement measures which will be monitored continually throughout the project.
Project Goal: Patients have access to timely, qualified health care interpreter services in their primary language, thereby increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and better health outcomes. This Project Area applies to both written and oral interpretation services. Cultural competence in health care describes the ability of systems to provide care to patients' with diverse values, beliefs and behaviors, including tailoring care delivery to meet patients' social, cultural, and linguistic needs. Cultural competence can be described both as a vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share. To achieve **organizational cultural competence** within the health care leadership and workforce, it is important to maximize diversity. To achieve **systemic cultural competence** (e.g., in the structures of the health care system) it is essential to address such initiatives as conducting community assessments, developing mechanisms for community and patient feedback, implementing systems for patient racial/ethnic and language preference data collection, developing quality measures for diverse patient populations, and ensuring culturally and linguistically appropriate health education materials and health promotion and disease prevention interventions. To attain **clinical cultural competence**, health care providers must: (1) be made aware of the impact of social and cultural factors on health beliefs and behaviors; (2) be equipped with the tools and skills to manage these factors appropriately through training and education; and (3) empower their patients to be more of an active partner in the medical management. By striving for the goals mentioned above, UTMB believes we can improve clinical outcomes and reduce the 30 day all cause readmission rate for these LEP patients through expanded interpretation services.
Challenges: A challenge that we may encounter is timely recruitment and on-boarding of the additional resources. However, through networking with various agencies including but not

limited to the Texas Association of Healthcare Interpreters and the Texas Department of Assistive and Rehabilitation Services, we will be able to overcome this challenge. Another challenge will be to adjust medical interpreter certifications to state and national standards as they are created and implemented. (Currently, there are no certifications officially designated by national and state agencies.)

5-year expected outcomes: At the end of the five years, UTMB is projected to have a sustainable clinical cultural competence program and comprehensive instruction on effective use of interpreters for both patients, families, staff and the community. 90% of Language Services' Spanish Medical Language Interpreters will have completed the 40+ hour course and passed the assessment. UTMB will have completed the identification of language access needs and gaps, will implement plans to address a significant portion of those and created plans for the addressing the remaining needs and gaps. UTMB will have expanded the use of healthcare interpretation technology, hired and certified additional healthcare interpreters and implemented training programs for faculty, staff, patients and their families on how to use health care interpreters. By tracking discharged patients using skilled Spanish medical interpreters, we anticipate a reduction in all cause 30 day readmission rates.

Regional goals: The work of this collaborative directly supports Region 2-wide goals

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement – *through regional capability-building*
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention– *by identifying and eliminating/reducing common barriers to effective patient self-management after discharge*
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management– *by decreasing unnecessary hospital days and over usage*

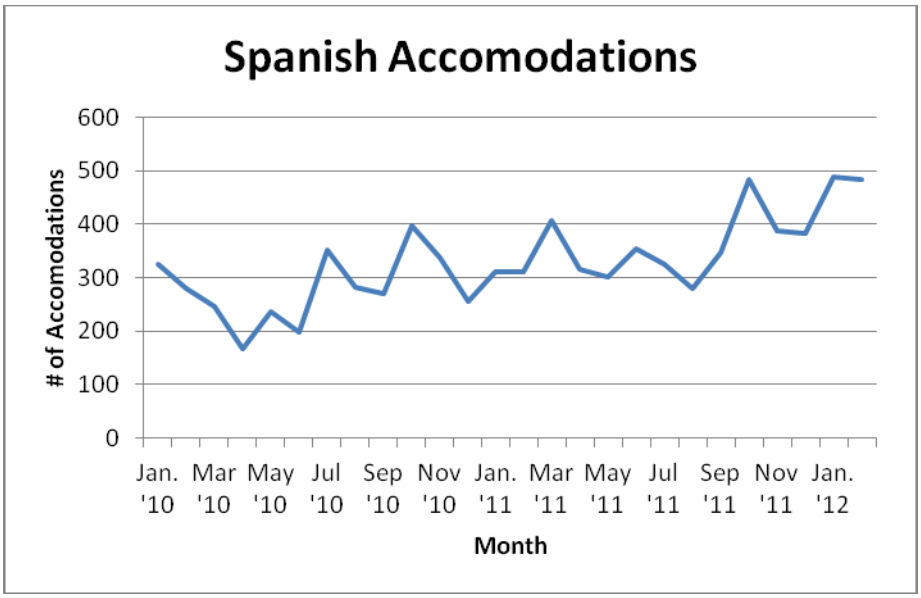
Starting Point/Baseline:

UTMB Health's Language Services currently, as of December 2012, employs 4 trained Medical Language Interpreters, 2 certified Language Specialists who conduct courses, assessments and medical translations and 1 manager. The Language Services office is overseen by the Director of Patient & Volunteer Services, and the Chief Quality, Safety & Clinical Information Officer. UTMB Health has assessed more than 80 faculty and staff throughout the Health System and deemed them to be "proficient" bilingual staff for Spanish medical interpretations. When UTMB medical interpreters are not available and/or a language other than Spanish is needed, a contracted vendor is available. American Sign Language Services are outsourced to a qualified vendor.

Per Joint Commission standards, UTMB Health also has a Patient Centered Communication Policy, which went into effect on July 1, 2012, to ensure individuals with Limited English Proficiency (LEP) or who are hearing impaired have meaningful access to services and an equal opportunity to participate in services in accordance with Title VI of the Civil Rights Act of 1964. Over the course of the project, we will be able to build a highly skilled and full service Language Services team with adequate resources to meet the diverse needs of UTMB Health's patient population and the surrounding community.

UTMB data from the last 2 years indicates the Spanish Accommodation volume has increased from 200 to 500 accommodations per month. UTMB is currently tracking 30 day readmission rates and will begin tracking those who use a healthcare interpreter.

.



Rationale:

It is important to make sure staff are fully trained and have the proper certifications necessary to optimize their performance in order to increase language access. National and state agencies recommend that medical language interpreters complete 40 hours of instruction and then sit for an assessment. Health care interpreters certified to interpret in multiple languages is another mechanism to expand existing workforce capacity. Sign Language costs are skyrocketing.

UTMB is currently exploring new ways to deliver improved interpretation services to our patients in a more cost effective manner. Therefore, we are requesting funding to implement "Video Remote Interpreting" (VRI) and to augment our current staffing which will allow us to better serve our patients and their families. Currently, the primary method for LEP interpretations is by phone. Sign Language interpretations are done in person by a contracted vendor at significant expense to UTMB. As of July 1, 2012, Joint Commission regulations require health care facilities to provide "proficient" medical language interpreters to LEP patients and the hearing impaired. UTMB has Spanish Medical Language Interpreters (MLI) on staff; however, due to limited staffing their services are only offered in person in the Emergency Department. If an MLI is not available, the Emergency Department must call the UTMB contracted vendor by phone. Other UTMB departments and clinics rely on either the UTMB MLI or the contracted language line which are both available by phone.

Project Option/Project Component: The project will incorporate all of the components of Option 1.4.1:

1.4.1 Expand access to written and oral interpretation services

a) Identify and address language access needs and/or gaps in language access

UTMB has identified and addressed some language access needs and gaps; however, there are still service areas which need to be identified and addressed.

During this project, UTMB will work with key stakeholders (providers, staff, patients and families) to identify and address additional language access needs and gaps and determine timelines and document an implementation plan (P-1). UTMB has identified a gap and need for improved technology (P-4) and increased staff. Current staffing levels and technology need to be increased / improved to expand access to written and oral interpretation services to patients and their families. Another gap already identified is (P-5 and P-6) enhanced training and certification of current and future medical interpreters, as well as the addition of new languages, including sign language. Training providers, staff, patients and their families on how to use interpretation services (P-7) will also lead to improved access.

b) Implement language access policies and procedures (in coordination with statewide and federal policies to ensure consistency across the state)

UTMB will review its Patient Centered Communication policy using best practices from other hospitals and organizations throughout the state and country such as TAHIT (Texas Association of Healthcare Interpreters and Translators). UTMB will look to improve consistency in procedures through additional training and certification of medical interpreters (P-5) UTMB will look to state and national agencies to determine the appropriate training and certifications.

c) Increase training to patients and providers at all levels of the organization (and organization-wide) related to language access and/or cultural competency/sensitivity

UTMB does provide internal certification training to providers and other staff who sit for UTMB's "proficient bilingual staff" designation. We need to provide additional training to all providers and staff related to language access, cultural competency/sensitivity and how to use the new technology. (P-4, P-5, P-7), thereby improving performance in the use of procedures. P-7 Train a number or proportion of providers (and other staff) to appropriately utilize health care interpreters (via video, phone or in-person). This metric explores the impact of interpreter training on staff comfort with using those services. Hiring the additional instructors will allow UTMB to provide more education to our faculty/staff, patients and their families regarding how to effectively use an interpreter, cultural competencies interpretation technology.

d) Increase interpretation staff

We aim to enhance the training and certification of current and future medical interpreters, as well as the addition of new languages, including sign language (P-5, P-6 and P-12). UTMB will use state and national agency-endorsed or recommended training and certifications.

Relation between Project Choices and Community Needs:

As reported in the Galveston County Needs Assessment Summary, "Immigrants are disproportionately low users of medical care (Goldman et.al, 2006)". The summary also cites US Census Bureau data indicating that among those who report speaking English as a second language, 6.9% of Galveston County population reports speaking English less than "very well." This data also correlates with UTMB's estimate that 30% of our patient population has Limited

English Proficiency. On average, UTMB Health provides ASL interpreting services 58 times per month with the average encounter lasting 3.5 hours. (This does not include occurrences for "no shows" or last minute cancellations.) These key indicators support the need for bridging the gap between cultural competencies and educating our staff and the community on the importance of and accessibility to qualified medical interpreters.

Unique Community Need Identification numbers:

CN.1	Access Barriers: Lack of Personal Resources
CN.2	Access Barriers: Lack of Insurance
CN.11	30 Day Readmission Rates

Expansion or enhancement:

This project would be an expansion of current services offered by UTMB Health for its patients, their families, faculty, staff and the community at large. This expansion of services will allow us to make significant improvements in a much shorter amount of time. Without this support, it could take twice as long as the five year plan proposed in this project request. We are not currently receiving funding from the US Department of Health and Human Services for our Language Services program.

As previously stated, UTMB Health is currently assessing interpreter qualifications; however, this program would provide the resources for more comprehensive training and make in-person and remote video interpreting more accessible to our patients and their care providers. This will also provide the opportunity for UTMB to have an American Sign Language interpreter on staff.

Related Category 3 Outcome Measures:

OD-3 – Potentially Preventable Re-Admissions – 30 Day Readmission Rates (PPRs)

IT-3.1 All cause 30 day readmission rate – NQF 1789 [250] (standalone measure)

Reason/rationale for selecting outcome measure: IT-3.1 All cause 30 day readmission rates is the best measure that reflects the overall regional improvement area identified.

In an article published by the Department of Family Medicine and Community Health, University of Massachusetts Medical School entitled, "Professional language interpretation and inpatient length of stay and readmission rates", the study conducted by Lindholm, Hargraves, Ferguson and Reed, indicates that LEP patients who did receive qualified interpretation services at admission and /or discharge were less likely to be readmitted within 30 days, than those who did not receive interpretation services. The Galveston County Needs Assessment also indicates the need for improving the health of Medicaid clients. Qualified interpreters and community education programs which meet the needs of LEP patients would have a significant impact on improving the health care for all LEP patients, including Medicaid and uninsured populations in Galveston County.

Relationship to other Projects:

This project's focus on enhancing interpretation services and emphasis on improved access to care ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 121805903.1.3,

284333601.1.1, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on Enhance Interpretation Services and Culturally Competent Care. There are no other related Category 1 similar projects in our RHP.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.8	1.4.1	1.4.1 (A – D)	REGION 2 COLLABORATIVE TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
University of Texas Medical Branch Hospital				TPI - 094092602
Related Category 3 Outcome Measure(s):	094092602.3.17	IT-6.1	Percent over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Expand qualified health care interpretation technology Metric 1 [P-4.1]: Video or audio conferencing interpreter terminals and/or areas/units of the Performing Provider with access to health care interpretation technology, for example: Numerator: Number of terminals of video or audio conferencing available in each unit/department/clinics. Denominator: Total number of video or audio conferencing terminals in the health system. Goal: Purchase equipment and schedule implementation and training for remote video interpreting services. The goal is to improve patient access to interpreter services using technology. UTMB will begin by purchasing equipment for our areas with high volume and emergent interpretation needs. Video remove interpreting equipment will be purchased initially for: Emergency Department, Audiology Clinic, Day Surgery Operating Suite, Pediatric Clinic.	**Milestone 2** [P-5]: Train/certify additional health care interpreters Metric 1 [P-5.1]: Expand capacity of qualified health care interpretation workforce Numerator: Number of newly trained/certified interpreters Denominator: Total number of trained/certified interpreters Goal: Send Manager and Language Specialists to "train the trainer" training, so they can begin teaching the 40 hour sessions and certification exams for UTMB faculty and staff. Certify additional staff in high volume departments and clinics with large Medicaid populations, such as the Emergency Department and the Regional Maternal Child Health Clinics. Will increase the number of certified interpreters by 50% in the RMCHP clinics and by 20% in the Emergency Department. Data Source: HR workforce training data, program materials Rationale/Evidence: It is important to make sure staff are fully trained and have the proper certifications necessary to		**Milestone 4** [I-13]: Improve language access Metric 1 [I-13.1]: The number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year Numerator: Average number of remote video/voice and/or in-person interpreter encounters recorded per month. Denominator: Average number of encounters recorded per month by the end of DY4. Goal: Increase number of encounters to an average of 400 calls per month by end of DY 4. Data Source: Automated report (such as from Health Care Interpreter Network or Video Medical Interpretation and/or other encounter data report) Rationale/Evidence: Interpreter encounters per month is the current industry standard for how to measure language access. As a result of high numbers of patients whose primary language is not English, the current provision of interpretation services is not	**Milestone 5** [I-13]: Improve language access Metric 1 [I-13.1]: The number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year Numerator: Average number of remote video/voice and/or in-person interpreter encounters recorded per month. Denominator: Average number of encounters recorded per month by the end of DY5 Goal: Increase number of encounters to an average of 500 calls per month by end of DY5. Data Source: Automated report (such as from Health Care Interpreter Network or Video Medical Interpretation and/or other encounter data report) Rationale/Evidence: Interpreter encounters per month is the current industry standard for how to measure language access. As a result of high numbers of patients whose primary language is not English, the current provision of interpretation services is not

094092602.1.8	1.4.1	1.4.1 (A – D)	REGION 2 COLLABORATIVE TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
University of Texas Medical Branch Hospital				**TPI - 094092602**
Related Category 3 Outcome Measure(s):	**094092602.3.17**	**IT-6.1**	**Percent over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Automated report (such as from Health Care Interpreter Network or Video Medical Interpretation and/or other encounter data report) Rationale/Evidence: Provision of interpreter services results in patients asking more questions, having a better understanding of treatment plans, and reporting higher patient satisfaction scores. Milestone 1 Estimated Incentive Payment *(maximum amount):* $277,952	optimize their performance in order to increase language access Milestone 2 Estimated Incentive Payment: $976,700		meeting the demand. Provision of interpreter services results in patients asking more questions, having a better understanding of treatment plans, and reporting higher patient satisfaction scores (Ku, Health Affairs, 2005). **Milestone 4** Estimated Incentive Payment: $1,078,248	meeting the demand. Provision of interpreter services results in patients asking more questions, having a better understanding of treatment plans, and reporting higher patient satisfaction scores (Ku, Health Affairs, 2005). Milestone 6 Estimated Incentive Payment: $921,171
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $277,952	Year 3 Estimated Milestone Bundle Amount: $967,700		Year 4 Estimated Milestone Bundle Amount: $1,078,248	Year 5 Estimated Milestone Bundle Amount: $921,171
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,245,071				

PROJECT OPTION: 1.5.3 Implement project to enhance collection, interpretation, and/or use of REAL data

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.1.9 – Pass 2
PERFORMING PROVIDER NAME/TPI: University of Texas Medical Branch at Galveston/094092602

Title of project: "Strengthening the UTMB health information system to Reduce Health Disparities"

Provider description: UTMB is an academic health center comprised of a 475 bed acute care hospital, Level 1 Trauma Center, 44 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.

Intervention(s). This project proposes to develop an information infrastructure, and support research and development of interventions to address health disparities in UTMB's clinical and hospital patient population. This project will allow UTMB to stratify patient outcomes, diagnoses, and quality measures along the lines of race, ethnicity, language, and billing/insurance status, including using both two-way and three-way interactions (race and quality; gender, race, and quality) to identify priority health disparities. Action plans to address priority issues will include community-based preventive approaches as well as clinical and hospital interventions.

Project goal(s). The overall goal of this project is to reduce health disparities in the UTMB patient population, and more broadly in the general population, by improving the UTMB health information system to report on REAL data related to health disparities, and to develop and implement interventions based on that information. Specifically, this project conforms to the goal explicated in the RHP Planning Protocol: "To improve the collection of valid and reliable self-reported data on the demographics of patients receiving care, the quality of care delivered, and implementing stratification capabilities to stratify clinical/quality data, and analyzing data by relevant demographic categories: race, ethnicity, sex, primary language and disability status.[1]. The project focuses on efforts to reduce health and mental health disparities, disparities among racial/ethnic groups, women, seniors, children, rural populations, and those with disabilities and their families.

Need for the project: Currently, UTMB's health information system is not designed to allow collection and analysis of health disparities based on REAL data stratifiers, and we do not have access to health disparities data within the patient population. Consequently, we cannot identify priority health disparities issues and which populations are most affected by health disparities, and cannot develop effective, efficient interventions to reduce disparities.

Target population: Number of patients the project will serve. This project will serve the approximately 750,000 patients UTMB admits and registers each year through our clinics and hospitals, who are largely residents of Galveston County. In FY2012, this included over 26,000 patients, with more than 680,000 hospital and clinic outpatient admissions and almost 37,000

1 http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

emergency room visits. This project also serves the more than 1,000 UTMB staff will be trained to accurately and consistently collect and record REAL data. Additionally, because the data may be useful in identifying disparities within the broader population base, and population-based and community interventions will be utilized, Galveston County the community population (over 291,000 residents) in general may also benefit from the project. Collecting and analyzing REAL data from our patients could be used to learn more about health disparities at other institutions with similar patient demographics and payer mixes. It is difficult to assess exactly how many patients within the REAL data disparities categories will be served. Galveston County's population is approximately 50% minority, with a 13% poverty rate, but the City of Galveston and UTMB populations tend to have more minority patients and significantly more poverty and low-income patients. A conservative estimate would be that our disparities target population would be approximately 14,000 patients, with potentially many more Galveston County residents affected if community interventions are undertaken to address disparities issues seen in the hospital and/or clinical care setting.

How Medicaid and/or indigent patients will benefit from the project: Health disparities typically impact the worst-off in society, especially those who are economically disadvantaged and comprise the Medicaid and/or indigent population. Economic disadvantage is highly correlated to education, race/ethnicity and other disparity stratifiers for which data will be collected and analyzed. Disparities prioritized for improvement as well as improvement targets, then, will most benefit Medicaid and/or indigent patients. Disparities can been seen among groups based on race and ethnicity, language, economic factors, education, insurance status, geographic location (rural vs. urban, zip code) , gender, sexual orientation and many other social determinants of health. The collection of REAL data helps providers to delineate potential categories of differences in observed health status." This project will specifically benefit Medicaid and Uninsured patients (as well as broader patient populations) seen at UTMB each year, who make up one-third of the payer mix (approximately 9,000 patients per year).

Expected benefit of the project to patients:

Category 1 milestones. Category 1 milestones involve setting up the information system to collect and allow analysis of REAL data; training on data collection and the use/meaning of the data and findings; setting up analysis and research protocols; refining and improving the system; testing ideas, practices, tools and solutions; and data analysis to identify priority issues. All of these activities are essential steps to developing effective interventions to address important health disparities affecting our patient population, particularly those with low incomes or other disparity stratifiers. Category 1 milestones will also benefit patients by increasing awareness of disparities and the factors that shape disparities among UTMB providers and patients themselves UTMB will now be able to target the areas of patient need and align interventions with that need.

Category 3 outcome measures: Identifying health disparities through the collection and analysis of REAL data, and the activities undertaken through Category 1 milestones and Category 3 process milestones, will allow UTMB to . reduce disparities related to HbA1c poor control, or another priority health disparity as indicated by the baseline assessment. Improved HbA1c control will reduce the health harms of diabetes, including reduced deaths, amputations, blindness, and kidney failure, as well as reduce health care costs and improve patients' general quality of life Seeing an improvement in clinical outcomes for the health disparity population

identified through this project will benefit not only the patients who are in this particular disparity group, but all patients who might fall into a disparity group in the future as the systems, policies and procedures put in place through this project will allow for continual analysis of health disparities within UTMB.

Project Description. We have chosen Project Area 1.5 Collect Valid and Reliable Race, Ethnicity, and Language (REAL) Data to Reduce Disparities and Project Option 1.5.3 Implement project to enhance collection, interpretation, and/or use of REAL data. We plan to implement all required core project components. We will a) Redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care using HIT to link administrative and billing databases with clinical and hospital patients' medical records, and by adding new fields including Race/Ethnicity data aligned with Census Bureau categories. Data will also be (newly) collected for Charity Care applicants to allow disparities analysis of provision of charity care. We will b) *Implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes*. This component will be implemented by first linking administrative and billing databases with medical records and adding new REAL-related fields, then by engaging health disparities and patient safety experts at UTMB to develop research and analysis protocols to use the data to identify disparities in patient health risks, diagnoses, quality of care, and other issues. We will c) *Develop improvement plans, which include a continuous quality improvement plan, to address key root causes of disparities within the selected population,* using the data analysis to identify key disparities issues to develop community, hospital, and/or clinical intervention plans. We will d) *Use data to undertake interventions aimed at reducing health and health care disparities (tackling "the gap") for target patient populations through improvements in areas such as preventive care, patient experience, and/or health outcomes*, partnering with community partners and reaching out to various hospital departments and administrative entities to support implementation of plans.

Challenges related to implementation include ensuring data is entered into the database in a way that supports efficient analysis of aggregated data in relation to key health indicators ensuring databases within the health information system are appropriately linked and training of providers and administrators on the implementation of the project and proper data entry methods. A final challenge relates to identification of priority disparity issues and intervention plans.

The 5-year expected outcome for Performing Provider and patients is to reduce key health disparities issues in the UTMB patient population, including "A reduction in health and health care disparities (tackling "the gap") for target patient populations through improvements in areas such as preventive care, patient experience, and/or health outcomes." Specific outcomes for UTMB include: redesigned care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care; a new training curriculum that includes effective strategies to explain the relevance of collecting REAL data to patients and staff; ongoing implementation of standardized policies and procedures to ensure the consistent and accurate collection of data; established pathways for continuous quality improvement that include reports on 5 years of project data reviews and results of tests of new ideas, practices, tools, or solutions; establishing a system that allows stratification of patient outcomes and quality measures by patient REAL

demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes; reports on quality outcomes by REAL data categories to identify potential areas of disparities, a report on three health disparities priorities within the patient population; a set of improvement plans, which include a continuous quality improvement plan, to reduce disparities within the selected population. Additionally, 5 year expected outcomes include reduced disparities in diabetes control, along with related reductions in premature death, amputations, blindness, and kidney failure, and improved quality of life among target populations.

Relation of the project to the regional goals. This project relates to all of the regional goals for the RHP by creating a system for monitoring, and developing specific proposals to address health disparities. Without specific attention to improving the health of disparity populations, we are unlikely to achieve the health gains that we desire.

Starting Point/Baseline: UTMB has not previously had the capacity (information) to identify health disparities and/or disparities in care for UTMB patients. There are no clients served by the project at present because this is a new project. Currently, the billing databases, administrative databases and patient medical records are not linked, and although the patient medical record includes "race" as a field, there is no standardization and the field does not reflect U.S. Census categories. Ethnicity and other disparities-related indicators such as level of education and income are not recorded. No providers have been trained in the project to date. This project is expected to affect the approximately 745,000 patient encounters at UTMB each year (data based on FY2012).

Time period for baseline. This is a new project, which is just now beginning implementation. By April 2013, we will have purchased the software to connect the billing and EMR databases; begun staff training; and created a linked database system to allow preliminary analyses. The baseline data on health disparities for this project will be collected during DY2 and DY3. Baseline data will analyze health diagnoses based on REAL data stratifiers.

Rationale: We have chosen Project Area 1.5 Collect Valid and Reliable Race, Ethnicity, and Language (REAL) Data to Reduce Disparities and Project Option 1.5.3 Implement project to enhance collection, interpretation, and / or use of REAL data. We are planning to implement all 4 required core project components, ranging from redesigning care pathways, to creating a system that allows disparities analysis across a range of issues and sub-populations, to identifying priorities, to developing and implementing interventions to reduce disparities and "tackle the gap."

This project option and components are relevant to the RHP's population and circumstances because they will enhance UTMB's ability to identify key health disparities within our patient population, and identify opportunities for reducing inequities through clinical care, hospital care, and community interventions to improve population health and advance prevention. Especially in the south part of Galveston County, where UTMB is located, there is a disproportionate number of poor and minority residents. For example, 9% of households in the northern half of the county live under poverty compared to 19% in the southern half; 34% of the population in the northern half of the county are racial / ethnic minorities compared to 50% in the southern half. It is estimated that there will be 14,473 Medicaid patients by 2016 in southern Galveston County, an increase of 79% over 2011 levels (from Galveston County CNA).

These "at-risk" populations would benefit from targeted interventions. UTMB focuses on health disparities in the surrounding community through research, education, and community outreach for preventive and clinical services. Local, hospital-level data on health disparities can help strengthen and direct the ongoing work of UTMB through their Center to Eliminate Health Disparities, Oliver Center for Patient Safety, and other entities working to reduce disparities.

More generally, the RHP Planning Protocol states that "In 2002, the Institute of Medicine report… signified a new era of national attention to racial and ethnic disparities in the American health care system", and that research across the country consistently finds that health disparities exist, and most affect low-income, racial and ethnic minority, limited-English proficient, and other underserved populations. This project, following the RHP Protocol, is a first step toward achieving that goal.

This project option and components are related to community need. While "health disparities" are not explicitly addressed in the CNA, the need is implied by the high levels of uninsurance, representation of disparity populations and wherever poor health outcomes are shown. Specifically for Galveston County, the county's profile report states: "The population is older than the average population of Texas…and has more Black/African Americans... Galveston County has 8 of its 24 zip code areas designated as areas of concern for pediatric blood lead levels (largely related to housing stock age and poverty). The rate of children under the age of 6 with blood lead levels greater than 10 µg/dL is higher than the state average. The county is among the worst (bottom 25% of counties in the state) in 5 out of 7 communicable diseases. For cancer incidence, Galveston's rates were among the worst (in the bottom 25% or 10% of counties in the state) for 9 of 15 cancer sites, and for all cancers (bottom 25% of counties in the state). Galveston's mortality rates for 8 of the 11 mortality indicators were among the worst compared to all other Texas counties also, especially for homicides and HIV disease....The rates of preterm births, low birth-weight births, and infant mortality are higher in the county than in Texas and the US." Further, the geographic distribution of residents with incomes below poverty, concentrations of minorities, and other populations served by UTMB through the Medicaid program are not evenly distributed within the County. The northern half of the county is predominately White, non-Hispanic with relatively higher incomes, compared to the southern half. This project will enable the examination of community-level as well as clinical, factors related to the creation and perpetuation of health disparities. Understanding the relationships among these clinical and community-level factors can aid in targeting interventions to be more effective.

This project and components are a priority for the RHP's starting point because we know little about specific health disparities on a hospital level and at a community level, and current data is insufficient for planning to address disparities. In order to do so, we need to be able to collect, access and analyze REAL data because health disparities are drawn along racial/ethnic, income, and language barrier lines.

We also know that poverty, lack of education and other forms of social exclusion limit access to healthcare and health-advancing resources. According to the Texas Region 2 Health Partnership Galveston County Profile report, "The barriers to being healthy reported by the community fell into 7 categories: access, education, environment, lifestyle, population characteristics, quality of care, resource utilization. Knowing which groups face poor health outcomes that are related

to these barriers can help us target community outreach, prevention and interventions to improve the health of disparity groups and the entire community.

Category 1 Milestones and metrics. After careful review of the justifications listed in the RHP Planning Protocol, we selected Milestones P-1, P-2, P-3, P-5, P-7, I-9, and I-11, which relate to developing templates, modifying registration screens and written materials, developing and implementing training curricula, developing a plan to ensure data is collected in all relevant patient systems, reviewing project data on a weekly basis, collecting data using a uniform framework, analyzing and reporting on quality outcomes to identify disparities, and identifying the top 3 disparities and developing a plan to address them. We chose these Milestones because, as a new project, we will need to invest in a significant amount of infrastructure in order to create an effective health information system for measuring and tracking health disparities. These milestones create a continuous pathway to development of an effective research tool to allow UTMB to implement evidence-based interventions to address our local health disparities.

We did not adopt Milestone P-4 (Implement standardized policies and procedures to ensure the consistent and accurate collection of data) because we felt the other milestones chosen would sufficiently support that goal. We did not adopt Milestones P-6 (Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects) and P-8 (Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects) because no other providers in Region 2 are implementing such a project. We did not adopt I-10 because the process and goals involved will be captured through I-11 (that is, it would be redundant). We did not adopt I-12 because it is recommended for use with an innovative project option, which we did not propose.

For DY1: Milestone 1 P-1: Develop REAL data template and/or integrate it into data warehouse, electronic health record (EHR), and/or registries. Metric 1 P-1.1: Documentation of REAL data template. Baseline: None exists. Goal: REAL data fields incorporated into electronic medical record billing and patient records systems. Data Source: Print screen, report, printout or another source of documentation showing capability to integrate REAL data, REAL database, data warehouse, EHR or registry.

Milestone 2 P-2: Modify registration screens and written registration materials in order to increase the collection of consistent, valid and reliable data. Metric 1 P-2.1: Documentation of registration screens in place. Baseline: Modification needed. Goal: REAL data fields incorporated into 100% of UTMB registration screens / materials. Data Source: Submission of registration print-screen, patient registration system.

Milestone 3 P-3: Develop curriculum or implement an existing evidence-based curriculum that includes effective strategies to explain relevance of collecting REAL data to patients and staff. Metric 1 P-3.1: Number or proportion of staff trained on curriculum. Baseline: None previously offered. Goal: 1,000 current staff trained. Data Source: HR workforce training data.

Milestone 4 P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested

per quarter (24 total in DY2, assuming start by 5/1/2013). Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals.

Milestone 5 P-5: Develop a plan to propagate, establish, and document standard REAL data in all relevant patient care systems participating in enterprise standard registration approach. Metric 1 P-5.1: Description of elements of the system. Baseline: No current capacity for REAL data collection or analysis. Goal: Description of policies and procedures for REAL data collection completed. Data Source: Documentation of system/processes being implemented, Policies, procedures, or other similar sources.

For DY2: Milestone 6 P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals.

Milestone 7 I-9: Collect valid, reliable REAL data fields as structured data, using a uniform framework. This framework provides a process improvement tool for health care organizations to systematically collect demographic and communications data from patients or their caregivers. Metric 1 I-9.1: The number or percent of patients registered with the Performing Provider. Goal: at least 30% of unique patients registered with designated REAL data fields (out of approximately 26,000 total unique patients registered). Data Source: Registry, electronic medical record, or other registration system (EPIC).

Milestone 8 I-11: Identify top three health care disparities within the patient population and develop an improvement plan to address them. Specifically, (1) Conduct an analysis of health outcomes by REAL data fields. (2) Submit the top three targeted disparities. (3) Submit the improvement plan to address those disparities. Metric 1 I-11.1: Documentation of disparities and improvement plan. Goal: Analysis of at least 1 disparity stratifier completed, health disparities identified, and improvement plan submitted to UTMB Health executive leadership. Data Source: electronic medical record; submitted improvement plan.

For DY4: Milestone 9 P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals.

Milestone 10 I-9: Collect valid, reliable REAL data fields as structured data, using a uniform framework. This framework provides a process improvement tool for health care organizations to systematically collect demographic and communications data from patients or their caregivers. Metric 1 I-9.1: The number or percent of patients registered with the Performing Provider. Goal: at least 50% of unique patients registered with designated REAL data fields (out of approximately 26,000 total unique patients registered). Data Source: Registry, electronic health record, or other registration system (EPIC).

Milestone 11 I-11: Identify top three health care disparities within the patient population and develop an improvement plan to address them. Specifically, (1) Conduct an analysis of health outcomes by REAL data fields. (2) Submit the top three targeted disparities. (3) Submit the improvement plan to address those disparities. Metric 1 I-11.1: Documentation of disparities and improvement plan. Goal: Analysis of at least 2 disparity stratifiers completed, health disparities identified, and improvement plan submitted to UTMB Health executive leadership. Data Source: electronic medical record; documentation of improvement plan proposal.

For DY5: Milestone 12 P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals.

Milestone 13 I-11: Identify top three health care disparities within the patient population and develop an improvement plan to address them. Specifically, (1) Conduct an analysis of health outcomes by REAL data fields. (2) Submit the top three targeted disparities. (3) Submit the improvement plan to address those disparities. Metric 1 I-11.1: Documentation of disparities and improvement plan. Goal: Top health disparities monitored, and improvement plan developed. Data Source: electronic medical record; documentation of improvement plan proposal. Rationale: Several RHPs within Texas focus on health disparities in communities through research, education, and community relations. To build upon the existing infrastructure to address health disparities in Texas, RHPs will select projects appropriate to specific populations based on relevancy to the RHP needs assessment. Some populations experience disparities in health, quality of care, health outcomes, and incidence as related to conditions such as: tuberculosis, congestive heart failure, stroke, COPD, Chlamydia, cervical cancer, liver cancer, stomach cancer, gallbladder cancer, child and adolescent leukemia, neural tube defects, other birth defects, obesity, diabetes, and pesticide poisoning. Disparities can been seen among groups based on race and ethnicity, language, economic factors, education, insurance status, geographic location (rural vs. urban, zip code) , gender, sexual orientation and many other social determinants of health. The collection of REAL data helps providers to delineate potential categories of differences in observed health status.

Unique community need identification number the project addresses. This project addresses the following community needs: CN.1, CN.2, and CN.12-18.

New or enhanced initiative, and DHHS funding. This project represents a new initiative for UTMB Health. This will be the first time the billing/registration and medical record software systems will be merged, allowing for the first time the type of health disparity analysis proposed in this project. This project does not receive any funding from the U.S. Department of Health and Human Services.

Category 3 Outcome Measure: OD-11 Addressing Health Disparities in Minority Populations; IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group (HbA1c poor control among African Americans).

In DY2 we selected P-3 Develop and Test Data Systems (data source: reports from the electronic medical record). We selected this Process Milestone because we need to ensure that our data system is set up to record outcomes for a range of clinical indicators that we may select based on the health disparity analysis that is part of this project. **In DY3** we selected P-2: Establish Baseline Rates (data source: electronic medical record). We selected this Process Milestone because we do not have a baseline for disparities data in relation to patient health experiences, access, and outcomes. Establishing baseline rates is necessary if we are to monitor and measure our progress toward improving a clinical indicator in a disparity group. By establishing the baseline rates after we have developed and tested the system, we can ensure that the baseline is more accurate. **In DY 4 and DY5** we selected IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group (OD- 11 Addressing Health Disparities in Minority Populations). We selected this Improvement Target because it best lent itself to disparities related work, provided a clear path for making sustainable evidence based change, and could be accomplished in the time frame allowed. The clinical indicator to be improved and disparity group addressed will be determined in DY3 once data on health disparities is collected and analyzed. **Metric**: Our Improvement Target will be: % improvement over baseline (TBD in DY3) of disparity in HbA1c poor control (>9.0%) Because we have never before had the capacity to analyze and identify disparities in clinical indicators, the decision regarding which clinical indicator to improve is based on research describing common disparities. However, if the baseline data (to be collected in DY3) suggests that this is not a priority clinical indicator to address, we hope to able to redefine our outcome measure in consultation with HHSC and/or CMS. **Numerator**: # of disparity population patients with HbA1c poor control divided by # of total disparity population patients with diabetes. **Denominator**: # of total patients with HbA1c poor control divided by # of total patients with diabetes (E.g. African American patients with uncontrolled diabetes/African American patients with diabetes, divided by Total patients with uncontrolled diabetes/Total patients with diabetes). **Data source**: electronic medical record. **Goal**: In DY4, and DY5, our goal is to see an improvement over the baseline , set in DY3 The % improvement will be determined in DY3, based on reasonable impact expectations of the interventions proposed, as indicated in the research literature.

Rationale: We selected this Improvement Target because it best lent itself to disparities related work, provided a clear path for making sustainable evidence based change, and could be accomplished in the time frame allowed. The clinical indicator to be improved will be HbA1C poor control and disparity group addressed will be African Americans, unless data collected for baseline rates in DY3 indicate that this disparity issue and group is not a priority.

This Category 1 Project Area—1.5 Collect Valid and Reliable Race, Ethnicity, and Language (REAL) Data to Reduce Disparities—**is directly related to Category 3 Improvement Target IT-11.1** Improvement in Clinical Indicator in Identified Disparity Group because the evidence base for selecting an appropriate Clinical Indicator for which to reduce disparities depends on the collection of appropriate data. We will not be able to develop effective plans for reducing disparities, nor monitoring progress, without a system for measuring and tracking disparities.

Focusing on the outcomes will help improve the health of low-income populations. Reducing health disparities is one of the most direct ways to improve the health of low-income populations, because they suffer most from disparities. Many of the factors that contribute to poor health (including in terms of prevention, access to care, and quality of care) are

concentrated in or directly related to being part of low income populations, racial/ethnic minorities and individuals with limited English proficiency.

Relationship to other Projects:

This project's focus on data systems and emphasis on race, ethnicity, and language data ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 094092602.1.9. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on strengthening the UTMB health information system to reduce health disparities through the collection of REAL data. There are no other related Category 1 simlar projects in the RHP.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.

- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.1.9	1.5.3	1.5.3.(A-D)	STRENGTHENING THE UTMB HEALTH INFORMATION SYSTEM TO REDUCE HEALTH DISPARITIES	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	**094092602.3.18**	**3.IT-11.1**	**Improvement in Clinical Indicator in Identified Disparity Group (HbA1c poor control among African Americans)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Develop REAL data template and/or integrate it into data warehouse, electronic health record (EHR), and/or registries Metric 1 P-1.1]: Documentation of REAL data template Baseline: None exists Goal: REAL data fields incorporated into electronic medical record billing and patient records systems Data Source: Print screen, report, printout or another source of documentation showing capability to integrate REAL data, REAL database, data warehouse, EHR or registry Milestone 1 Estimated Incentive Payment : $547,849 **Milestone 2** P-2: Modify registration screens and written registration materials in order to increase the collection of consistent, valid and reliable data Metric 1 P-2.1: Documentation of registration screens in place Baseline: None Goal: REAL data fields incorporated into 100% of UTMB registration screens / materials	**Milestone 6** P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals Milestone 6 Estimated Incentive Payment: $148,712 **Milestone 6** I-9: Collect valid, reliable REAL data fields as structured data, using a uniform framework. This framework provides a process improvement tool for health care organizations to systematically collect demographic and		**Milestone 9** P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals Milestone 9 Estimated Incentive Payment: $127,885 **Milestone 10** I-9: Collect valid, reliable REAL data fields as structured data, using a uniform framework. This framework provides a process improvement tool for health care organizations to systematically collect demographic and communications	**Milestone 12** P-7: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals Milestone 12 Estimated Incentive Payment: $145,379 **Milestone 13** I-11: Identify top three health care disparities within the patient population and develop an improvement plan to address them. Specifically,

094092602.1.9	1.5.3	1.5.3.(A-D)	STRENGTHENING THE UTMB HEALTH INFORMATION SYSTEM TO REDUCE HEALTH DISPARITIES	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	**094092602.3.18**	**3.IT-11.1**	**Improvement in Clinical Indicator in Identified Disparity Group (HbA1c poor control among African Americans)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Submission of registration print-screen, patient registration system Milestone 2 Estimated Incentive Payment: $547,849 **Milestone 3** P-3: Develop curriculum or implement an existing evidence-based curriculum that includes effective strategies to explain relevance of collecting REAL data to patients and staff Metric 1 P-3.1: Number or proportion of staff trained on curriculum Baseline: None currently exists Goal: 1,000 current staff trained Data Source: HR workforce training data Milestone 3 Estimated Incentive Payment: $547,849 **Milestone 4** P-7: 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	communications data from patients or their caregivers. Metric 1 I-9.1: The number or percent of patients registered with the Performing Provider. Goal: at least 30% of unique patients registered with designated REAL data fields (out of approximately 26,000 total unique patients registered) Data Source: Registry, electronic medical record, or other registration system (EPIC) Milestone 7 Estimated Incentive Payment: $148,712 **Milestone 8** I-11: Identify top three health care disparities within the patient population and develop an improvement plan to address them. Specifically, (1) Conduct an analysis of health outcomes by REAL data fields. (2) Submit the top three targeted disparities. (3) Submit the improvement plan to address those disparities. Metric 1 I-11.1: Documentation of disparities and improvement plan		data from patients or their caregivers. Metric 1 I-9.1: The number or percent of patients registered with the Performing Provider. Goal: Goal: at least 50% of unique patients registered with designated REAL data fields (out of approximately 26,000 total unique patients registered) Data Source: Registry, electronic health record, or other registration system (EPIC) Milestone 10 Estimated Incentive Payment: $127,885 **Milestone 11** I-11: Identify top three health care disparities within the patient population and develop an improvement plan to address them. Specifically, (1) Conduct an analysis of health outcomes by REAL data fields. (2) Submit the top three targeted disparities. (3) Submit the improvement plan to address those disparities.	(1) Conduct an analysis of health outcomes by REAL data fields. (2) Submit the top three targeted disparities. (3) Submit the improvement plan to address those disparities. Metric 1 I-11.1: Documentation of disparities and improvement plan Goal: Top health disparities monitored, and improvement plan developed Data Source: electronic medical record; documentation of improvement plan proposal Milestone 13 Estimated Incentive Payment: $145,379

094092602.1.9	1.5.3	1.5.3.(A-D)	STRENGTHENING THE UTMB HEALTH INFORMATION SYSTEM TO REDUCE HEALTH DISPARITIES	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	**094092602.3.18**	**3.IT-11.1**	**Improvement in Clinical Indicator in Identified Disparity Group (HbA1c poor control among African Americans)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
sampling that is sufficient for the purposes of improvement. Metric 1 P-7.1: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: 12 new ideas, practices, tools, or solutions identified or tested per quarter (24 total in DY2, assuming start by 5/1/2013) Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals Milestone 4 Estimated Incentive Payment: $547,849 **Milestone 5** P-5: Develop a plan to propagate, establish, and document standard REAL data in all relevant patient care systems participating in enterprise standard registration approach. Metric 1 P-5.1: Description of elements of the system Baseline: No current capacity for REAL data collection or analysis Goal: Description of policies and procedures for REAL data collection completed	Goal: Analysis of at least 1 disparity stratifier completed, health disparities identified, and improvement plan submitted to UTMB Health executive leadership Data Source: electronic medical record; submitted improvement plan Milestone 8 Estimated Incentive Payment: $148,711		Metric 1 I-11.1: Documentation of disparities and improvement plan Goal: Analysis of at least 2 disparity stratifiers completed, health disparities identified, and improvement plan submitted to UTMB Health executive leadership Data Source: electronic medical record; documentation of improvement plan proposal Milestone 11 Estimated Incentive Payment: $127,886	

094092602.1.9	1.5.3	1.5.3.(A-D)	STRENGTHENING THE UTMB HEALTH INFORMATION SYSTEM TO REDUCE HEALTH DISPARITIES	
The University of Texas Medical Branch at Galveston				**094092602**
Related Category 3 Outcome Measure(s):	**094092602.3.18**	**3.IT-11.1**	**Improvement in Clinical Indicator in Identified Disparity Group (HbA1c poor control among African Americans)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of system/processes being implemented, Policies, procedures, or other similar sources Milestone 5 Estimated Incentive Payment: $547,849				
Year 2 Estimated Milestone Bundle Amount: $2,739,245	Year 3 Estimated Milestone Bundle Amount: $446,135		Year 4 Estimated Milestone Bundle Amount: $383,656	Year 5 Estimated Milestone Bundle Amount: $290,758
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,859,794				

PROJECT OPTION 1.9.1 - Expand Specialty Care Capacity Through Training for Burn and Trauma Care
UNIQUE RHP PROJECT ID: 094092602.1.10 - Pass 2
PERFORMING PROVIDER NAME/TPI - University of Texas Medical Branch/094092602

Provider: UTMB is an academic health center comprised of a 475 bed acute care hospital, Level 1 Trauma Center, 44 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
Intervention(s): This project will develop a data base and measurements to focus educational sessions to pre-hospital and hospital healthcare providers in Region 2 that care for patients with burns and trauma injuries in order to prevent complications related to the pre-hospital treatment and delays in transfer to a Burn or Trauma Center for better outcomes.
Need for the project: There is a high rate of mortality from "accidents" in the region. The community needs assessment documents mortality rates in Region 2 due to accidents ranges from 45.4 to 92.2 per 100,000 population. This rate is higher than the Texas and the US average rate. This area of the country has a very high rate of morbidity and mortality from burn and trauma injuries. Training of health care workers in the emergency management of burn and trauma care will help reduce the mortality rate associated with complications from delayed access to burn and trauma.

Additionally, high rates of emergency department utilization are a major issue for region 2. The county rates of emergency department visits for the region range from 17,461 to 78,955 per 100,000 populations. Providing proper training for first responders as well as emergency rooms and educating hospital personnel on the American Burn Association burn referral guidelines will result in a decrease unnecessary utilization of emergency departments.
Target Population*:* In FY12, our facility had 600 (400 UTMB, 200 SHC) acute burn admissions and 1,519 trauma admissions. Of those admissions, 38% burn and 45% trauma admissions in FY12 were Medicaid and uninsured. We follow over 5,000 active burn outpatients and about 150 trauma outpatients for follow-up care yearly. These numbers do not include follow up care to specialty clinics such as orthopedists, plastics, oral surgery, etc.
Category 1 or 2 expected patient benefits: The project seeks to provide improvement over baseline rate of complications for burn and trauma patients transferred to UTMB and Shriners Hospital by educating pre-hospital and hospital healthcare providers and provide resources for early transfer to a Burn or Trauma Center.
Category 3 outcomes: IT-4.1 Our goal is to improve risk adjusted Potentially Preventable Complications rate(s) of Renal Failure, Respiratory Failure, Injury adjusted risk for mortality, Length of Stay, and Compartment Syndromes for burn and trauma patients transferred to UTMB and Shriners Hospital by 5% in DY4 and by 10% in DY5.
Project Description
UTMB Health proposes to create an educational and training program to address Burn and Trauma Care through the collaborations of Burn and Trauma Services of the University of Texas Medical Branch and Shriners Hospital for Children in Galveston.

This proposal will provide a mechanism to close the gap for underserved populations related to burn and traumatic injuries. By improving today's traditional health care plan for underserved populations through health care system reform, we can improve access to care through education of pre-hospital care and emergency department care providers in order to improve access to specialty care burn and trauma units which will lead to improvements in morbidity and mortality, long term outcomes, patient satisfaction and quality of life. Texas chemical manufacturers account for more than 50% of the total US chemical production with 400 chemical plants and refineries along the Texas Gulf Coast (the largest petrochemical complex in the world). Houston is considered the energy capital of the nation and a world center with 16 of the nation's top 20 oil pipelines companies. Baytown houses the largest refinery in the nation. This region's providers must be educated and prepared to handle a disaster when (not if) a disaster occurs.

UTMB has a long standing commitment to Trauma and Burn care highlighted by its response in high profile incidents such as the 1947 Texas City blast involving the ships "Grandcamp" and High Flyer" and most recently the 2005 Texas City-BP disaster. With the exception of a 4 month interruption to the Burn Center and a 9 month disruption following Hurricane Ike in September of 2008, UTMB has been verified by the Texas Department of Health and the American College of Surgeons Committee on Trauma as a Level 1 Trauma center since 1999, and a verified Burn center since 1996. These programs involve a multidisciplinary effort to provide the highest levels of care for all injured patients during the course of their treatment from the ER, to the OR, to the ICU and throughout recovery and rehabilitation.

UTMB serves as a regional referral resource for patient care of injured patients including Trauma and Burns, and provide ongoing educational support for physicians, nurses and pre-hospital providers. In addition to clinical education and support we participate in injury prevention programs in the community to increase awareness and limit the epidemic of injury in our region. As part of the Regional Healthcare Partnership Plan we anticipate considerable expansion of our clinical outreach and referral programs, along with our education, injury prevention and epidemiology programs as we include the 8 other counties in Region 2 (San Jacinto, Polk, Tyler, Angelina, Nacogdoches, San Augustine, Shelby, Sabine).
The project includes a multidisciplinary approach to expanding the training of specialty care capacity in burn and trauma care. The Burn and Trauma Pre-hospital Educational and Safety Program will be primarily an outreach program. We will travel to Pre-hospital settings such as ambulance services, industrial plants, community hospitals and fire services within Region 2 to provide them educational programs and educational resources to provide optimal burn care prior to transfer of these patients. By providing pre-hospital educational programs we anticipate a reduction in the unnecessary use of emergency room services and decrease/avoidance in complications to this patient population. Additionally, the project will expand a critical care fellowship program along with additional training of physicians, nurses, therapist and other health care workers specializing in the care of burn and trauma victims. As world leaders in burn care, SHC -Galveston and the University of Texas Medical Branch-Blocker Burn Unit have the burn and trauma expertise, knowledge base and experience to provide hands on educational programs to meet the expanding educational needs.

Our target population for this project includes both the recipients of the proposed education and training throughout Region 2 as well as the acute burn and trauma admissions at UTMB.

Goals and Relationship to Regional Goals:

The goal of this project is to use the expertise from UTMB's Burn and Trauma Services to increase the access to specialized services in our region by providing educational programs to physicians, first responders, nurses, therapist and other specialty care providers in our region.

Federal funding (Medicare Direct Graduate Medical Education or DGME) for residency training is capped at 1996 levels for the direct support of graduate medical education. The cap only supports a third of the costs of 4,056 of the 4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13%.

In FY12, we had 400 acute burn admissions. Of those 38% were admitted to UTMB and the reminder to Shriners Hospital. In FY12, UTMB had 1,519 trauma admissions. Of the total admissions, 38% burn and 45% trauma admissions in FY12 were Medicaid and uninsured. We follow over 5,000 active burn outpatients and about 150 trauma outpatients for follow-up care yearly. These numbers do not include follow up care to specialty clinics such as orthopedists, plastics, oral surgery, etc.

Project goal(s):

1. Increase the burn and trauma knowledge base of all pre-hospital and hospital personnel region 2.
2. Promote burn and trauma prevention strategies in our communities and throughout Texas.
3. Provide burn and trauma resources for medical facilities in our region.
4. Improve risk adjusted of Potentially Preventable Complications such as length of stay, ventilator days, renal failure, risks adjusted mortality, and compartment syndrome.

This project meets the following regional goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, and reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce.

Challenges:

- Data availability for the region related to burn and trauma care. The state registry has not been consistent through all counties.
- EMS availability for educational programs. EMS in rural areas are often volunteers and we might have difficulties engaging them as they may have personal commitments and full time jobs to fulfill. We will do educational sessions with short lectures, handouts and other reference material that can be used when needed.

The 5-year expected outcome(s) for Provider and Patients:

UTMB and Shriners Hospital will collaborate to improve pre-hospital care of burn and trauma patients by educating community medical personnel by expanding specialty care capacity training in burn and trauma care for physicians, nurses and other health care workers.

- Improve mortality rates for burn and trauma patients
- Improve access and care to trauma patients
- Reduce unnecessary emergency room visits

Starting Point/Baseline:

We will gather baseline data regarding incidence, mortality, and time to definitive treatment for burn and trauma patients in Region 2. We may be only to obtain data from those patients that were transferred to UTMB and Shriners hospitals. Training with Galveston EMS and adjacent EMS providers has been ongoing. Galveston EMS participates in training offered at UTMB and in case review with collaboration of the Emergency Services Nursing Staff. The Burn Center staff has been providing burn care presentations to counties near UTMB.

Rationale:

We selected the following project components:

1.9.1 Increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so patients have increased access to specialty services.

We propose to meet project components.

a) Identify gaps in care and coordination for Burn and Trauma patients.

b) Increase the number of residents/trainees choosing Burn or Trauma specialties by providing fellows with the opportunity to participate in the project.

c) Design workforce enhancement initiatives to support access to Burn and Trauma providers in underserved markets and areas.

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

We chose the following project Milestones: P-1 Conduct specialty care gap assessment based on community needs; P-2: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties.

Fire is the fifth leading cause of unintentional injury and the third leading cause of fatal home injury in the U.S. Approximately 450,000 burn injuries receive medical treatment each year, and 3,500 people die in fire related accidents each year. (1) According to the Center for Disease Control (CDC), each year, trauma accounts for 42 million emergency department visits and 2 million hospital admissions across the nation. (2)

Burn and Trauma center care have been associated with improved survival, decrease hospital costs, and shorter length of stay. Early and appropriate treatment is critical to the outcome of the burn and the trauma victim. Inappropriate initial treatment can lead to patients renal

failure, increased length of stay, increased ventilator days, compartment syndrome and high mortality.

Access to Burn and Trauma care is imperative for delivering the right care, at the right place, at the right time. CDC supported research shows a 25% reduction in deaths for severely injured patients who receive care at a Level I trauma center rather than at a non-trauma center. (3)
Providing education to rural areas far away from Burn and Trauma centers will greatly increase access to specialty care and improved outcomes. Based on our region's needs, we must also include education related to the industrial community. Texas chemical manufacturers account for more than 50% of the total US chemical production with 400 chemical plants and refineries along the Texas Gulf Coast (the largest petrochemical complex in the world). Houston is considered the energy capital of the nation and a world center with 16 of the nation's top 20 oil pipelines companies and Baytown houses the largest refinery in the nation. These statistics demonstrate the great risk this region has for industrial disasters. This region must be educated and prepared to handle a disaster when (not if) a disaster occurs.

There is a high rate of mortality from "accidents" in the region. The community needs assessment documents mortality rates in Region 2 due to accidents ranges from 45.4 to 92.2 per 100,000 population. This rate is higher than the Texas and the US average rate. This area of the country has a very high rate of morbidity and mortality from burn injuries. Training of health care workers in the emergency management of burn care will help reduce the mortality rate from burn related accidents. Additionally, high rates of emergency department utilization are a major issue for region 2. The county rates of emergency department visits for the region range from 17,461 to 78,955 per 100,000 population. Furthermore, there is a high lack of specialty care physicians and other health care workers in Region 2. The community needs assessment documents a lack of specialty care physician in our Region to be 65.9 per 100,000. We have only half of the specialty care physicians in our area that we should have according to estimates.

References:
(1)http://ameriburn.org/resources_factsheet.php?PHPSESSID=7ff4976025bb95f31afc087aa7e86649
(2)http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html
(3)http://www.cdc.gov/traumacare/access_trauma.html

Unique Community Need Identification numbers:

This project will identify and address education gaps for pre-hospital and hospital healthcare providers necessary for the timely care of burn and trauma patients.

- CN.4-Lack of specialty care physicians
- CN.5-Lack of mid-level providers
- CN.16-High mortality rate from accidents
- CN.10-High rates of emergency department utilization

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

Currently Burn and Trauma Services at UTMB provide education to adjacent communities within our county. This is an expansion to Region 2 of the services we currently provide. The

ability to reach rural areas within Region 2 with education will enhance the pre-hospital treatment and provide opportunities for early transfer to a Burn or Trauma Center for better outcomes.

Related Category 3 Outcome Measure(s):

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

IT-4.1 Improvement in risk adjusted Potentially Preventable Complications rate(s) (Standalone measure)

a) Percent change in risk adjusted PPC rate for targeted conditions. The following are 5 of the 10 highest volume of complication amongst burn and trauma patients:
    1) Renal Failure
    2) Length of Stay
    3) Ventilator Days
    4) Compartment Syndrome
    5) Risk Adjusted Mortality

Reasons/rationale for selecting the outcome measures:

There is a high rate of mortality from "accidents" in the region. The community needs assessment documents mortality rates in Region 2 due to accidents ranges from 45.4 to 92.2 per 100,000 population. This rate is higher than the Texas and the US average rate. This area of the country has a very high rate of morbidity and mortality from burn and trauma injuries. Training of health care workers in the emergency management of burn and trauma care will help reduce the mortality rate associated with complications from delayed access to burn and trauma.

Additionally, high rates of emergency department utilization are a major issue for region 2. The county rates of emergency department visits for the region range from 17,461 to 78,955 per 100,000 population. Providing proper training for first responders as well as emergency rooms and educating hospital personnel on the American Burn Association burn referral guidelines will result in a decrease unnecessary utilization of emergency departments.

Relationship to other Projects:

This project's focus on expanding access to specialty care and emphasis on burn and trauma care ties to these Category 1 and 2 projects in our RHP: 109372601.2.1, 109372601.1.1, 131030203.1.4, 094092602.1.10. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on expanding high impact specialty care capacity through burn and trauma care. There are no related similar projects in the RHP.

Plan for the Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase.

The target population for all of services is largely uninsured individuals or those with Medicaid/Medicare for whom no providers are available in the service region. One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness. We are anticipating increasing our total number served through our Expansion of Behavioral Healthcare project at a rate to be later determined. Individuals identified as having health risk factors will receive targeted support services from peer specialists as well as linking to primary and preventative care. In the end individuals in our target population will have better health risk outcomes which impact the number of primary care visits they would throughout the year.

094092602.1.10	1.9.1	1.9.1 (A-C)	Expand Specialty Care Capacity Through Training for Burn and Trauma Care
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.19	IT-4.1	Improvement in risk adjusted Potentially Preventable Complications rate(s) (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] Conduct specialty care gap assessment based on community needs **Metric 1**: [P-1.1]: Documentation of assessment identifying complication rates and time to definitive care for burn and trauma patients transferred to UTMB and Shriners Hospital. **Goal:** Establish baseline rates of current complications providing increased risk to patient morbidity and mortality (Renal Failure, Respiratory Failure, Injury adjusted risk for mortality, Length of Stay, Compartment Syndromes) for burn and trauma patients transferred to UTMB and Shriners Hospital and complete implementation plan by 9/30/13. **Data Source:** Hospital transfer data and database complication data. **Milestone 1 Estimated Incentive Payment** (maximum amount): $137,212	**Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. **Metric 1** [P-2]: Training of staff and providers on referral guidelines, process and Technology **Baseline:** Currently providing some trauma and burn care in rural areas. **Goal:** Train 100 healthcare personnel by 9/30/2014. **Data Source:** Training curriculum and rosters. **Milestone 2 Estimated Incentive** Payment: $957,094	**Milestone 3** [P-14]: Expand targeted specialty care training in burn and trauma care. **Metric 1** [P-14.1]: Expand the TSC residency, mid-level provider (physician assistants and nurse practitioners), and/or other specialized clinician/staff training programs and/or rotations **Goal:** Train 100 healthcare personnel by 9/30/2014. **Baseline:** Currently providing some trauma and burn care in rural areas. **Data Source:** Training curriculum and rosters. **Milestone 3 Estimated Incentive** Payment: $839,294	**Milestone 3** [P-14]: Expand targeted specialty care training in burn and trauma care. **Metric 1** [P-14.1]: Expand the TSC residency, mid-level provider (physician assistants and nurse practitioners), and/or other specialized clinician/staff training programs and/or rotations **Goal:** Train an additional 100 healthcare personnel by 9/30/2016. **Baseline:** Currently providing some trauma and burn care in rural areas. **Data Source:** Training curriculum and rosters. **Milestone 4 Estimated Incentive** Payment: $650,075

094092602.1.10	1.9.1	1.9.1 (A-C)	Expand Specialty Care Capacity Through Training for Burn and Trauma Care
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.19	IT-4.1	Improvement in risk adjusted Potentially Preventable Complications rate(s) (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $137,212	Year 3 Estimated Milestone Bundle Amount: $957,094	Year 4 Estimated Milestone Bundle Amount: $839,284	Year 5 Estimated Milestone Bundle Amount: $650,075
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,583,665			

PROJECT OPTION: 1.9.2 - Expand Specialty Care Access in Galveston and Brazoria Counties

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 109372601.1.1
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/109372601

Title of project: 1.9.2 Expand Specialty Care Access in Galveston and Brazoria Counties by increasing service availability and implementing transparent, standardized referrals across the system.
PROVIDER: UTMB's Faculty Group Practice is a premier academic multi-specialty medical group with more than 500 physicians providing specialty care and primary care for the entire family. We provide state-of-the-art preventive, diagnostic and treatment services. As an academic medical practice, many of our physicians are also teachers and researchers working toward the continued improvement of the practice of medicine. The Faculty Group Practice physicians provide medical services primarily at UTMB Hospitals & Clinics, as well as other medical facilities throughout Southeast Texas.
INTERVENTIONS: This project will expand specialty care capacity for Galveston and Brazoria Counties by increasing service availability, and implementing transparent, standardized referrals across the system. A specialty care gap assessment will be performed to identify the specific specialty needs of the populations and staff will be trained on referral guidelines, processes, and technology.
NEED FOR THE PROJECT: Both Brazoria and Galveston counties are underserved by many specialty care providers per 100'000 and many UTMB Health specialty services have wait times of greater than 2 weeks for the third available appointment, resulting in a shortage of specialty care access. Brazoria County alone has a rate less than 1/3 of the Texas rate for specialty care providers.

Specialty Care Physician Shortage:

- Galveston: 69.5 specialty care physicians per 100,000
- Brazoria: 30.5 specialty care physicians per 100,000
- Texas: 95.5 specialty care physicians per 100,000

TARGET POPULATION: Our target population is composed of the medically underserved areas with in Galveston and Brazoria counties, as well as, the portion of the population that is suffering from chronic diseases, with an emphasis on the diabetes and obesity. In RHP 2, the prevalence of diabetes is 9.3%-13.4% and the prevalence of obesity is 27.3%-32.5%.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project aims to increase specialty care access for patients and improve their ability to manage and prevent chronic disease by using the technology to improve transparency and the referral process. With increased access to specialists, patients will better be able to better control their chronic disease and by DY5 improve blood pressure control (< 140/80mm Hg) for patients 18-75.
CATEGORY 3 OUTCOME: IT-1.11 – Our goal is to improve diabetes blood pressure control (<140/80mm Hg). This improvement target was chosen because diabetes is one of the most costly and highly prevalent chronic diseases in the United States.

PROJECT DESCRIPTION:

Galveston and Brazoria Counties are underserved by many specialty care providers. The possible expansion of Medicaid services in 2014, with the inherent pent-up demand for services, will exacerbate this shortage. Multiple sources of information document a specialty care shortage in many specialties. Many of UTMB Health specialty services have wait times of greater than 2 weeks for the third available appointment, our primary care network is growing rapidly, the north county area of Galveston and Brazoria Counties are rapidly growing in population, and UTMB Health's clinic encounters in Galveston and Brazoria Counties have grown by nearly 50,000 each over the last 2 fiscal years.

Additional specialty access will improve the quality of care and health care outcomes in both Galveston and Brazoria Counties. Expanding specialty services will also help expand preventive services for Medicaid patients in this area. Community Perspective conducted interviews, surveys and focus groups that determined the need for increased access to specialty care. Brazoria County has a rate less than 1/3 of Texas rate of specialty care providers. A specialty care gap assessment will be completed in DY2 , (P-1). From that assessment; further plans to expand access could include hiring additional specialists and/or increasing clinic time of current specialists to increase access for Medicaid patients.

Our electronic medical record will allow seamless referrals and communication between our primary care and specialist providers. In order to create a comprehensive safety net health system in Galveston and Brazoria Counties, we plan to implement transparent, standardized referral processes across the system (I-24), and train UTMB staff and providers working in specialty care and in medical specialty clinics on general/operational referral guidelines, process, and technology to create the capacity to consistently and uniformly manage all referrals into medical specialties, (P-2).

Project goal(s):

The goal of this project is to increase access for specialty care services to better accommodate the high demand for these services so that Medicaid patients have increased access to specialty services within Galveston and Brazoria Counties. Our goal is to complete a specialty gap assessment to determine what specialties lack adequate access Additionally, our goal is to train 75% of UTMB specialty providers and staff within medical specialty clinics in DY 3-5 on general/operational processes, guidelines and technology for referrals and consultations through documented materials.

Anticipated challenges:

The primary challenge for this project will be to effectively introduce new specialists to UTMB Health providers as well as the physicians/providers in the communities in Galveston and Brazoria Counties to refer patients for specialty consults. A second challenge will be to promote team work between primary care providers and specialists in managing a population of patients. We will strive to work with UTMB Health primary care providers to support population management of our patients and their preventive and disease management needs. Another challenge will be engaging the patients and their families or caregivers in their own health care.

The 5-year expected outcome(s):

To complete a specialty gap assessment for Galveston and Brazoria Counties to determine the specialty areas that are lacking adequate access. UTMB will review the plan to assess the number of specialist to hire in order to close the gaps to obtaining services. 75% of UTMB specialty providers and staff will be trained on general/operational processes, policies and technologies for referrals and consultations and 75% of the medical specialty clinics will implement a specialty care access program. As a result of increased access to specialists, we hope to improve blood pressure control for patient with diabetes.

IT-1.11 Diabetes care: *BP control (<140/80mm Hg)*[1] – *NQF* 0061

The 5-year expected outcome/goal is to improve blood pressure control (<140/80mm Hg) for patients that are 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2). Automated data from Epic will be used to identify the most recent blood pressure (BP) reading during the measurement year. New specialists will promote better health for individuals and better care for the communities.

[1]http://www.qualitymeasures.ahrq.gov/content.aspx?id=34667

Regional goals:

To create a coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.

This project meets the following Region 2 goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

We know that specialty care access is limited in many areas according to different sources of information regarding the number of specialty care physicians per 100,000 population. A specialty care gap assessment will be completed to identify the specific specialty shortage areas within Galveston and Brazoria Counties so a plan can be developed to narrow the gaps in specialty services.

RATIONALE:

Galveston and Brazoria Counties are both underserved by specialty care physicians compared to the average rates for Texas and the USA. Galveston has 65.9 specialty care physicians per 100,000 population, and Brazoria has 30.5. These compare to 95.5 and 125.9 per 100,000 for Texas and the USA. Additional specialists would support addressing documented health issues in these counties. Galveston is in the bottom 25% of all Texas counties for mortality from: aortic aneurysm and dissection, cerebrovascular events, chronic liver disease and cirrhosis, hypertension and hypertensive renal disease, and HIV disease. Brazoria County is in the bottom 10% of all Texas counties for mortality from aortic aneurysm and dissection, and in the bottom 25% for mortality from hypertension and hypertensive renal disease. Both counties have cancer incidence rates in the bottom 25% of all Texas counties. In addition, both Galveston and

Brazoria Counties are in the bottom 25% of all Texas counties in the rate of tuberculosis and primary/secondary syphilis. Galveston County is also bottom 25% of Texas counties in the rates of AIDS, Varicella, and Gonorrhea. Additionally, the recent report of the Committee on Physician Distribution and Health Care Access cites psychiatry and child/adolescent psychiatry where the ratios per 100,000 population are 56.7% and 67% of the US ratios, respectively.
Finally, Region 2's health assessment identified specialty care access as a challenge/barrier to care, according to community leader and member surveys in both counties.

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. We will need to implement transparent, standardized referral processes across the system.

The RHP2 Summary of Community Needs is validation that there is indeed a specialty care physician shortage per the Texas Medical Board and US HHSC HRSA. This document is also validation for Chronic Disease treatment, such as diabetes, obesity and heart and vascular related diseases/disorders. Diabetes Prevalence is 9.3%-13.4% and the Diabetes Mortality Rate per 100,000: 16.9-36.6; Obesity Prevalence: 27.3%-32.5%, Physical Inactivity: 25%-35%; and Hypertension Mortality Rate per 100,000: 6.9-13.1 per the National Center for Chronic Disease Prevention and Health Promotion, (Calculated using BRFSS data), and the Texas Department of State Health Services Death Statistics.

By setting an outcome/goal to monitor blood pressure control for patients with diabetes, we are hoping, by managing this for patients 18-75 years of age, to also make an impact in CN.13 Obesity (especially with Type II Diabetes management), and also some heart and vascular related diseases/disorders.

Unique Community Need Identification numbers:

- CN.4 - Specialty Care Physician Shortage
- CN.12 - Chronic Diseases: Diabetes
- CN.13 – Chronic Diseases: Obesity
- CN.14 – Chronic Diseases: Heart & Vascular Related Diseases & Disorders
- CN.15 – Chronic Diseases: Pulmonary Diseases
- CN.18 – Cancer Incidence

Expansion or enhancement*:*

By expanding specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services, patients will have increased access to specialty services.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD1 – Primary Care and Chronic Disease Management:
IT-1.11 – Diabetes care: BP control (<140/80mm Hg)[234] – NQF 0061 (standalone measure)
Reasons/rationale for selecting the outcome measure:

This improvement target was chosen because 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:

This project's focus on expanding specialty and preventive services and emphasis on Galveston and Brazoria Counties as well as the use of a electronic health records to facilitate referrals and communication ties to these Category 1 and 2 projects in our RHP: 109372601.2.1, 096166602.1.1, 109372601.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the improvement of access to specialty care along with these other Category 1 projects in our RHP: 0818444501.1.1 - Expanded psychiatry delivery program; 109372601.1.1-Expand specialty Brazoria County and 131030203.1.4- Improve Access to Specialty Care.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health

care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.1.1	1.9.2	1.9.2 (C)	EXPAND SPECIALTY CARE ACCESS IN GALVESTON AND BRAZORIA COUNTIES	
The University of Texas Medical Branch at Galveston				109372601
Related Category 3 Outcome Measure(s):	109372601.3.1	IT-1.11	Diabetes care: BP control (<140/80mm Hg)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Baseline: No current gap assessment Goal: Complete gap assessment and determine baseline for moving forward. Data Source: Assessment including consultants' reports, service line plans. Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,015,441	**Milestone 2 [**P-2]: Train care providers and staff on general/operational processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 2 [P-2.1]: Training of staff and providers on general/operational referral guidelines, process and technology. Goal: 25% of specialty providers and staff will be trained and document training materials. Data Source: Log of specialty care personnel trained and Curriculum for training. Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,094,489 **Milestone 3 [**I-24]: Implement specialty care access programs (e.g. referral technologies). Metric 3 [I-24.1]Number of medical specialty clinics with specialty care access programs.	**Milestone 4 [**P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 4[P-2.1]: Training of staff and providers on general/operational referral guidelines, process and technology. Goal: 50% of specialty providers and staff will be trained within DY 3 and DY 4 and document training materials. Data Source: Log of specialty care personnel trained and Curriculum for training. Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,240,616 **Milestone 5 [**I-24]: Implement specialty care access programs (e.g. referral technologies). Metric 5 [I-24.1]Number of medical specialty clinics with specialty care access programs.	**Milestone 6[**P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 6 [P-2.1]: Training of staff and providers on general/operational referral guidelines, process and technology. Goal: 75% of specialty providers and staff will be trained within DY 3-5 and document training materials. Data Source: Log of specialty care personnel trained and Curriculum for training. Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,164,846 **Milestone 7 [**I-24]: Implement specialty care access programs (e.g. referral technologies). Metric **7** [I-24.1]Number of medical specialty clinics with specialty care

109372601.1.1	1.9.2	1.9.2 (C)	EXPAND SPECIALTY CARE ACCESS IN GALVESTON AND BRAZORIA COUNTIES	
The University of Texas Medical Branch at Galveston				109372601
Related Category 3 Outcome Measure(s):	109372601.3.1	IT-1.11	Diabetes care: BP control (<140/80mm Hg)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Numerator: Number of medical specialty clinics with specialty care access programs. Denominator: Total number of medical specialty clinics. Data Source: Written workflows of referral management processes, documentation of specialty care access programs in patient's paper or electronic medical record. Goal: 25% of medical specialty clinics with specialty care access programs. Milestone 3 Estimated Incentive Payment $2,094,489		Numerator: Number of medical specialty clinics with specialty care access programs. Denominator: Total number of medical specialty clinics. Data Source: Written workflows of referral management processes, documentation of specialty care access programs in patient's paper or electronic medical record. Goal: 50% of medical specialty clinics with specialty care access programs. Milestone 5 Estimated Incentive Payment: $2,240,616	access programs. Numerator: Number of medical specialty clinics with specialty care access programs. Denominator: Total number of medical specialty clinics. Data Source: Written workflows of referral management processes, documentation of specialty care access programs in patient's paper or electronic medical record. Goal: 75% of medical specialty clinics with specialty care access programs. Milestone 7 Estimated Incentive Payment *(maximum amount):* $2,164,846
Year 2 Estimated Milestone Bundle Amount: $4,015,441	Year 3 Estimated Milestone Bundle Amount: $4,188,978		Year 4 Estimated Milestone Bundle Amount: $4,481,232	Year 5 Estimated Milestone Bundle Amount: $4,329,693
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $17,015,343				

PROJECT OPTION: 1.11.2 Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services

UNIQUE RHP PROJECT IDENTIFICATION NUMBER*:* 109372601.1.2
PERFORMING PROVIDER NAME/TPI*:* The University of Texas Medical Branch at Galveston/109372601

Title of project: Providing Psychiatry Telemedicine Clinics to RHP 2 and the State of Texas

PROVIDER: UTMB's Faculty Group Practice is a premier academic multi-specialty medical group with more than 500 physicians providing specialty care and primary care for the entire family. We provide state-of-the-art preventive, diagnostic and treatment services. As an academic medical practice, many of our physicians are also teachers and researchers working toward the continued improvement of the practice of medicine. The Faculty Group Practice physicians provide medical services primarily at UTMB Hospitals & Clinics, as well as other medical facilities throughout Southeast Texas.
INTERVENTIONS: This project will utilize UTMB Health's telemedicine capabilities and experiences with the Texas Health and Human Services Commission and Frew Advisory Committee Funded Demonstration Project to develop a new model for child and/or adult Psychiatry Telemedicine clinics in RHP 2.
NEED FOR THE PROJECT: In 2009, 171 Texas counties did not have a psychiatrist, 102 counties did not have a psychologist, 40 counties did not have a social worker and 48 counties did not have a licensed professional counselor. There are 195 Texas counties (77% of all Texas counties) that have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health.
TARGET POPULATION: Our target population includes the underserved adult and child populations (Medicaid, specifically, Medicaid Managed Care enrollees), including those who are underserved due to a lack of providers within RHP 2 and Texas. In Galveston County alone, there are 8 census tracts that are federally designated as Medically Underserved Areas and in Brazoria County there are 6 large areas designated as Medically Underserved Areas.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project aims to expand access to psychiatric services by establishing a new Psychiatry telemedicine model with our operational partners, which will drive increases in patient satisfaction within our region.
CATEGORY 3 OUTCOME: IT-6.1 The goal of the project is to increase patient satisfaction by improving access to telemental services Medicaid Managed Care enrollees and compare, if available, to the patient satisfaction of traditional non-telemedicine Psychiatry services.
EXPLANATION OF CAT 3 IT AND IMPROVEMENT MILESTONES:
Our plan is to do satisfaction surveys but the survey respondents are different for each one. Specifically, as this is a new model we want to ensure the sustainability of the model as well as the patient satisfaction with the Psychiatry services especially compared to the traditional face-to-face Psychiatry visits.

Milestones 4 and 6, I-15 surveys will be for our operational partners in setting up the new clinics. This will include our Medicaid Managed Care plans, remote locations and our

Psychiatrists to ensure that we set up a sustainable model. Based off these satisfaction surveys our goal is to modify our operational model where necessary to ensure our partners continue so we can have long-term sustainability in servicing the Medicaid Managed Care population.

Our Cat 3 outcome IT-6.1 will focus on our Medicaid Managed Care patient(s) satisfaction and will utilize certain supplemental modules for the adult CG-CAHPS, if available. Our goal is to ensure our patients are satisfied with Psychiatry telemedicine clinical services and allow the opportunity to modify our clinical model. In addition, we have the further goal of comparing our patient satisfaction survey responses to non-psychiatry telemedicine clinics' patient satisfaction surveys, if available.

PROJECT DESCRIPTION:

Refine a new model for child and/or adult Psychiatry Telemedicine clinics and implement in RHP2 and the State of Texas using UTMB Health's telemedicine capabilities and experiences including the UTMB Health and Texas Health and Human Services Commission and Frew Advisory Committee Funded Demonstration Project. The target population includes underserved adult and child populations, including those who are underserved due to a lack of providers.

Our project will focus on the Medicaid population for RHP2 and the State of Texas. This project focuses on Medicaid beneficiaries, specifically Medicaid Managed Care enrollees to start. In addition, we will also look across Texas (other RHP areas) to also provide Medicaid Psychiatry services as this need for the Medicaid population is pervasive in Texas and telemedicine could address many barriers to access for this population. Per the Texas Health and Human Services Commission website, the February, 2013 Point in Time Count – Medicaid Enrollment identified 174,821 "Total Enrollment" for RHP2 and 3,333,064 "Total Enrollment" for Texas (website accessed February 7, 2013 http://www.hhsc.state.tx.us/research/MedicaidEnrollment/PIT/201302.html).

Our project goal involves setting up models with a remote site (possibly a current MHMR location), a Medicaid Managed Care plan and the utilization of UTMB Psychiatrists, predominantly. The models will be new clinics for Psychiatry services. We typically will start with a ½ day (4 hour clinic session) or full day (two, 4 hour clinic sessions) for appointments including new patients and then subsequently follow-up patients as well as new patients. Assuming a full day clinic once a week we would expect approximately 400 patient visits scheduled with approximately 250 patient visits seen with an estimated approximation of 38% no show rate on an annual basis. The approximation numbers are based off our first Telemedicine Psychiatry clinic implemented in DY 2 (utilizing November, December 2012 and January 2013 actual numbers and annualizing).

Our project plans to set up new Psychiatry Telemedicine clinics for Medicaid Managed Care enrollees. Based on our initial success we would expect to set up a second clinic in DY 2 and then two more clinics for each subsequent DY. Due to timing of contractual agreements with three parties (Medicaid Managed Care plans, remote locations that possibly will be MHMRs and UTMB for the Psychiatrists the actual clinic start date may not fit specifically within each DY but

our goal is to have a total of 8 full day (two, 4 hour clinic sessions) weekly clinics up and operating by the end of DY 5. The 8 full day clinics would result in approximately 3,200 patient visits scheduled, 2,000 patient visits seen using an estimated 38% no show rate on an annual basis.

Project goal(s):

Texas faces several access barriers that make the deployment of workable integrated health care models a challenge. Specifically, Texas is composed of 254 counties, the majority of which can be classified as either "rural" or "frontier". The availability of health care providers is severely limited in many of these sparsely populated areas. While these shortages make access to physical healthcare difficult for those who reside in these rural areas, the impact on individuals with behavioral health needs is even more severe. For example, in 2009, 171 Texas counties did not have a psychiatrist, 102 counties did not have a psychologist, 40 counties did not have a social worker and 48 counties did not have a licensed professional counselor.

There are 195 Texas counties (77% of all Texas counties) that have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health. Furthermore, certain specialties (such as Child Psychiatrists) are virtually non-existent in the vast majority of the rural and frontier areas of the state. Additionally, the size of the state makes travel from these underserved areas to larger urban settings difficult. For individuals who lack reliable transportation, or are disabled, or have other challenges that restrict driving, accessing health care may be virtually impossible. Furthermore, there are many non-rural areas of the state where the availability of health care professionals is greatly limited. For example, in Bexar country, which has one of the largest urban populations in Texas, there are 123 areas within the county that have been designated as HPSAs by HRSA. Similar shortages can be found in most Texas urban counties. Modern communications technology holds the greatest promise of bridging the gap between medical need in underserved areas and the provision of needed services. The developments in internet-based communications that began with voice messaging have been extended to video in the form of widely available video compression technologies that allow for high quality, real time, face-to-face communications and consultations over relatively inexpensive telecommunications equipment. With this new technology, in any area of the state where high speed broadband internet access is available, access to many forms of health care can become a reality. To leverage the promise of this new technology, Texas would like to expand the use of telemedicine, telehealth, and telemonitoring to thereby increase access to, and coordination of, physical and behavioral healthcare.

Televideo technology can be used to provide a variety of what have been referred to as "Telemental Health" services. These services may include mental health assessments, treatment, education, monitoring, mentoring and collaboration. These services may be used in a variety of locations (schools, nursing facilities, and even in homes) in any geographical location where traditional service providers are in short supply. Providers can include psychiatrists, nurse practitioners, physician assistants, social workers, pharmacists, psychologists, counselors, PCPs, and nurses. For example, telemental health could be used to provide follow-up outpatient consults with a psychiatrist or other mental health professional

within 7 or 30 days of discharge from the inpatient hospital. These virtual follow-up visits could focus on monitoring for remission of symptoms, adjusting psychotropic medications, and developing a treatment plan to prevent readmissions in partnership with the primary care provider. Telemental services could also be used to provide medication management services to community mental health patients with severe mental illness to ensure appropriate medication treatment and compliance, preventing psychiatric crises which would require psychiatric hospitalization.

Anticipated challenges:

One of the anticipated challenges that this project faces lies in the creation of mutually acceptable agreements with Medicaid Managed Care plans in Texas, as well as the creation of mutually acceptable agreements with MHMR sites in Region 2 and the State of Texas. An additional challenge will be in the recruitment of additional UTMB Health adult and/or child psychiatric service providers due to the limited supply of these providers. And finally, the additional costs of adding technology to sites that do not possess proper equipment, as well as upgrading UTMB Health's telemedicine equipment.

Mental/behavioral health services access has been identified in RHP2 as a program that would improve health, and the lack of access to these services, as a challenge/barrier to health. RHP2 local leaders and community members identified this issue in the Region Community Health Assessment. Many of the Region 2 MHMR's have wait lists of months to greater than one year. Adult and/or child Psychiatric services are limited in all areas of the State beyond the urban areas. Our Frew Demonstration project is a clear proof of concept that Psychiatric Telemedicine services can be effective. Additionally, UTMB is a state leader in telemental services. Our track record of experience and expertise will help us meet these challenges.

The 5-year expected outcome(s):

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 5-year expected outcome/goal is to show percentage 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. The numerator for this goal is the percent improvement in targeted patient satisfaction domain using a patient survey as our data source. The denominator will be the number of patients who were administered the survey. In DY2 we will review and finalize the specific supplemental modules for the adult and/or child CG-CAHPS surveys we will be implementing in DY 4 and DY5 based on the populations we will serve with our Psychiatry telemedicine clinics. Our expected outcomes includes a refined new model for child and/or adult Psychiatry Telemedicine clinics that is sustainable, development of a manual for adult and/or child Psychiatric Telemedicine clinic operations with administrative protocols and clinical guidelines and high patient satisfaction scores.

Regional goals:

We plan to implement Psychiatry Telemedicine clinics in RHP2 and the State of Texas that will achieve our RHP2 shared mission that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably. Our Psychiatry Telemedicine clinics will be compatible and consistent with our overall RHP2 Goals listed below.

Region 2 Goals

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

In DY2 we will review and finalize the specific supplemental modules for the adult and/or child CG-CAHPS surveys we will be implementing in DY4 and DY5 based on the populations we will serve with our Psychiatry Telemedicine clinics. A baseline in DY3 will be established for the selected patient satisfaction domains. We will engage all stakeholders, identify current capacity and needed resources, determine timelines and document an implementation plan. Currently, no patient satisfaction data is available. The Psychiatry Telemedicine clinics is a refined model to provide adult and/or child Psychiatry services based off our past Frew Demonstration project model. Our goal is to create a sustainable Psychiatry Telemedicine clinic model that can be replicated.

RATIONALE

Relation between Project Choices and Community Needs

1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers).

We will address all the required core project components in our Psychiatry Telemedicine clinics project that are listed below in our planning documents. UTMB Health has prior, extensive experience in telemedicine operations and we plan to utilize this experience as we build a sustainable model for adult and/or child Psychiatry Telemedicine clinics.

Required core project components:

a) Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.
b) Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.
c) Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer.
d) Identify modifiers needed to track encounters performed via telehealth technology

e) Develop and implement data collection and reporting standards for electronically delivered services
f) Review the intervention(s) impact on access to specialty care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.
g) Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully-functional telehealth, telemonitoring, telementoring, or telemedicine program. Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations.
h) Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions)

There are 195 Texas counties (77% of all Texas counties) that have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health. In 2009, 171 Texas counties did not have a psychiatrist, 102 counties did not have a psychologist, 40 counties did not have a social worker and 48 counties did not have a licensed professional counselor. Furthermore, certain specialties (such as Child Psychiatrists) are virtually non-existent in the vast majority of the rural and frontier areas of the state.

The size of the state makes travel from underserved areas to larger urban settings difficult. For individuals who lack reliable transportation or have disabilities that restrict driving, the challenge of accessing health care may be virtually insurmountable. With this new technology, in any area of the state where high speed broadband internet access is available, access to many forms of health care can become a reality. To leverage the promise of this new technology, Texas would like to expand the use of telemedicine, telehealth, and telemonitoring to thereby increase access to, and coordination of, physical and behavioral healthcare.

Unique Community Need Identification numbers:

CN.5, CN.1

Expansion or enhancement:

This project is to refine a Psychiatry Telemedicine clinic model that is sustainable for adult and/or child Psychiatry services in RHP2 and the State of Texas. We are enhancing our experiences from the Frew Demonstration project to create a sustainable Psychiatry Telemedicine model. This will expand and enhance Psychiatry services to populations that do not currently have Psychiatry services readily available.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

- OD-6 Patient Satisfaction
- 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)

Improvement Target: 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 numerator is the percent improvement in targeted patient satisfaction domain. The denominator is number of patients who were administered the survey. The data source will be our patient survey. The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. Our project will use the CG-CAHPS surveys that are part of the overall CAHPS initiative. The surveys are designed to produce comparable data on the patients' perspective on care that allows objective and meaningful comparisons between institutions and providers on domains that are important to consumers. Public reporting of the survey results is designed to create incentives to improve 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. Our project is to implement Psychiatry Telemedicine clinics in RHP2 and the State of Texas that will achieve our RHP2 shared mission that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably. This project will likely improve the health of low-income populations in particular as the Medicaid population in general has transportation challenges, especially in non-suburban locations. We will refine a new model for child and/or adult Psychiatry Telemedicine clinics and implement in RHP2 and the State of Texas using UTMB Health's telemedicine capabilities and experiences. Modern communications technology holds the greatest promise of bridging the gap between medical need in underserved areas and the provision of needed services. The developments in internet-based communications that began with voice messaging have been extended to video in the form of widely available video compression technologies that allow for high quality, real time, face-to-face communications and consultations over relatively inexpensive telecommunications equipment. With this new technology, in any area of the state where high speed broadband internet access is available, access to many forms of health care can become a reality. To leverage the promise of this new technology, Texas would like to expand the use of telemedicine, telehealth, and telemonitoring to thereby increase access to, and coordination of, physical and behavioral healthcare. The Regional Healthcare Partnership (RHP) Planning Protocol clearly states the Psychiatry services deficiency in the State of Texas. There are 195 Texas counties (77% of all Texas counties) that have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health. In 2009, 171 Texas counties did not have a psychiatrist, 102 counties did not have a psychologist, 40 counties did not have a social worker and 48 counties did not have a licensed professional counselor. Furthermore, certain specialties (such as Child Psychiatrists) are virtually non-existent in the vast majority of the rural and frontier areas of the state.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on providing psychiatric telemedicine and emphasis on underserved adult and child patients throught Region 2 and the state ties to these Category 1 and 2 projects in our RHP 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of technology-assisted services to support, coordinate, or deliver behavioral health services along with these other Category 1 projects in our RHP: 135222109.1.4 - Telemedicine access to ED and adult mental health routine services; 109372601.1.2 - Providing psychiatry telemedicine clinics to RHP 2 and the state of Texas.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.

- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.1.2	1.11.2	1.11.2 (A-H)	PROVIDING PSYCHIATRY TELEMEDICINE CLINICS TO RHP2 AND THE STATE OF TEXAS
The University of Texas Medical Branch at Galveston			109372601
Related Category 3 Outcome Measure(s):	109372601.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-9. Development of manual of telemedicine or telehealth operations with administrative protocols and clinical guidelines. Metric: P-9.1 Documentation of completion of manual and of use of manual in training sessions of providers/peers. Baseline: N/A No manual. Goal: Complete the initial draft of the manual for telemedicine or telehealth operations with administrative protocols and clinical guidelines. Data Source: Operations manual with written protocols and guidelines. Milestone 3 Estimated Incentive Payment (maximum amount): $3,408,796	**Milestone 2** P-9. Development of manual of telemedicine or telehealth operations with administrative protocols and clinical guidelines. Metric: P-9.1 Documentation of completion of manual and of use of manual in training sessions of providers/peers. Baseline: Initial draft Goal: Finalize the draft of the manual for telemedicine or telehealth operations with administrative protocols and clinical guidelines. Data Source: Operations manual with written protocols and guidelines. Milestone 3 Estimated Incentive Payment (maximum amount): $3,556,115	**Milestone 3** P-9. Development of manual of telemedicine or telehealth operations with administrative protocols and clinical guidelines. Metric: P-9.1 Documentation of completion of manual and of use of manual in training sessions of providers/peers. Baseline: Final manual Goal: Implement the manual for telemedicine or telehealth operations with administrative protocols. Data Source: Operations manual with written protocols and guidelines. Milestone 3 Estimated Incentive Payment (maximum amount): $1,902,108 **Milestone 4** I-15 Satisfaction with telemental services Metric: I-15.1 TBD # % of operational partners and provider surveys indicate satisfaction with telemental operational model. Numerator is Number of Managed Care Plans, remote locations and providers reporting satisfaction.	**Milestone 5** P-9. Development of manual of telemedicine or telehealth operations with administrative protocols and clinical guidelines. Metric: P-9.1 Documentation of completion of manual and of use of manual in training sessions of providers/peers. Baseline: Final manual Goal: Implement the manual for telemedicine or telehealth operations with administrative protocols and clinical guidelines. Data Source: Operations manual with written protocols and guidelines. Milestone 3 Estimated Incentive Payment (maximum amount): $1,837,785 **Milestone 6** I-15 Satisfaction with telemental operational model services Metric: I-15.1 TBD # % of operational partners and provider surveys indicate satisfaction with telemental operational model services. Numerator is Number of Managed Care Plans, remote locations , and

109372601.1.2	1.11.2	1.11.2 (A-H)	PROVIDING PSYCHIATRY TELEMEDICINE CLINICS TO RHP2 AND THE STATE OF TEXAS	
The University of Texas Medical Branch at Galveston				109372601
Related Category 3 Outcome Measure(s):	109372601.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Denominator is Number of , Managed Care Plans, remote locations and providers surveyed. Goal: Determine baseline operational partners' satisfaction. Data Source: Operational partners satisfaction survey results. Milestone 4 Estimated Incentive Payment (maximum amount):$1,902,108	providers reporting satisfaction. Denominator is Number of , Managed Care Plans, remote locations, and providers surveyed. Goal: Improve from the baseline operational partners' satisfaction score from DY4. Data Source: Operational partners satisfaction survey results. Milestone 6 Estimated Incentive Payment (maximum amount):$1,837,785
Year 2 Estimated Milestone Bundle Amount::$3,408,796	Year 3 Estimated Milestone Bundle Amount: $3,556,115		Year 4 Estimated Milestone Bundle Amount: $3,804,216	Year 5 Estimated Milestone Bundle Amount: $3,675,571
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $14,444,697				

PROJECT OPTION: 1.2.1 Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement.
UNIQUE RHP PROJECT IDENTIFICATION NUMBER: **109372601.1.3 – Pass 2**

PERFORMING PROVIDER/TPI: University of Texas Medical Branch at Galveston/109372601
Title of project
New Model Clinic: Medical homes for patients as education homes for trainees
Category Project Area
1.2 Increase Training of Primary Care Workforce

Provider: The University of Texas Medical Branch is an integrated academic health center with fully accredited schools of Medicine, Nursing, Health Professions, and Graduate Biomedical Sciences in addition to comprehensive ambulatory and inpatient clinical facilities and services. It is the Region 2 Anchor.
Intervention: This project seeks to implement and evaluate a new primary care clinic model that will:

1. train more workforce members in an "education home," i.e., an interprofessional team-based patient-centered medical home (PCMH), in which they will acquire and demonstrate competence to function in and lead such clinics during their careers, and

2. expand current primary care capacity in the targeted geographic area through effective implementation of the PCMH model coupled with the education home model.

This project will include primary care faculty physicians in supervisory and teaching roles; primary care residents in teaching, clinic operations, and patient care roles; medical students in clinic operations and patient care roles; advanced practice clinicians (APCs) in patient care roles; and community health workers in outreach, care coordination, and teaching roles. At baseline, UTMB has no clinics operating under this model. The 5-year expected outcomes include the successful establishment of the clinic, training of 30 medical students and 10 primary care residents, provision of over 20,000 primary care visits annually by year 5 primarily to Medicaid patients, and lowered LDL-cholesterol levels for patients with atherosclerotic cardiovascular disease.
Need for project: Shortages of health care providers, along with increasing demand for chronic disease management has spurred new models of health care provision, such as the PCMH, which require training in new skills. In addition to increasing access to care by improving efficiency of care delivery, the PCMH model has the potential to encourage trainees to pursue primary care as a career. But in order to produce physicians that can effectively function in this model, medical student and resident training programs need to provide education and experience in effective interprofessional team-based care and population health management. This project will develop training focused on skills needed for effective practice in a PCMH by employing an interprofessional team approach to primary care and promoting competency

development by assigning students and residents to this PCMH as an "education home" for expanded longitudinal clinic experiences.

Target population: This project will target Medicaid patients in southern Galveston County. Current projections indicate there will be 14,473 Medicaid patients by 2016 in this geographic region, an increase of 79% over 2011 levels (from Galveston County CNA). Currently there is insufficient primary care capacity to serve this rapid growth.

Category 2 expected benefits: The project seeks:

- to train 10 primary care residents and 30 medical students in this delivery model by the end of year 5, and
- to provide over 20,000 primary care visits annually by year 5.

Category 3 outcomes: IT-1.6 This project seeks to improve management of low-density lipoprotein cholesterol (LDL-C) levels in patients discharged from the hospital with a diagnosis of atherosclerotic cardiovascular disease, with a target LDL-C concentration below 100 mg/dL.

Project Description:

This project seeks to implement and evaluate a new primary care clinic model that will:

1. train more workforce members in an "education home," i.e., an interprofessional team-based patient-centered medical home (PCMH), in which they will acquire and demonstrate competence to function in and lead such clinics during their careers, and
2. expand current primary care capacity in the targeted geographic area through effective implementation of the PCMH model coupled with the education home model.

The clinic model includes primary care faculty physicians in supervisory and teaching roles; primary care residents in teaching, clinic operations, and patient care roles; medical students in clinic operations and patient care roles; advanced practice clinicians (APCs) in patient care roles; and community health workers in outreach, care coordination, and teaching roles. At baseline, UTMB has no clinics operating under this model. The 5-year expected outcomes include the successful establishment of the clinic, training of 30 students and 10 primary care residents, provision of over 20,000 primary care visits by year 5 (primarily to Medicaid patients), and lowered LDL-cholesterol levels for patients with discharge diagnoses related to atherosclerotic cardiovascular disease.

Project goal(s):

This project will develop training focused on skills needed for effective practice in a PCMH by employing an interprofessional team approach to primary care and promoting competency development by assigning students and residents to this PCMH as an "education home" for expanded longitudinal clinic experiences. At baseline, UTMB has no clinics operating under this model.

The 5-year expected outcomes include:

- the successful establishment of the clinic
- training of 30 students and 10 primary care residents, and
- provision of over 20,000 primary care visits annually by year 5, primarily to Medicaid patients.

In addition, the clinical outcome measure (Category 3) seeks to lower LDL-cholesterol levels to target (<100 mg/dL) in patients with discharge diagnoses related to atherosclerotic cardiovascular disease: acute myocardial infarction, coronary artery bypass graft, percutaneous coronary interventions, or ischemic vascular disease.

Anticipated challenges:

Anticipated challenges include:

- Establishing the patient home/education home clinic model – Response: Prior to opening the clinic, faculty, APCs, and clinic staff will undergo training in the PCMH model and will map out patient flows and work routines. All clinic operations will be subject to continuous quality improvement utilizing a short-cycle PDSA approach.
- Development of new training materials and assessments – Response: Clinic faculty and staff will work with UTMB student and resident education leaders to identify and/or develop appropriate training materials. Competency-based assessment will be designed and implemented in conjunction with active development currently underway at the student and resident levels at UTMB.
- Recruitment of new medical trainees into this primary care education model – Response: Students and resident volunteers will be solicited for participation. Given historical student interest in primary care at UTMB, the residency requirements regarding longitudinal clinic experience, and the emphasis on teaching that the clinic will feature, we anticipate being able to fill all available positions with volunteers.
- Attracting patients – Response: The Medicaid population in southern Galveston County is projected to grow by 79% from 2011-2016. There is currently little excess capacity to serve this rapidly growing population. The clinic location will be convenient to the targeted population.
- Identification of patients with appropriate discharge diagnoses for Category 3 endpoint – Response: UTMB's electronic health record will be utilized to identify patients in the targeted geographic area prior to discharge.

The 5-year expected outcome(s):

IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)[54]

The 5-year expected outcome/goal is to improve cholesterol management for patients with cardiovascular conditions. Patients will include those aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year.

[54] http://qualitymeasures.ahrq.gov/content.aspx?id=34654

We will provide students and residents with longitudinal ambulatory training experiences in a setting with a stable patient population and a stable interprofessional clinic team. Additionally, we plan to enhance and supplement students' and residents' clinical management training with clinic and practice management skills and interprofessional teamwork, along with opportunities to serve in these roles during regular and after-hours clinics, performing tasks in which they have demonstrated competence. And finally, for all clinic personnel, we plan to maximize the match between level of training and clinic roles ("top of license" practice), utilize community health workers to optimize chronic care and population management, and train learners how to work in a patient (and education) centered home.

Regional goals:

A coordinated system of patient centered care will achieve the "Triple Aim" of regional shared mission and quality goals of improving the patient experience (increased access to appropriate levels of care), improving the health of the population, and using resources more efficiently, effectively and equitably.

Region 2 Goals

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

Starting Point/Baseline:

The "New Model Clinic" is a new and innovative model for care and training that will be developed at UTMB Health. Presently, we do not utilize this model of clinical care; therefore, we do not have any baseline information. The proposed model is based upon a paper published by the project leaders in Academic Medicine.[55]

Rationale

Relation between Project Choices and Community Needs:

Shortages of health care providers, along with increasing demand for chronic disease management has spurred new models of health care provision, such as the PCMH, which require training in new skills. In addition to increasing access to care by improving efficiency of care delivery, the PCMH model has the potential to encourage trainees to pursue primary care as a career. But in order to produce physicians that can effectively function in this model, medical student and resident training programs need to provide education and experience in effective interprofessional team-based care and population health management.

[55] Academic Medicine. 86(11):1342, 2011 Nov.

- **1.2.1 Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement**

Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a dearth in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem. Galveston and Brazoria Counties are both underserved by primary care physicians compared to the average rates for Texas and the USA. Galveston has 55.6 primary care physicians per 100,000 population, and Brazoria has 44.2. These compare to 69.5 and 91.0 per 100,000 for Texas and the USA, respectively. Additional data sources document a shortage of primary care in southern Galveston County and the entire Bay Area of Houston. Adding to this shortage of primary care will be the aging of the population as well as the increase in demand for primary care as a result of health care reform implementation in 2014. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Our analysis suggests that the number of patients with Medicaid coverage in the south county communities of Santa Fe, La Marque, Hitchcock, and Dickinson will increase from 8,076 in 2011 to 14,473 in 2016. Many of these patients will have been historically unsponsored and will have a need for medical care, including preventive services.

Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. The extended primary care workforce will also be trained to operate in patient-centered medical homes, expanding future primary care capacity. A greater focus on primary care will be crucial to the success of an integrated health care system.

In order to effectively operate in a medical home model, there is a need for residency and training programs to expand the capabilities of primary care providers and other staff to effectively provide interprofessional team-based care and manage population health. Therefore, the need to expand the responsibilities of primary care workforce members will be even more important.

Milestone 1 in DY2: P-X Confirm clinic location, identify faculty. Metric: P-X.1: Final confirmation of clinic site and identification of faculty members to run and staff the clinic. Baseline: No current clinic location or faculty identified . Goal: Complete these steps in anticipation of clinic “go-live” 10/1/13. Data Source: Facilities agreements, faculty named.

Milestone 2 in DY3: P-X Hire staff, train faculty and staff in team PCMH model, plan clinic operations and patient flow. Metric: P-X.2: Training of two-three faculty members, and all clinic staff excluding residents and students. Work with program directors to identify residents and students. Faculty and staff to develop plans for clinic operation. Baseline: No current

personnel or operations plans. Goal: Complete these steps in time for clinic "go-live" 10/1/13. Data Source: Clinic staff roster, work schedule, written operations plans

Milestone 3, 6, 9 in DY3, DY4 and DY5: P-3. Expand positive primary care exposure for residents/trainees. Metric: P-3.2. Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: 0 primary care resident trainees and medical student trainees enrolled in plan. Goal: Implement training plan, and enroll 2 primary care resident trainees and 6 medical student trainees in training program in DY 3, and 4 primary care resident trainees and 12 medical student trainees in training program each year in DY 4 and 5. Data Source: Curriculum, rotation hours, and /or patient panels assigned to resident /trainee.

Milestone 4, 7, 10 in DY3, DY4 and DY5: I-11. Increase primary care training and/or rotations. Metric : I-11.6 Improvement in trainee knowledge assessment scores. Numerator: Sum of differences in pre and post training assessment scores. Denominator: Number of graduates training in the program. Data Source: Knowledge assessment tool. Rationale/Evidence: Regular assessment of trainee knowledge is critical to adapting programs to address needs and capacity to serve in primary care settings. Improvement of knowledge reflects effectiveness of the training program vs. just the increase in the number of enrollments.

Milestone 5, 8, 11 in DY3, DY4, and DY5: I-15. Increase primary care training in Continuity Clinics,[1] which may be in diverse, low-income, community-based settings. Metric: Increase number of Continuity Clinic sessions available for primary care trainees. Baseline: 0 patient sessions. Numerator: Number of Continuity Clinic Sessions utilizing primary care trainees. Denominator: Total number of Continuity Clinic Sessions. Goal: 6,000 in DY3, 18,000 in DY4, and 20,000 in DY5. Data Source: EHR, claims data or other reports. Rationale/Evidence: Residents/trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her patients in order to build continuity with his/her patients.

Unique Community Need Identification numbers:

CN.3, CN.14

New initiative, expansion or enhancement:

This is a new project that will expand and enhance our clinical training programs for undergraduate and graduate medical education. This will promote trainees at all levels gaining experience in the primary care clinic of the future and stimulate their choice to become primary care physicians and providers. Increased primary care physicians and providers are necessary to create the transformed health care system of the future.

This project will not utilize any DHHS funding, to our knowledge.

[1] Per the Accreditation Council for Graduate Medical Education (ACGME), "Setting for a longitudinal experience in which residents develop a continuous, long-term therapeutic relationship with a panel of patients." For more information, please see http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf.

Related Category 3 Outcome Measures:

- Outcome Domain: OD1 – Primary Care and Chronic Disease Management
- Improvement Target: IT-1.6 – Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)

Improvement Target: IT-1.6 – Cholesterol management for patients with cardiovascular conditions

The numerator is the number of patients who had each of the following during the reporting period:

- Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
- LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

The denominator is patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year. The data source will be our EHR. This improvement target was chosen because total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Relationship to other Projects:

This project's focus on establishing a new primary care clinic and emphasis on a medical home for patients ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 094092602.2.1, 284333601.1.1 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the expansion of the primary care workforce along with these other Category 1 projects in our RHP: 139172412.1.2 Increase Training of Primary Care Workforce-Outreach

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation: Total Score = 16

A. Population affected Score: 4

Justification: 2016 Medicaid population estimates for the targeted geographic region= 14,473. The New Model Clinic will serve 50% of these = 7237 patients by 2016.

B. Severity Score: 3

Justification: CNA indication: moderate (1 point). Severity: moderate (2 points)

C. Cost-Effectiveness Score: 5

Justification: Total expenses (DY 2-5): $2,916,676; Average # patients per year (y3-5): 6598; average costs: $129-152 per patient per year (3 visits per patient per year).

D. Community Benefit Score: 4

Justification: improves access (1 point); improves quality (1 point); improves costs (long-term cost-savings) (1 point); transformative (Innovative) (1 point)

109372601.1.3	1.2.1 UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT	N/A	TRAINEE EDUCATION ON PATIENT CENTERED MEDICAL HOMES
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**109372601.3.7**	**IT-1.6**	**Cholesterol management for patients with cardiovascular conditions**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 **P-X Confirm clinic location, identify faculty** **Metric** **P-X.1** Final confirmation of clinic site and identification of faculty members to run and staff the clinic. **Baseline**: No current clinic location or faculty identified. **Goal:** Complete these steps in anticipation of clinic "go-live" 10/1/13 Data Source: Facilities agreements, faculty named. Milestone 1 Estimated Incentive Payment: $252,849	**Milestone 2** **P-X Hire staff, train faculty and staff in team PCMH model, plan clinic operations and patient flow** **Metric** P-X.2 Training of two-three faculty members, and all clinic staff excluding residents and students. Work with program directors to identify residents and students. Faculty and staff to develop plans for clinic operation. Baseline: No current personnel or operations plans. Goal: Complete these steps in time for clinic "go-live" 10/1/13 Data Source: Clinic staff roster, work schedule, written operations plans Milestone 2 Estimated Incentive Payment: $223,230 **Milestone 3** **P-3. Expand positive primary care**	**Milestone 6** **P-3. Expand positive primary care exposure for residents/trainees** Metric P-3.2. Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Goal: Implement training plan, and enroll 4 additional primary care resident trainees and 12 additional medical student trainees in training program. Data Source: Curriculum, rotation hours, and /or patient panels assigned to resident /trainee. Milestone 6 Estimated Incentive Payment: $313,220 **Milestone7** **I-11. Increase primary care training and/or rotations**	**Milestone 9** **P-3. Expand positive primary care exposure for residents/trainees** Metric P-3.2. Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Goal: Implement training plan, and enroll 4 additional primary care resident trainees and 12 additional medical student trainees in training program. Data Source: Curriculum, rotation hours, and /or patient panels assigned to resident /trainee. Milestone 9 Estimated Incentive Payment: $392,174 **Milestone 10** **I-11. Increase primary care training and/or rotations**

109372601.1.3	1.2.1 UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT	N/A	TRAINEE EDUCATION ON PATIENT CENTERED MEDICAL HOMES
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**109372601.3.7**	**IT-1.6**	**Cholesterol management for patients with cardiovascular conditions**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	exposure for residents/trainees Metric P-3.2. Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: 0 primary care resident trainees and medical student trainees trained in PCMH educational model Goal: Implement training plan, and provide training and experience for 2 primary care residents and 6 medical students during DY3. Data Source: Curriculum, rotation hours, and /or patient panels assigned to resident /trainee. Milestone 3 Estimated Incentive Payment (maximum amount): $223,230 **Milestone 4** **I-11. Increase primary care training**	Metric I-11.6 Improvement in trainee knowledge assessment scores Numerator: Sum of differences in pre and post training assessment scores for all trainees. Denominator: Number of trainees participating in training program. Data Source: Knowledge assessment tool Rationale/Evidence: Regular assessment of trainee knowledge is critical to adapting programs to address needs and capacity to serve in primary care settings. Improvement of knowledge reflects effectiveness of the training program vs. just the increase in the number of enrollments. Milestone 7 Estimated Incentive Payment: $313,220	Metric I-11.6 Improvement in trainee knowledge assessment scores for all trainees Numerator: Sum of differences in pre and post training assessment scores. Denominator: Number of trainees participating in training program. Data Source: Knowledge assessment tool Rationale/Evidence: Regular assessment of trainee knowledge is critical to adapting programs to address needs and capacity to serve in primary care settings. Improvement of knowledge reflects effectiveness of the training program vs. just the increase in the number of enrollments. Milestone 10 Estimated Incentive Payment: $392,174

109372601.1.3	1.2.1 UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT	N/A	TRAINEE EDUCATION ON PATIENT CENTERED MEDICAL HOMES
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**109372601.3.7**	**IT-1.6**	**Cholesterol management for patients with cardiovascular conditions**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	and/or rotations Metric I-11.6 Improvement in trainee knowledge assessment scores Numerator: Sum of differences in pre and post training assessment scores for all trainees. Denominator: Number of trainees participating in training program. Data Source: Knowledge assessment tool Rationale/Evidence: Regular assessment of trainee knowledge is critical to adapting programs to address needs and capacity to serve in primary care settings. Improvement of knowledge reflects effectiveness of the training program vs. just the increase in the number of enrollments. Milestone 4 Estimated Incentive Payment: $223,230	**Milestone 8** **I-15: Increase primary care training in Continuity Clinics** Metric I-15.1: Increase number of Continuity Clinic sessions available for primary care trainees. Numerator: Number of Continuity Clinic Sessions utilizing primary care trainees. Denominator: Total number of Continuity Clinic Sessions. Goal: 18,000 patient sessions Data Source: Number of trainee office visits, such as from disease registry, EHR, claims data or other reports. Rationale/Evidence: Residents / trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her	**Milestone 11** **I-15: Increase primary care training in Continuity Clinics** Metric I-15.1: Increase number of Continuity Clinic sessions available for primary care trainees. Numerator: Number of Continuity Clinic Sessions utilizing primary care trainees. Denominator: Total number of Continuity Clinic Sessions. Goal: 20,000 patient sessions Data Source: Number of trainee office visits, such as from disease registry, EHR, claims data or other reports. Rationale/Evidence: Residents / trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her

109372601.1.3	1.2.1 UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT	N/A	TRAINEE EDUCATION ON PATIENT CENTERED MEDICAL HOMES
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**109372601.3.7**	**IT-1.6**	**Cholesterol management for patients with cardiovascular conditions**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 5 **I-15: Increase primary care training in Continuity Clinics** Metric I-15.1: Increase number of Continuity Clinic sessions available for primary care trainees. Numerator: Number of Continuity Clinic Sessions utilizing primary care trainees. Denominator: Total number of Continuity Clinic Sessions. Baseline: 0 patient sessions Goal: 6,000 patient sessions Data Source: Number of trainee office visits, such as from disease registry, EHR, claims data or other reports. Rationale/Evidence: Residents / trainees have the opportunity to	patients in order to build continuity with his/her patients. Milestone 8 Estimated Incentive Payment (maximum amount): $313,221	patients in order to build continuity with his/her patients. Milestone 11 Estimated Incentive Payment: $392,175

109372601.1.3	1.2.1 UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT	N/A	TRAINEE EDUCATION ON PATIENT CENTERED MEDICAL HOMES
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**109372601.3.7**	**IT-1.6**	**Cholesterol management for patients with cardiovascular conditions**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her patients in order to build continuity with his/her patients. Milestone 5 Estimated Incentive Payment: $223,230		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $252,849	Year 3 Estimated Milestone Bundle Amount: $892,920	Year 4 Estimated Milestone Bundle Amount: $939,661	Year 5 Estimated Milestone Bundle Amount: $1,176,523
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add+ milestone bundle amounts over Years 2-5)**:*** $3,261,953			

SECTION V:

D. Category 2:
Program Innovation and Redesign

PROJECT OPTION: 2.9.1 - Establish/Expand a Patient Care Navigation Program

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 121805903.2.1
PERFORMING PROVIDER/TPI: Angleton Danbury Hospital District/121805903

- Provider: Angleton-Danbury Hospital District is a 64-bed hospital in Angleton, Texas serving 417.27 square mile area and coverage of over 60,000 lives.
- Intervention(s): This project will introduce a Patient Navigator component to provide patient consultations by a Registered Nurse to a targeted all cause readmission population that has been identified as at risk of receiving disconnected and fragmented care.
- Need for the project: Angleton-Danbury Hospital District currently has a large diabetic population with chronic diseases with barriers to continuum of care which results in ED frequent visits and unnecessary admissions due to complications of chronic diseases. In 2012, Southern Brazoria County has a Medicaid population of 26,303 enrollees and an uninsured population of 43,471.
- Target Population: . Any individual with a readmission which is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.
- Category 1 or 2 expected patient benefits: The project seeks to provide Navigational Services through the continuum of care in DY4 and DY5 by establishing the program, increase the number of patients enrolled in the program, PCP referrals and appointments, providing education and compliance for their chronic disease management.
- Category 3 outcomes: To decrease the 30 day readmissions rate in DY4 and DY5 for patients discharged from the hospital with a principal diagnosis of diabetes.

PROJECT DESCRIPTION:
Angleton Danbury Hospital District will have a customized medically equipped mobile bus. The Navigation team will include 1 CHW, 1 RN, 1 Case Worker and 1 Project Coordinator. The team will make home visits to a targeted population to ensure that patients receive coordinated, timely, and site appropriate health care services. These patients will receive medical screenings, individualized education, and follow up to ensure compliance with treatment plan. We will also work with other community partners such as churches, clinics, schools, and industry to help identify these high risk populations. The targeted patient population will reside in the following zip codes: 77515, 77541, 77534, 77583, 77531, 77566, 77511, 77512, 77577, 77578, 77486 and 77541.

Project Goal(s):
The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of health care services. Patient

Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. RHPs implementing this project will identify health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through integrated health care delivery systems.

By putting this navigation team on a mobile medical bus, we are able to impact this targeted population in their environment to identify challenges and provide evaluations, screenings, and education for their chronic disease management after they have been discharged. Screening will include: pulse oximetry and spirometry testing medication management, blood sugar checks, neuropathy checks, blood pressure, and weight. This navigation team will ensure that each patient in this target group will be guided and lead through the healthcare system in order to receive the more cost effective and appropriate care in the right setting. Compliance is the ultimate goal.

Challenges:

Some challenges identified in this program are as followings: securing a competent/skilled workforce, patient compliance (a huge concern), and safety for staff members as they travel into the targeted population's home environment. We will address these challenges by providing a commitment of training and recruiting competent staff members and providing regular visits to our targeted population to encourage compliance with their established program.

5-year Expected Outcome(s) for Performing Provider and Patients:

We will develop a program to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Outcome Domain 3 All Cause 30 Day Readmission Rate was selected in conjunction with the chosen Category 2.9 Project of establishing a patient care navigation program because 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. According to the Centers for Disease Control, Stroke is the 3rd leading cause of death in the United States with 140,000 people dying each year from a stroke and stroke is a leading cause of disability in the U.S. Each year, approximately 795,000 people suffer a stroke, about 600,000 of these are first attacks,

and 185,000 are recurrent attacks. On average, someone in the United States has a stroke every 40 seconds. High blood pressure is the most important risk factor for a stroke which directly coordinates with obesity, smokers and COPD.

Chronic Obstructive Pulmonary Disease (COPD) is one of the most common lung diseases. It makes it difficult to breathe. The American Lung Association (2006 State of Air Report) reports that Brazoria County received an ozone grade of "F" for air quality. One of the greatest risk factors for COPD is exposure to certain gases or fumes in the workplace. Brazoria County has 12% of its population identified with some type of lung disease according to the Centers for Disease Control. The majority of business and industry in Brazoria County is made up of the petro chemical, oil and gas companies which factor into the growing statistic we see. There is a high incidence rate of adult asthma, chronic bronchitis, emphysema, COPD and lung cancer.

According to the American Heart Association, Cardiovascular Disease takes the lives of more than 2,150 Americans each day, an average of 1 death every 40 seconds. As documented in the community needs assessment, Brazoria County has 223 deaths per 100,000 related to Heart Disease which is higher than both the State and National average.

By the end of DY 5 we anticipate a decrease in the percentage of readmissions from baseline (established in DY2) 9.1% to 3%.

Relationship to Regional Goals:

Our regional goal is to improve the health of our region by expanding and coordinating access to patient-centered primary care services that include health promotion and disease prevention.

STARTING POINT/BASELINE:

Our starting point will be the purchase/equip customized Wellness Bus, Hire/Train Staff to include CHW, Case Worker, & RN and evaluate/purchase tracking software. We will also initiate gathering our baseline information through our hospital EHR system – identifying individuals with recent admissions with the primary diagnosis of diabetes. The community needs assessment supports this program based on the primary care shortage and the chronic disease (esp. diabetes) prevalence in the community.

RATIONALE:

Our project option for the Patient Navigation is: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others). Among the initial tasks of this project is to identify this targeted population that either experience or are at high risk for disconnect in the health care system. These individuals will be included in the navigation services so that they are able to

optimize the healthcare systems and receive timely and appropriate care for their disease process.

To be most effective we will identify frequent ED users and use navigators as part of a preventable ED reduction program as well as train health care navigators in cultural competency. Next we will deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators; and through this program we will connect patients to primary and preventive care. The goal of the navigation program is to increase access to care management and/or chronic care management, including education in chronic disease self-management. Thorough out the program we will conduct quality improvement strategies for this 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.

The project option chosen is: 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others).

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to

site-appropriate locations. RHPs implementing this project will identify health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through integrated health care delivery systems. 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. We feel the combination of adding these services on a mobile wellness bus will provide and assist with the growing healthcare needs in the region as demonstrated in the CNA According to the Centers for Disease Control, Stroke is the 3rd leading cause of death in the United States with 140,000 people dying each year from a stroke and stroke is a leading cause of disability in the U.S. Each year, approximately 795,000 people suffer a stroke, about 600,000 of these are first attacks, and 185,000 are recurrent attacks. On average, someone in the United States has a stroke every 40 seconds. High blood pressure is the most important risk factor for a stroke which directly coordinates with obesity, smokers and COPD.

Chronic Obstructive Pulmonary Disease (COPD) is one of the most common lung diseases. It makes it difficult to breathe. The American Lung Association (2006 State of Air Report) reports that Brazoria County received an ozone grade of "F" for air quality. One of the greatest risk factors for COPD is exposure to certain gases or fumes in the workplace. Brazoria County has 12% of its population identified with some type of lung disease according to the Centers for Disease Control. The majority of business and industry in Brazoria County is made up of the petro chemical, oil and gas companies which factor into the growing statistic we see. There is a high incidence rate of adult asthma, chronic bronchitis, emphysema, COPD and lung cancer.

According to the American Heart Association, Cardiovascular Disease takes the lives of more than 2,150 Americans each day, an average of 1 death every 40 seconds. As documented in the community needs assessment, Brazoria County has 223 deaths per 100,000 related to Heart Disease which is higher than both the State and National average.

Unique Community Need Identification numbers:

CN1 – Access barriers: lack of personal resources
CN2 – Access barriers: lack of insurance
CN3 – Primary Care Physician Shortage
CN10 – High ED Utilization Rate
CN 11- 30 day readmission rate
CN 12 – Chronic diseases: Diabetes
CN 13- Chronic diseases: Obesity
CN 14 – Chronic diseases: Heart and Vascular Disease Disorders
CN-15- Pulmonary Diseases

Expansion or enhancement:

This patient navigation system is a new initiative by the hospital district and we currently do not receive any State or Federal funding for this project.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Process Milestone needed to prepare to collect outcome data include P-2 with several metrics identified for program implementation. Outcome Domain 3 IT 3. 1 All cause 30 Day Readmission Rate-NQF 1789 was selected in conjunction with the chosen Category 2.9.1 Project of establishing a patient care navigation program because diabetes is one of the most costly and highly prevalent chronic diseases in the United States.

Outcome Domain 3 IT 3.1 All cause 30 day readmission rate-NQF 1789 (Standalone measure) Data Source: EHR Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older.

With the high incidence of diabetes in the community (according to the CNA), diabetes preventable admission can be achieved by taking appropriate pro-active steps to avoid conditions that can lead to expensive care in the ED and inpatient settings. With the help of the mobile bus and navigational services to the targeted population who are at high risk, we will be able to connect patients to primary and preventative care services – leading to the right care in the right setting. The baseline population for this measure will be gathered though the electronic medical record found within the hospital. All patients with a principle diagnosis of diabetes will be categorized into this outcome measure.

We will continue to monitor and expand the target group by 6% by the end of the waiver period. The overall goal of this measure is to reduce the Potentially Preventable 30-day readmissions by 6% in the identified target group by the end of the waiver period

Because of the barriers; lack of transportation, uninsured, and low /no income we will increase access to health care, navigate through the fragmented healthcare system, and provide valuable screenings and bridge the gaps.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on providing patient navigation and emphasis on patient outreach ties to these Category 1 and 2 projects in our RHP: 121805903.2.1, 112706003.2.3, 094092602.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on establishing/expanding patient care navigation programs along with these other Category 2 projects in our RHP: 121805903.2.1-Establish/expand a patient care navigation program; 094148602.2.2-Expand care transition program; 094092602.2.3-Establish/expand a patient navigation program - community health program, chronic disease education; 112706003.2.4- Establish/Expand a Patient Care Navigation Program.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The patient navigation system and mobile health bus would add much value to the community – especially to our targeted diabetic population. The project will navigate the targeted population through the healthcare system so that they receive timely services in the right setting. This project will also promote education and 1-1 chronic disease management; so that individuals will be less likely to suffer added complications due to diabetes while supporting improved personal compliance and quality.

Brazoria County is the 5th fastest growing county in Texas and is among the largest counties in Texas. A mobile health bus will cover a huge service area while addressing the transportation

barriers in the community. In 2012, Southern Brazoria County has 26,303 enrollees in Medicaid and 43,471 uninsured individuals. We will serve both the Medicaid and uninsured population through various outreach strategies while targeting high risk individuals. The community needs assessment supports the demand for this project. Access barriers (lack of personal resources and lack of insurance), Primary Care Physician Shortage, and High Chronic disease are proven factors within the community. According to the Community Needs Assessment, we have a high identified diabetic population and many that may currently be undiagnosed and unmanaged.

Providing the targeted population with proactive care early on in their disease process will result in savings if the patient condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring, and screening, ADHD anticipates a reduction in our 30 Day all cause Readmission Rates to the Hospital.

Currently Angleton Danbury Hospital District is not receiving any additional federal funding to support chronic disease management.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

121805903.2.1	2.9.1	2.9.1 (A-E)	Establish/Expand a Patient Care Navigation Program	
Angleton Danbury Hospital District				121805903
Related Category 3 Outcome Measure(s):	121805903.3.3	IT-3.1	All Cause 30 day readmission rate-NQF 1789 (Standalone measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 – P-2 Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care[1] including program to train the navigators, develop procedures and establish continuing navigator education. P-2.1Metric: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Goal: Purchase customized medically equipped mobile bus. Hire 1 CHW, 1 RN, 1 Case Worker, and 1 Project Coordinator a) Workforce development plan for patient navigator recruitment, training and education Data Source: employee records	**Milestone 2** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care[2] including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 P-2.3: Metric: Frequency of contact with care navigators for high risk patients. Numerator: Number of care navigation encounters Denominator: Number of unique patients enrolled in patient navigation program. Data Source: Patient navigation program materials and database, EHR Goal: Baseline of 1664 patient encounters	**Milestone 3**[P-3): Provide care management/navigation services to targeted patients. Metric 1 [P-2.3: Metric: Frequency of contact with care navigators for high risk patients. Numerator: Number of care navigation encounters Denominator: Number of unique patients enrolled in patient navigation program. Data Source: Patient navigation program materials and database, EHR Goal: Increase in the number of patient encounters by 20% from DY3 to equal at minimum 1996 encounters. Data Source: Enrollment Reports	**Milestone 5** P-4: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources (P-4.1) Metric: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program Numerator: Number of patients enrolled in patient engagement programs Denominator: Number of patients eligible to participate in engagement programs, as determined by provider. Data Source: Enrollment Reports Goal: Increase in the number of

1 Could be facility-oriented, illness/condition-oriented, and/or focused on patient populations who are at most risk of disconnected care (e.g., "Limited English Proficiency Patient Family Advocate" available here http://www.innovations.ahrq.gov/content.aspx?id=2726, urgent care, ED)
2 Could be facility-oriented, illness/condition-oriented, and/or focused on patient populations who are at most risk of disconnected care (e.g., "Limited English Proficiency Patient Family Advocate" available here http://www.innovations.ahrq.gov/content.aspx?id=2726, urgent care, ED)

121805903.2.1	2.9.1	2.9.1 (A-E)	Establish/Expand a Patient Care Navigation Program	
Angleton Danbury Hospital District				121805903
Related Category 3 Outcome Measure(s):	121805903.3.3	IT-3.1	All Cause 30 day readmission rate-NQF 1789 (Standalone measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Rationale: A navigator's education and skill level are the main determinants of the cost of patient navigation Milestone 1 Estimated Incentive Payment (maximum amount): $332,844	Milestone 2 Estimated Incentive Payment: $363,115	Milestone 3 Estimated Incentive Payment: $145,668 **Milestone 4** I-6: Increase the number of PCP referrals for patients without a medical home who use the ED, urgent care, and or hospital services. Metric 1 I-6.4 : Percent of patients without a PCP that are given a scheduled PCP appointment. Goal: 50% of patients will be given a scheduled PCP appointment Data Source: Navigation Software Milestone 4 Estimated Incentive Payment: $218,502	patient encounters by 40% from DY3 to equal at minimum 2329 encounters Data Source: Enrollment Reports Milestone 5: Estimated Incentive Payment: $180,501 **Milestone 6** I-6: Increase the number of PCP referrals for patients without a medical home who use the ED, urgent care, and or hospital services. Metric 1 I-6.4 : Percent of patients without a PCP that are given a scheduled PCP appointment. **Goal:** 60% of patients will be given a scheduled PCP appointment Data Source: Navigation Software Milestone 6 Estimated Incentive Payment: $120,335
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $332,844	Year 3 Estimated Milestone Bundle Amount: $363,115	Year 4 Estimated Milestone Bundle Amount: $364,170	Year 5 Estimated Milestone Bundle Amount: $300,836
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $1,360,965			

PROJECT OPTION: 2.2.2 – Expand Chronic Care Management Models

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094148602.2.1
PERFORMING PROVIDER/TPI: Baptist Hospitals of Southeast Texas Beaumont ("Baptist")/094148602

Project Summary:
Provider: Baptist Hospital of Southeast Texas Beaumont ("Baptist") is a 500 bed hospital located in Beaumont, Jefferson County, Texas. Baptist serves 496,000 people in 46 zip codes.
Interventions: Baptist will develop a program to teach patients to manage their chronic disease (such as, heart failure, pneumonia and myocardial infarctions and called patient activation) and establish a post-discharge planning program that prepares patients for self-management. Our target population will be patient that have the before mentioned diagnoses and are underserved, indigent, uninsured, or have Medicaid. In addition, Baptist will help patients set up a medication regiment that is safe and appropriate. Individuals served by this program will experience improvement in the care of chronic ailments which in turn will ensure them a better quality of life. Using follow-up and follow-along phone calls, we will ensure these people are compliant with their plan of care including the acquisition of and proper administration of all their medications. Through the phone calls we will also ensure they meet their post-discharge physician appointments. This will be verified by record keeping and review. Included will be 30-day readmission rates, average lengths of stay, medication compliance rates, compliance rates with physician post-discharge follow up, and HCAPS data reviews.
Need for the Project: Patients lack the medical and professional support they need to manage their medications, diet, activity level, and stress, which can lead to acute episodes requiring hospitalization or readmission. Many readmissions can be avoided through inpatient teaching, medication reconciliation and appropriate post-discharge follow-along care.
Target Population: Baptist serves approximately 500,000 in its catchment area. Approximately 31,786 are 65 years old and older, 57,013 live at or below the poverty level, 63,572 are uninsured (0-64 years of age), and 37,639 are on Medicaid. In addition, almost 2,900 patients in the community currently suffer from chronic disease. It is estimated that 14% of Baptist's catchment area patients suffer from chronic disease, of which 40% are Medicaid and uninsured.
Category 1 or 2 Expected Benefit: The goal of this project is to increase the number of patients that self-manage their chronic disease by 80%. This will improve the overall health of the target population and develop and implement chronic disease management interventions for congestive heart failure (CHF) and other chronic conditions prevalent in the community, which will ultimately improve patient clinical indicators, health outcomes and quality, and reduce unnecessary acute and emergency care utilization.
Category 3 Outcome: Baptist expects to decrease the current 30-day readmission rate of 16.11% to 10% and have 80% of patients admitted for congestive heart failure enrolled in a self-management program over the next five years.
PROJECT DESCRIPTION:
Through this project, Baptist will take a comprehensive approach to assisting patients in managing chronic disease. Too often patients lack the medical and professional support they

need to manage their medications, diet, activity level, and stress, which can lead to acute episodes requiring hospitalization. Although the hospital setting is not an optimal learning environment for patients, chronic patients' home planning program that prepares patients for self-management and ensures the post-discharge setting spital admissions allow Baptist an opportunity to teach patients how to care for themselves after discharge. However, this project is dedicated to not only teaching patients how to care for themselves after discharge, but also to establish a post-discharge is supportive, which Baptist hopes will reduce patients' chances of hospital readmission.

Baptist has a multi-faceted plan for addressing chronic disease management post discharge. Baptist currently operates a self-management program, but it does not take the expansive approach that this project will. First, Baptist will train its nurses to engage in the "teach back" method pre-discharge when communicating with clients about managing their conditions. This method entails explaining discharge instructions to patients in a manner that they will understand, and testing their comprehension and retention of the instructions by having them repeat back the instructions. This method is a tried and true way to engage patients in their own care and to ensure that they absorb more of the content they receive from their healthcare providers. Second, the hospital's providers will be trained to use similar methods in educating hospitalized patients' families on how to care for and support their loved one, using a similar "teach back" methodology. In the immediate days post-discharge, the hospital staff that cared for the patient will engage in routine follow-up calls with patients, answering questions and providing support. Finally, the keystone piece of this project will involve the use of telehealth technology to assist patients in managing their conditions and avoiding readmission. Baptist intends to target the most prevalent chronic diseases in the surrounding community, and to link patients at risk for readmission with Patient Navigation devices operated by a third party company called Texas Medical Enterprises ("TME"). These monitoring devices function much like "black boxes" in an airplane –they will provide real-time data to TME of relevant health data (e.g. patient's heart rate), will provide patients will appointment reminders, and will allow for TME to contact patients' medical providers when the patients' conditions or comments indicate that they require medical intervention (as the patients are also able to give feedback through the monitors as to how they are feeling on a regular basis). This post-discharge monitoring is intended to assist patients in managing their conditions and to reduce the rate of readmission for chronic diseases.

Project Goal(s):

The goal of this project is to develop and implement chronic disease management interventions for congestive heart failure (CHF) and other chronic conditions prevalent in the community, which will ultimately improve patient clinical indicators, health outcomes and quality, and reduce unnecessary acute and emergency care utilization. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions.

This program will be geared to patient activation teaching patients with CHF and other targeted chronic conditions to care for themselves after discharge. It addition it will partner with the Patient Navigation system to complete follow along calling after discharge. Specific goals include:

- Establishing a hospital-based system for identification of patients with a diagnosis of CHF on the day of admission
- Identification of barriers for learning (language, co-morbidities, cultural, etc), paired with starting the "teach back" program on day one of a patient's stay in the hospital
- Completing medication reconciliation at discharge
- Ensuring the post discharge setting is supportive to the patient's self-care skills and ability.
- Identification of other chronic diseases to target through the program, which may include diabetes, chronic obstructive pulmonary disease and asthma (all of which are prone to co-occurring health conditions and risks).

Challenges:

Baptist expects the following challenges and will address them in the following manner:

- Training providers in the "teach back" method – Baptist will appoint staff and/or hire professionals to train and engage the nursing staff to implement these protocols.
- Imparting to patients the importance of self-management in an outpatient setting – Baptist will also train its providers to communicate effectively about the risk for readmission or complications if a patient does not follow his/her providers' instructions.
- Coordinating with TME to effectively monitor patients through Patient Navigation – Baptist will set up protocols for obtaining and analyzing the information provided through TME.

5-Year Expected Outcome(s) for Performing Provider and Patients:

In 5 years, Baptist hopes to have every patient admitted with a diagnosis of CHF engaged a self-management program. In addition, we hope to reduce the readmission rate for this diagnosis to less than 10%. We will be working with the Patient Navigator program and joined with other community health care providers sharing best practices and lessons learned.

Relationship to Regional Goals:

Regionally, we are making an effort to join together to ensure that CHF patients have an improved quality of life and that costs associated with this diagnosis are significantly decreased. Every County in the region is addressing this problem, and the goal is for Region 2 providers to come together to share best practices and lessons learned.

STARTING POINT/BASELINE:

Currently, we serve 2-3 in-patients per week with a diagnosis of CHF who are at a high-risk for readmission. A first round of "teach back" training was just completed with the staff, the medication reconciliation process has been revamped, , and only a few patients currently receive phone calls post discharge. Baptist had a total of 422 inpatients over the last 12 months with a diagnosis of CHF, and 123,399 outpatient visits with CHF during the same period. Of the 422 inpatients, 68 (or 16.11%) were readmitted within 30 days of discharge. 1.9% of the

Jefferson County population has heart disease, there is no breakdown on how many of those have HF.

RATIONALE:

Jefferson County has a total of 252,273 residents. 12.6% of those are 65+ years of age, 22.6% are living below the poverty level, 25.2% are uninsured, and 14.92% are on Medicaid only. Additionally, Jefferson County residents have a higher rate of physical inactivity, obesity, adult smoking, hypertension, and poor physical health days than the statewide average, each of which increases a patient's risk of CHF and being high-risk. Jefferson County has a higher rate of mortality from aortic aneurysm and diseases of the heart than the statewide average, indicating that CHF is a chronic disease that needs to be better managed both by providers and patients. Finally, elderly patients are at an especially risk for CHF and, since that population primarily live on fixed incomes (and many are considered living at or below the poverty lower), management of the disease is often lacking. Patient activation and self-management are a must, but often patients still require continued support. Our program aims to teach self-management, ensure a stable post discharge environment, and support post-discharge for 60 days (with the Patient Navigation system).

Information source: RHP 2, Jefferson County Profile (August 2012); Region 2 Community Needs Summary

Unique Community Need Identification Numbers:

CN.1, CN.10, CN.11, CN.13, CN.14

Expansion or Enhancement:

We have never identified a specific group of patients by diagnosis to address for special needs support. This will be a landmark initiative for our facility. In addition, our goal includes reaching out to other community health care providers and joining them in providing support and care for these patients. It will be expanded by working in concert with the outpatient Patient Navigator to ensure follow along services with the goal of decreasing admissions and providing follow along support in the community.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD 3: Potentially Preventable Readmissions; IT 3.2: CHF 30 day readmission rate (all-cause).

Baptist chose this outcome because it expects the result of its project to improve patient self-management, with CHF as the initial and primary target, to be a decrease in readmissions within 30 days of discharge. This outcome is important to improving the long- and short-term patient outcomes of patients with CHF, and to reducing the systemic cost of treating these patients (as ED visits and hospital admissions are far more expensive than outpatient and primary care settings).

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on using a comprehensive approach to managing chronic disease and emphasis on patient education, discharge planning, and post discharge support to reduce

readmission ties to these Category 1 and 2 projects in our RHP: 112671602.2.1, 112706003.2.1, 138296208.2.1, 094092602.2.6,094148602.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFOMRING PROVIDERS' PROJECTS IN THE RHP:

Every County in our region has CHF as a targeted project. We are working on a plan to join them in the future for collaboration and shared learning.

This project focuses on the expansion of chronic care management models along with these other Category 2 projects in our RHP: 094148602.2.1-Expand chronic care management models; 112671602.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 112706003.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 138296208.2.1-Expanding chronic care management models (high risk healthcare needs).

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of each Baptist project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Chronic disease management is essential to improving the short- and long-term health outcomes for Jefferson County's residents, and for reducing the cost of health care delivery in the Region. Jefferson has a high mortality rate from heart disease, and a high number of residents who at risk for developing CHF presently or in the future. Thus, the project will touch a broad base of the surrounding population. The project will take initial investment

to create the parameters and identify the target population, and afterward to maintain communication with patients to manage their conditions and medication.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094148602.2.1	2.2	2.2.2	Expand Chronic Care Management Models	
Baptist Hospitals of Southeast Texas - Beaumont				094128602
Related Category 3 Outcome Measure(s):	094148602.3.2	IT-3.2	Congestive Heart Failure Readmission Rate (CHF)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone [P-3] Develop a comprehensive care management program **Metric:** Documentation of Care management program. **Baseline Information for the Milestone/Metric:** Currently, Baptist is working to establish a comprehensive approach to chronic disease management rate. **Goal for this Milestone/Metric:** Baptist will develop and create the infrastructure for its multi-faceted approach to CHF and other chronic diseases, which will include staff training and partnering with TME Baptist will develop and create the infrastructure for its multi-faceted approach to CHF, PN, AMI, Renal Failure, Sepsis, and COPD, which will include staff training, will work with other community facilities and programs and will include partnering with TME. **Data Source:** Program materials **Milestone Estimated Payment Amount - $1,389,801**	**Milestone [P-10]:** Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types **Metric**Increase patients who experience interactions beyond one-to-one visits such as group visits, telephone visits, and other interactions.**Baseline Information for the Milestone/Metric:** Currently, very few CHF patients receive calls post-discharge and none are part of a telehealth program through Baptist. **Goal for this Milestone/Metric:** The goal for year three is to reach a total of 921 patients through the Chronic Care Management program. This goal is for patients who meet the targeted criteria of uninsured, underserved, indigent, or on Medicaid and have a diagnosis of HF, COPD, PN, AMI, Renal Failure, or Sepsis. **Data Source:** Records maintained in 3M, the EHR, and Crimson.	**Milestone [I-18]:** Improve the percentage of patients with self-management goals. **Metric:** Patients with self-management goals Numerator: number of patients with the specified chronic condition in the registry with at least on recorded self-management goal Denominator: Total number of patients with the specified chronic condition in the registry **Baseline Information for the Milestone/Metric:** **In the most current month 13.33% (4/30)** of the patients identified in Baptist's records with Heart Failure tested as high risk for readmission within 30 days of discharge and are enrolled in the self-management program. **Goal for this Milestone/Metric:** In year four, our goal is to increase the number of patients who have recorded self-management goals to approximately 70% of the patients enrolled in the chronic care management model. (approximately 1200 patients expected to be enrolled)	**Milestone [I-18]** Improve the percentage of patients with self-management goals. **Metric:** Patients with self-management goals Numerator: number of patients with the specified chronic condition in the registry with at least on recorded self-management goal Denominator: Total number of patients with the specified chronic condition in the registr **Baseline Information for the Milestone/Metric:** **In the most current month 13.33% (4/30)** of the patients identified in Baptist's records with Heart Failure tested as high risk for readmission within 30 days of discharge and are enrolled in the self-management program. **Goal for this Milestone/Metric:** In In year five, our goal is to increase the number of patients who have recorded self-management goals to approximately 90% of the patients enrolled in the chronic care management model. (approximately 1400 patients expected to be enrolled).**Data Source:**

094148602.2.1	2.2	2.2.2	Expand Chronic Care Management Models	
Baptist Hospitals of Southeast Texas - Beaumont				094128602
Related Category 3 Outcome Measure(s):	**094148602.3.2**	**IT-3.2**	**Congestive Heart Failure Readmission Rate (CHF)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone Estimated Payment Amount - $1,421,436		**Data Source:** Records maintained in 3M, the EHR, and Crimson. **Milestone Estimated Payment Amount - $1,419,232**	Records maintained in 3M, the EHR, and Crimson. **Milestone Estimated Payment Amount - $1,145,964**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,389,801	Year 3 Estimated Milestone Bundle Amount: $1,421,436		Year 4 Estimated Milestone Bundle Amount: $1,419,232	Year 5 Estimated Milestone Bundle Amount: $1,145,964
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD - $5,376,433				

PROJECT OPTION: 2.9.1- Expand Care Transition Program

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094148602.2.2
PERFORMING PROVIDER/TPI: Baptist Hospitals of Southeast Texas Beaumont/094148602

Provider: Baptist Hospital of Southeast Texas Beaumont ("Baptist") is a 500 bed hospital located in Beaumont, Jefferson County, Texas. Baptist serves 496,000 people in 46 zip codes.
Interventions: Baptist will develop a community-wide network and support system for patients who have Medicaid, who are uninsured, underserved, or are indigent and have been diagnosed with heart failure, pneumonia, AMI, COPD, Sepsis, or renal failure. Through this network, Baptist will deploy case managers/workers, community health workers and other health professionals as patient navigators to provide enhanced social support and competent care to vulnerable and high-risk patients. Individuals served by this program will experience an error free transition of care from hospital to home which in turn will ensure them a better quality of life. Using follow-up and follow-along phone calls, we will ensure these people are discharge to home is a positive experience and, in addition, we will ensure they are compliant with their plan of care including the acquisition of and proper administration of all their medications. Through the phone calls we will also ensure they meet their post-discharge physician appointments. This will be verified by record keeping and review. Included will be 30-day readmission rates, average lengths of stay, medication compliance rates, compliance rates with physician post-discharge follow up, and HCAPS data reviews.
Need for the Project: Patients lack the medical and professional support they need to manage heart failure due to poor education, socio-economic and language barriers, and cultural barriers. These lead to higher readmission rates. Currently this program only attends heart failure patients who are at high risk for return to the hospital within 30 days of discharge. Baptist plans to include all high risk patients in this program with special attention to patients that are uninsured, transient, underserved or have Medicaid. In the most recent 12 month period this included 484 Inpatients and 31,056 outpatients that are uninsured or have Medicaid and have one of the three major chronic diseases (Heart Failure, Pneumonia, and Acute Myocardial Infarction). Adding COPD, renal failure, and diabetes to this count demonstrates the huge need for special care for the very large population of individuals with chronic disease and have no insurance or are covered through Medicaid.
Target Population: Baptist's catchment area of almost a half of a million people has a large Medicaid, Medicare and uninsured population. Approximately 31,786 are 65 years old and older, 57,013 live at or below the poverty level, 63,572 are uninsured (0-64 years of age), and 37,639 are on Medicaid. It is estimated that 14% of Baptist's catchment area patients suffer from chronic disease, of which 40% are Medicaid and uninsured.
Category 1 or 2 Expected Benefit: Jefferson County has a high mortality rate from heart disease and a high number of residents who are at risk of for developing congestive heart failure. The goal of this program is to provide education and continuing support to the residents of Jefferson County, who suffer for heart failure or are at high risk of heart failure and other chronic diseases. This will improve the overall health of the target population and develop and implement chronic disease management interventions for congestive heart failure (CHF) and

other chronic conditions prevalent in the community (PN, AMI, COPD, Renal Failure, and Diabetes), which will ultimately improve patient clinical indicators, health outcomes and quality, and reduce unnecessary acute and emergency care utilization.

Our goal is to serve 780 individuals in year two of the program. Subsequently, we will serve 921 individuals in year three, 1,183 in year four, and 1,360 in year five. These individuals will not only have chronic disease but will either be uninsured, underserved, indigent, or on Medicaid. Services for these people will include teach back and dedicated medication reconciliation to ensure success after discharge. Our plan is to include individuals with chronic disease and that are at high risk of readmission. Chronic diseases included in our program include HF, COPD, AMI, PN, Sepsis, and Renal Failure.

Category 3 Outcome: Baptist expects to increase the number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 7% and reduce the congestive heart failure rate by 8%.

PROJECT DESCRIPTION:

Baptist Hospitals of Southeast Texas ("BHSET") recognizes a need for learning and support in the population of citizen in Jefferson County who have a diagnosis of heart failure (HF), and particularly for those who either do not have insurance or who have either Medicare or Medicaid. BHSET intends to set up a community-wide support network in coordination with other community health care provides that will ensure this population can have an improved quality of life with minimal hospitalization.

Specifically, this project expands BHSET's care transition program to develop a community-wide network and support system for Medicaid, Medicare, and uninsured patients diagnosed with heart failure. All health care entities in the area will share responsibility and tracking of these individuals. The network will share knowledge and outcomes in an effort to improve the quality of life of this population while decreasing their risk of hospitalization. All this will be done at a cost lower than that currently experienced in hospitalizations over the span of a year.

This project meets all of the required core project components:

a) Identify patients who have a diagnosis of heart failure and are frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Project Goals/5-Year Expected Outcome:

- Expand services to patients diagnosed with heart failure in Jefferson County by decreasing their use of the ED to after hour, essential visits and daytime visits that would be classified as urgent with no PCP available.
- Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 7%
- 8% reduction in CHF admission rate
- Utilize Registered Nurses, social workers, or other types of health care professionals as patient navigators to provide enhanced social support and competent care to vulnerable and/or high-risk patients.
- Identify health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through integrated health care delivery systems.
- Develop a partnership with other community health care providers to set up a network for people with HF. This network would share the responsibility of ensuring this population is safe, well cared for, and have little risk for admission to the hospital.

Challenges:

- Patient self-management in monitoring condition to ensure that the patient does not develop an increased risk for hospitalization.
- Communication among health care entities in tracking program patients.
- Potential enrollees may opt-out of participating.
- Barriers to care such as: financial, socioeconomic, and availability to providers.

BHSET will address these challenges by thoughtfully creating a plan to effectively communicate with patients and their caregivers about next steps and to establish a trusting, cooperative relationship. Additionally, this project addresses patient self-management challenges through PNs. BHSET's PNs will ensure this population is taught to care for themselves while monitoring them regularly. In addition, anyone hospitalized will have the aspects of self-care inculcated using a teach-and-teach- back system. On day one, patients will be taught their care taking into consideration any barriers to learning (language, education, cultural, etc.). After that, the patient will be required to teach back what they learned with prompting and re-teaching as necessary. Finally, patients will be educated and encouraged to participate in the program, and the providers will work with clients to address financial and other barriers to participation.

Relationship to Regional Goals:

There will be a region- wide network for learning and sharing information. All health care providers in the Region will "hold hands" to improve care to this population. Region 2 is committed to reducing heart failure admission rates and to institute innovative programs to increase quality of care.

STARTING POINT/BASELINE:

BHSET currently has a formal care transition program for patients that have been hospitalized and who have a high risk for readmission. The program currently in place manages patients'

hospital stays with teach back, med rec, and SBAR programs. The hospital also has 6 month phone call follow along program to ensure the patient is seeing their PCP and taking their medications. However, BHSET does not yet have a community wide concerted effort to serve this population. Over the last 12 month period, BHSET had a total of 422 people with this diagnosis receiving hospital care and 16.11% or 68 of these patients were readmitted within 30 days of discharge.

This project will target patients who are uninsured, who have Medicaid, and who have Medicare and have a diagnosis of heart failure. The total number of patients for September 2011 through August 2012 was 285, and approximately 20 of those patients were partially served by our staff; the baseline rate for the target population is 7%. In regards to the admission rate, 68 of the designated patients return to the hospital within 30 days of discharge. Approximately 80% of these patients are admitted through the ED – 54 patients.

RATIONALE:

Jefferson County, where BHSET is located, has a large Medicare, Medicaid, and uninsured population, and the County has a high rate of heart failure. 12.6% of this population is 65+ years old, 25.2% are uninsured, 15.6% are disabled, 31.6% have adult obesity, and 14.92% are on Medicaid. The uninsured, disabled, adult obesity, and Medicaid percentages exceed both the state and the national percentages. In addition, 22.6% of the population is living below the poverty level. The likelihood is high that a patient diagnosed with HF falls into one or more if these categories. Additionally, patients with HF often times have multiple diseases (COPD, Diabetes, and Pneumonia) complicating their care. All told, people living in Jefferson County and having HF are at high risk for hospitalization and exacerbation of their disease resulting in a poor quality of life and increased cost to health care.

Milestones and Metrics:

BHSET selected the milestones and metrics it believes are most appropriate to implement the scope of this project. BHSET anticipates that most of the effort in the first couple years will be educational, to work with the expanded community of healthcare providers, including nursing homes, physicians, clinics and case workers, to coordinate care transition from one setting to another. Thereafter, with coordination and better transitions, it is anticipated that patients will be referred to the proper setting for post-discharge medical care and follow-up, coordinated through a medical home.

For the Improvement Milestone, Baptist chose I-7.1 reducing the number of avoidable admissions for six distinct chronic diseases. Although CHF is one of these diseases, it is only one of 6 that are addressed by the navigation program. Even though CHF is also addressed in IT-2.1 for the associated Category 3 outcome, this is not a duplicative because: (1) I-7.1 deals with readmissions and the associated IT-2.1 deals with all admissions; and (2) I-7.1 deals with a broader array of chronic conditions than CHF. IT-2.1 is specific to HF because of the large cost and poor success in treating this specific disease. It is appropriate that it be addressed apart from and beyond the navigation program. Consequently, Baptist feels that it is appropriate to keep both of these measures in the project.

Unique Community Need Identification Numbers: CN.1, CN.10, CN.11, CN.13, CN.14

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Avoidable hospitalizations and excessive use of ED are seen as key measures of patients' disconnect from the health care systems. As this is an innovative program, avoidable hospitalizations is a good measure of whether the program can have a direct impact on reducing this rate. Hospitalization of this population for September 2011 through August 2012 exceeded $4,000,000.00. Many of these individuals came into the hospital and returned during the year due to poor care much of which was due to lack of understanding of their disease and what causes its exasperation. Teaching these people how to care for themselves, providing the support they need to make it to their PCP, ensuring they have and take their medications, and tracking their disease is the key to avoiding hospitalization. The cost to provide this system in the first year would be less than $200,000.00. This would be paid for with a reduction in 21 admissions. Total admissions were 422 which would be a 5% reduction in this data point. This could be combatted by developing a community wide network that would not only work together to reduce admissions and readmissions, but would share ideas and information growing the entire system into a powerful and dynamic support system for this population.

RELATIONSHIP TO OTHER PROJECTS:

This project parallels but does not duplicate our **Expansion of Chronic Care Management Models.** This project also addresses people with HF. One of the projects (Expansion of Chronic Care Management Models) is responsible for patient activation in the inpatient setting while the other (Establish/Expand a Patient Care Navigation Program) assumes responsibility for the outpatient setting. The projects are complimentary and together should have a major impact on improving the quality of life for this population while reducing the health care cost associated with hospitalization.

This project's focus on care transition that creates a community-wide network of area health care entities and emphasis on patients diagnosed with heart failure ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on establishing/expanding patient care navigation programs along with these other Category 2 projects in our RHP: 121805903.2.1-Establish/expand a patient care navigation program; 094148602.2.2-Expand care transition program; 094092602.2.3-Establish/expand a patient navigation program - community health program, chronic disease education; 112706003.2.4- Establish/Expand a Patient Care Navigation Program.

PLAN FOR LEARNING COLLABORATIVE:

This project is designed to develop a community wide collaborative effort and, if funded, has the potential of expanding throughout the RHP.

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared

learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of each BHSET project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Chronic disease management is essential to improving the short- and long-term health outcomes for Jefferson County's residents, and for reducing the cost of health care delivery in the Region. Jefferson has a high mortality rate from heart disease, and a high number of residents who at risk for developing CHF presently or in the future. Thus, the project will touch a broad base of the surrounding population.

In valuing this project, BHSET examined the project's potential to decrease health care cost for this diagnosis by as much as 50%, which will amount to at least $1,000,000.00 the first year. BHSET also evaluated the impact this project will have on improving the health of the community at a minimal cost. Provider coordination is essential in improving health care outcomes and in improving patient-centered care. Through this project, BHSET and other providers will have the capacity to better coordinate patient care and reduce health failure mortality rates in the Region.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.

- Severity--Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094148602.2.2	2.9	2.9.1	Expand Care Transition Program	
Baptist Hospitals of Southeast Texas – Beaumont				094148602
Related Category 3 Outcome Measure(s):	094148602.3.2	IT-2.1	Congestive Heart Failure Admission rate (CHF)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: (P-2) Expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care, including program to train the navigators, develop procedures and establish continuing navigator education. Metric 2: (P-2.1) Develop workforce development plan for patient navigator recruitment Baseline/Goal: The hospital does not currently have a workforce development plan. Data Source: Workforce development plan **Milestone Estimated Payment Amount - $503,204** **Milestone 2**: (P-3) Provide care management/navigation services to targeted patients. Year one base line consisted of 285 patients who were either indigent, on Medicaid, underserved or uninsured. For year two, the goal is to increase the number served to 780 individuals.	**Milestone 3**: (P-3) Provide care management/navigation services to patients with a diagnosis of heart failure and that are within the hospital system. Metric 3: (P-3.1) Increase in the number or percent of targeted patients enrolled in the program Baseline: The total number of patients for September 2011 – August 2012 was 285 individual that were uninsured, underserved, indigent, or on Medicaid Goal: Our goal for year three is to increase the number of Medicaid, Medicare, underserved, and uninsured patients, that have been diagnosed with heart failure, AMI, COPD, or sepsis to a total of 921 patients served. Date Source: Crimson Database **Milestone Estimated Payment Amount - $1,029,316**	**Milestone 4**: (I-6) Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 4: (I-6.1) Increase medical home empanelment of patients referred from navigator program. Baseline/Goal: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services to at least 30% of patients in the navigation program. Data Source: Crimson Database, Community and State Demographic records, Care Navigator records **Milestone Estimated Payment Amount - $342,573.33** **Milestone 5**: (I-7) Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program Metric 5: (I-7.1)	**Milestone 6**: (P-3) Provide care management/navigation services to patients with a diagnosis of heart failure, AMI, Pneumonia, Sepsis, COPD or Renal Failure and that are uninsured, underserved, indigent or on Medicaid. Metric 6: (P-3.1) Increase in the number of targeted patients enrolled in the program The total number of targeted patients for September 2011 – August 2012 was 285. Goal: Increase to a total of 1,360 patients served. This will include patient who are uninsured, underserved, indigent, or on Medicaid and have been diagnosed with Heart Failure, AMI, Pneumonia, Sepsis, Renal Failure, or COPD. Data Source: Crimson Database, **Milestone Estimated Payment Amount - $829,836**

094148602.2.2	2.9	2.9.1	Expand Care Transition Program	
Baptist Hospitals of Southeast Texas – Beaumont				094148602
Related Category 3 Outcome Measure(s):	094148602.3.2	IT-2.1	Congestive Heart Failure Admission rate (CHF)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Metric 2: (P-3.1) Increase in the number of targeted patients enrolled in the program from the baseline of 285 to 780 for year two. Baseline/Goal: Identify indigent, underserved, uninsured, and those people on Medicaid that will benefit from navigated services and increase the number served to 780 focusing on chronic diseases that are difficult to manage. Data Source: Patient records reporting data **Milestone Estimated Payment Amount - $503,204**		ED visits and/or avoidable hospitalizations Baseline/Goal: Reduce 30-day readmission rates for patients diagnosed with heart failure, AMI, COPD, Sepsis, Renal Failure, or Pneumonia by 10%. Data Source: Hospital records **Milestone Estimated Payment Amount - $342,573.33** **Milestone 6**: (P-3) Provide care management/navigation services to patients with a diagnosis of heart failure, AMI, pneumonia, Sepsis, renal failure, or COPD and living within the hospital system. Metric 3: (P-3.1) Increase in the number or percent of targeted patients enrolled in the program Baseline: The total number of patients for September 2011 – August 2012 who are uninsured, underserved, indigent or who had Medicaid, was 285. By year four our goal is to increase the number of the targeted patients served to 1,183.	

094148602.2.2	2.9	2.9.1	Expand Care Transition Program	
Baptist Hospitals of Southeast Texas – Beaumont				094148602
Related Category 3 Outcome Measure(s):	**094148602.3.2**	**IT-2.1**	**Congestive Heart Failure Admission rate (CHF)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Goal: Increase the number of Medicaid, uninsured, indigent or underserved and uninsured patients, that have been diagnosed with heart failure, AMI, Pneumonia, COPD, Sepsis, or Renal Failure from the baseline of 285 to a total of 1,183 served. Date Source: Crimson Database **Milestone Estimated Payment Amount - $342,573.33**	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,006,408	Year 3 Estimated Milestone Bundle Amount: $1,029,316		Year 4 Estimated Milestone Bundle Amount: $1,027,720	Year 5 Estimated Milestone Bundle Amount: $829,836
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD - $ 3,893,280				

PROJECT OPTION: 2.2.2- Expand chronic care management models

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 112671602.2.1
PERFORMING PROVIDER/TPI: Brazosport Regional Health System – Lake Jackson Family Medicine Center (LJFMC)/TPI: 112671602

- Provider: Brazosport Regional Health System (BRHS) – Lake Jackson Family Medicine Center (LJFMC) is a division of BRHS that provides primary care to patients ages 5 and over. LJFMC is a primary care clinic, currently housing 2 full time physicians and a Certified Diabetic Educator (CDE) one day every 2 weeks, in Lake Jackson, Texas, serving a population of approximately 80,000 within the BRHS primary service area. In 2012, 4,946 LIFMC patient visits were coded with type II Diabetes Mellitus on their visit.
- Interventions: The project will use LJFMC as a base for expanding chronic care management models for patients diagnosed with diabetes. The project will expand on the CDE overseen self-management program for diabetes, which is already in its early stages, and also growth in the form of expanding the current Diabetes Outpatient Training Site (DOTS) program with increased course offerings and patient referrals for diabetes management.
- Need for the project: We are currently experiencing a severe shortage of primary care providers in the BRHS service area. Brazoria County has 44.2 primary care providers per 100,000 residents, falling far below the Texas and U.S. averages of 69.5 and 91.0 physicians per 100,000 residents, respectively. The most recent BRHS community health needs assessment also found the primary service area to have a large diabetic population with underutilized BRHS diabetes educational resources. The lack of primary care capabilities coupled with the limited reach of current diabetes management programs creates a serious shortage of primary care opportunities for diabetic patients.
- Target Population: The target populations are current LJFMC diabetic patients and diabetic patients who are looking for a new primary care provider with a focus on diabetes management. Approximately 25% of our current patients are either Medicaid or self-pay patients without insurance, so we expect they will benefit from the extended clinic hours and increased access to medical care. LJFMC is one of the few primary care practices in the BRHS primary service area that accepts new Medicaid patients.
- Category 2 expected patient benefits: The project seeks to increase the number of patients enrolled in the diabetes self-management program at LJFMC and to increase the number of patients enrolled in the DOTS program through increased course offerings. The goal for the project is to eventually serve at least 2% of the LIFMC diabetic population, or approximately 100 patients through the diabetes self-

management program. The goal is to eventually offer 6 DOTS sessions by DY5, serving approximately 50 patients.

- Category 3 outcomes: IT-1.10 The project seeks to reduce the percentage of diabetics in the program who have Hemoglobin A1C levels greater than 9.0%.

PROJECT DESCRIPTION:

The project proposes using Brazosport Regional Health System's (BRHS) Lake Jackson Family Medicine Center (LJFMC) as a base for expanding chronic care management models for patients diagnosed with diabetes. The project involves expanding self-management programs for patients diagnosed with diabetes (a chronic disease management program for diabetes and the DOTS program), measuring patient progress by monitoring the increased number of patients in the target population reached and measuring Hemoglobin A1c levels and comparing the results of the quality improvement initiative to other diabetic patients at LJFMC who do not choose to enroll in the programs offered. The project plans to begin with a self-management program based in LJFMC overseen by a Certified Diabetic Educator (CDE) Nurse Practitioner, with growth in the form of expanding the current Diabetes Outpatient Training Site (DOTS) program with increased patient referrals for additional chronic disease management.

Project goal(s):

The goal of this project is to develop and implement chronic disease management interventions, specifically for diabetes, that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute admissions and emergency care utilization. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Diabetes is a complication to other chronic health conditions, and can adversely affect a patients' risk of developing additional complications, co-morbidities, and/or utilization of acute or emergency services.

Challenges:

Anticipated challenges to achieving the goals of the project include:

- Non-compliance in patients enrolled in the program
- Concurrent chronic health conditions in patients will inhibit the improvements possible in decreasing Hemoglobin A1c levels to a "normal" range
    - Response: By only measuring number of patients and HbA1c levels as clinical indicators of the project effectiveness, other successes of the program cannot be measured as easily. The chronic conditions of some patients will make it very difficult to decrease HbA1c levels to what is defined as "normal" or "within acceptable range". Notes of other chronic conditions experienced by the patient will have to be made in order to have internal comprehension of any slowly progressing clinical improvements.
- Difficulty in increasing DOTS referrals

5-year Expected Outcome(s) for Performing Provider and Patients:

The improvement target for this project is to reduce the percentage of diabetes self-management program patients with hemoglobin A1c levels > 9.0%. The project proposes methods of patient self-management of diabetes, combined with primary care clinical monitoring, in an effort to reduce the hemoglobin A1c levels of the patients who agree to participate in the program. The program goals are to reduce the hemoglobin A1c levels of patients to less than 9.0%, and will measure the percentage of patients with hemoglobin A1c levels higher than 9.0% from the total patient population with diabetes. The goal is to expand the current program in year 2 using the small current patient population within Lake Jackson Family Medicine Center, to decrease the percentage of patients with poorly controlled hemoglobin A1c levels of greater than 9.0% compared to the total number of patients in year 3, to further decrease the percentage of patients with poorly controlled hemoglobin A1c levels of greater than 9.0% compared to the total number of patients in year 4, and to further decrease the percentage of patients with poorly controlled hemoglobin A1c levels of greater than 9.0% compared to the total number of patients in year 5 (goal for decrease for each year TBD based on baseline information). Because the proposal plans to expand the self-management program for patients with diabetes within year 2, the baseline information is not currently available and the specific percentage goals cannot be determined at this time. Once the baseline information is available the baseline information will be established and the improvement targets determined in year 3.

Relationship to Regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management

STARTING POINT/BASELINE:

The baseline for the clinical patient program is unique. Although there are diabetic patients enrolled in a preliminary diabetes self-management program that the project intends to follow, information on the total number of patients with diabetes at LJFMC is unknown and therefore the baseline percentage of diabetic patients enrolled in the program and the baseline percentage of patients with poorly controlled Hemoglobin A1c levels cannot be calculated. In the current (preliminary) diabetes self-management program at Lake Jackson Family Medicine Center the baseline population in year 2 begins at 3 sessions, but the number of patients in the past is too unpredictable to determine a baseline for the future defined program. There is also not a defined project method of obtaining hemoglobin A1c levels from patients in the program, so the baseline percentage of uncontrolled hemoglobin A1c patients cannot be determined at this time.

The baseline population for the future expansion of the community-based DOTS program is also not able to be determined at this time. The details of incorporating the DOTS program efforts with the chronic disease management program at LJFMC will be established in year 3 and the number of patients enrolled afterwards will be the baseline number of DOTS patients. The project will use current patient data, without identifiers, to determine the baseline number of

patients necessary for a self-management program group that will produce valid statistical results and baseline hemoglobin A1c levels. This baseline information will then be used to generate future goals.

RATIONALE:

Relation between Project Choices and Community Needs:

The rationale for the project is to better understand the impact of combining provider practices, such as medication management and patient education, and self-management patient practices of diabetic patients.

The community needs assessment suggests that the local community has higher number of diabetic patients when compared against national peer groups. The Community Health Needs Assessment for Brazoria County demonstrates the specific need for services targeting health improvements for patients with diabetes, which can have a significant impact on other chronic conditions prevalent in the community. The mortality for diabetes is higher in Brazoria County versus the United States (Brazoria County 23.8 deaths/100,000, US 20.9/100,000). Morbidity rates for diabetes in Brazoria County are also high, with 9.8% of the population affected. Also, the number of primary care providers in Brazoria County is less than half of the US rate per 100,000 people.

The significant health issues associated with diabetes and the benefits that can be achieved by properly controlling a patient's condition, particularly monitoring hemoglobin A1c, are key reasons for choosing this project. Diabetes is a serious problem, but the benefits possible by controlling the condition are achievable and extend well beyond the scope of decreasing acute issues.

The Project Area plan to expand chronic care management models is appropriate as the primary care providers are currently treating and managing these patients, but without a chronic condition management program. There is also a need for additional primary care providers in the area to assist in chronic care management. The existence of the DOTS program must be better publicized and utilized by primary care providers in order to cooperatively treat diabetic patients. The process milestone to develop and implement a program to assist patients to better self-manage their chronic conditions provides continuity from the project area. The proposed project will assist patients in managing diabetes, therefore assisting the patient in managing their chronic condition. The improvement milestone also provides continuity in the aforementioned project areas with the goal of controlling hemoglobin A1c levels, and therefore their diabetes and overall health. Each portion of the project aims to expand primary care initiatives for diabetic patients in order to better control their chronic condition and improve the health status of the community.

Unique Community Need Identification numbers:

CN.8: Midlevel Provider Shortage

CN.12: Chronic Diseases: Diabetes

Expansion or enhancement

The project area plan to expand and enhance chronic care management models is appropriate as the primary care providers are currently treating and managing diabetic patients, but without a well-defined chronic condition management program.

Each portion of the project aims to expand primary care initiatives for diabetic patients through

a chronic condition self-management program in order to better control patients' chronic conditions and improve the health status of the community. The DOTS program will also be incorporated in year 3 as an expansion of the chronic care management expansion initiative. Diabetes is currently being addressed by the primary care providers on a very limited basis and in small patient numbers by the DOTS program, but can be expanded to increase the effectiveness of these quality improvement initiatives.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

Process Milestone P-2: Establish baseline rates

The reasoning for this milestone prioritization is to provide sound information to establish correct baseline data to use for establishing future goals that are attainable. The project will need to have the most precise baseline data in order to make project plans to achieve the regional health improvement goals for diabetic patients.

Process Milestone P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

The reasoning for this milestone prioritization is to properly monitor data quality and the effects of the diabetes self-management program. The goal of this process milestone is to conduct a PDSA cycle once per quarter and have the information reported to the BRHS Performance Improvement Committee. This consistent monitoring is important to help achieve all category goals because the process must be consistently monitored and altered if necessary. The category 2 project will help achieve proper monitoring because it is a necessary part of the process in order to achieve success.

Outcome Improvement Target 1.10: Diabetes Care: HbA1c poor control (>9.0%)

The reasoning for this milestone prioritization is to provide a framework for the process improvement measurement. The project success will be measured within the parameters of what is defined as "controlled hemoglobin A1c". The project initiatives from the category 2 project will help achieve this target because the chronic disease management program will in theory assist in decreasing and controlling patients' hemoglobin A1c percentage.

RELATIONSHIP TO OTHER PROJECTS:

This project will support the other BRHS project initiatives for primary care expansion (Category 1) and hypertension management (Category 2). All three BRHS projects are planned to occur in the same geographic area and will serve a similar population base from patients at Lake Jackson Family Medicine Center. All projects aim to increase patient health management through primary care, and in particular, chronic condition management. Each project has goals of improving the overall health status of the community's population through increased primary care initiatives to decrease the percentage of patients with uncontrolled HbA1c levels.

This project's focus on using a comprehensive approach to managing chronic disease and emphasis on patient education, discharge planning, and post discharge support to reduce readmission ties to these Category 1 and 2 projects in our RHP: 112671602.2.1, 112706003.2.1, 138296208.2.1, 094092602.2.6, 094148602.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

Other providers that have proposed projects within the RHP from which BRHS would benefit knowledge sharing include: Angleton-Danbury Hospital, Baptist Hospitals of Southeast Texas, Baptist Orange, Christus, Memorial Medical Center-Lufkin, Memorial Medical Center-San

Augustine, Nacogdoches County Hospital District, Sweeny Hospital, and UTMB. Angleton-Danbury Hospital, Sweeny Hospital, and UTMB all proposed expanding primary care capabilities (not for specific chronic conditions) in the same geographic region as BRHS and could benefit chronic disease management initiatives throughout the county. Baptist Hospitals of Southeast Texas and Christus System both proposed expanding chronic care management models, but both are focused more on the effects seen on inpatient hospital admissions, not management through primary care clinics. Memorial Medical Centers in Lufkin and San Augustine, Nacogdoches County Hospital District, and UTMB all recommend creating a chronic disease management registry, from which BRHS could learn chronic condition data collection techniques. Christus and UTMB both propose chronic disease education programs, which would be very beneficial to our self-management program for educational diabetes materials. Although all of these ideas are in part related to chronic condition management, no other health system has proposed a diabetes self-management program within a primary care clinic. The regional systems within geographic proximity to BRHS will also have the option to refer patients to the DOTS program in order to increase intraregional cooperation for chronic disease management. The benefit will lie in creating a learning-collaborative with the aforementioned health systems to share best practices, new ideas, and solutions across Region 2. Most of the projects will likely only be able to benefit in this manner, as geography and distance will not allow the other organizations to target the same market share/population.

This project focuses on the expansion of chronic care management models along with these other Category 2 projects in our RHP: 094148602.2.1-Expand chronic care management models; 112671602.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 112706003.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 138296208.2.1-Expanding chronic care management models (high risk healthcare needs).

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and

improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation criteria used to determine the value of the project, and the value for each project year, was based on data obtained from the BRHS EMR. The team chose the DRGs for both inpatient and outpatient services that could result from uncontrolled diabetes and estimated that the Brazosport Regional Health System could save an estimated 25% of the total costs for these services if proper self-management programs were implemented in a primary care and/or outpatient setting. This approached allowed BHRS to look at the population it currently serves in Southern Brazoria County, eliminating other county-wide data that would generate an unrealistic view of the BRHS market share. This approach also allowed the team to examine the utilization and payment trends already occurring in the hospital to better predict the financial impact and cost avoidance created by the self-management diabetes programs.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity--Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

112671602.2.1	2.2	2.2.2	Expanding chronic care management model for Diabetes
Brazosport Regional Health System – Lake Jackson Family Medicine Center (LJFMC)			TPI - 112671602
Related Category 3 Outcome Measure(s):	112671602.3.1	IT – 1.10	Diabetes Care: HbA1c poor control (>9.0%) NQF 0059

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 **P-11**: Develop and implement program to assist patient to better self-manage their chronic conditions **Metric** **P-11.1**: Increase the number of patients enrolled in a self-management program **Baseline**: At the end of 2nd Quarter 2012 there were 20 participants in a diabetes self-management program. However, information on the total number of patients with diabetes at LJFMC is unknown and therefore the baseline percentage of diabetic patients enrolled in a program cannot be calculated. Baseline TBD after data collection. **Goal**: determine the total number of patients with diabetes at LJFMC to establish the baseline data **Numerator**: Number of patients with diabetes enrolled in a self-management program for diabetes **Denominator**: Number of patients at LJFMC with diabetes **Data source**: LJFMC Electronic Medical Record (EMR), Patient Registry **Milestone 1 Estimated Incentive Payment**: $850,000	**Milestone 2** **P-11**: Develop and implement program to assist patient to better self-manage their chronic conditions **Metric** **P-11.1**: Increase the number of patients enrolled in a self-management program **Goal** To expand enrollment of patients with diabetes in a diabetes self-management program within the population base of LJFMC. Specific goal TBD in Year 2 based on baseline findings. The project will serve an estimated 50 patients in year 3. **Numerator**: Number of patients with diabetes enrolled in a self-management program for diabetes **Denominator**: Number of patients with diabetes at LJFMC **Data source**: LJFMC EMR, Patient Registry **Milestone 2 Estimated Incentive Payment**: $480,000 **Milestone 3** **I-21**: Improvements in access to care of patients receiving chronic care management services using innovative project option (DOTS). **Metric**	**Milestone 4** **P-11**: Develop and implement program to assist patient to better self-manage their chronic conditions **Metric** **P-11.1**: Increase the number of patients enrolled in a self-management program **Goal** To expand enrollment of patients with diabetes in a diabetes self-management program within the population base of LJFMC. Specific goal TBD in Year 2 based on baseline findings. The project will serve an estimated 50 patients in year 4. **Numerator**: Number of patients enrolled in a self-management program for diabetes **Denominator**: Number of patients at LJFMC with diabetes **Data source**: LJFMC EMR, Patient Registry **Milestone 4 Estimated Incentive Payment**: $450,000 **Milestone 5** **I-21**: Improvements in access to care of patients receiving chronic care management services using innovative project option (DOTS). **Metric**	**Milestone 6** **I-21**: Improvements in access to care of patients receiving chronic care management services using the chronic disease management program for diabetes and the innovative project option (DOTS). **Metric** **I-21.2:** Increased number of unique patients served by the patient chronic disease management program for diabetes and the DOTS program. **Baseline**: number of current patients in the chronic disease management for diabetes TBD in Year 3. Currently three DOTS classes per year are offered. **Goal**: To increase the number of participants in the chronic disease management program for diabetes and the DOTS program at LJFMC over the prior reporting period (specific goal TBD based on baseline data). The project will serve an estimated 50 patients with 6 sessions in year 5. **Data source**: LJFMC EMR, Patient Registry **Milestone 6 Estimated Incentive Payment**: $684,000

112671602.2.1	2.2	2.2.2	Expanding chronic care management model for Diabetes
Brazosport Regional Health System – Lake Jackson Family Medicine Center (LJFMC)			TPI - 112671602
Related Category 3 Outcome Measure(s):	112671602.3.1	IT – 1.10	Diabetes Care: HbA1c poor control (>9.0%) NQF 0059

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	I-21.2: Increased number of unique patients served by innovative program (DOTS). **Baseline**: number of current patients TBD in Year 2. Currently three classes per year are offered. **Goal**: To increase the number of participants in the DOTS program over the prior reporting period (specific goal TBD based on baseline data). The project will serve an estimated 30 patients with 4 sessions in year 3. **Data source**: LJFMC EMR, Patient Registry **Milestone 3 Estimated Incentive Payment**: $480,000	**I-21.2:** Increased number of unique patients served by innovative program (DOTS). **Baseline**: number of current patients TBD in Year 3. Currently three classes per year are offered. **Goal**: To increase the number of participants in the DOTS diabetes self-management program at LJFMC over the prior reporting period (specific goal TBD based on baseline data). The project will serve an estimated 40 patients with 5 sessions in year 4. **Data source**: LJFMC EMR, Patient Registry **Milestone 5 Estimated Incentive Payment**: $450,000	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $850,000	Year 3 Estimated Milestone Bundle Amount: $960,000	Year 4 Estimated Milestone Bundle Amount: $900,000	Year 5 Estimated Milestone Bundle Amount: $684,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:**$3,394,000			

PROJECT OPTION: 2.2 2-Apply evidence-based care management model to patients identified as having high-risk health care needs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 112706003.2.1
PERFORMING PROVIDER NAME/TPI: CHRISTUS Jasper Memorial Hospital/TPI: 112706003

Provider: : Located 65 miles north of Beaumont, **CHRISTUS Jasper Memorial Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. This project is being performed under the collaborative option with two sister hospital CHRISTUS Hospital-St. Mary and CHRISTUS Hospital-St. Elizabeth. **CHRISTUS Hospital-St. Elizabeth,** a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatrics. **CHRISTUS Hospital-St. Mary,** a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. These three hospitals are collaborating on DSRIP projects with a combined service area that extends to the southeast coast of the state, to the southeast border with Louisiana, and northward into East Texas, and area which includes a catchment area of more than 585,000 individuals. The collaborative nature of this project is necessary for the project to reach a broad enough array of patient care and patient population to be truly transformative.
Interventions: Jasper will develop two chronic disease clinics and implement chronic disease management interventions that are geared toward improving effective self-management of chronic diseases such as CHF, diabetes, COPD, asthma and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.
Need for the Project: Jefferson County and Jasper County have a higher rate of mortality from aortic aneurysm, diseases of the heart, COPD, cerebrovascular conditions, chronic liver disease, and hypertension than the statewide average. These conditions can lead to acute episodes requiring admissions or re-admissions, where timely education, intervention and self-management could address the health issues in a more effective and efficient manner.
Target Population: The target population for this project is uninsured and indigent residents of the Jasper catchment area who suffer from chronic conditions. It is estimated that 11% of patients in the Jasper catchment area suffer from chronic disease, of which 39% are Medicaid or uninsured. Therefore, the target population for our catchment area is approximately 25,000 patients.
Category 1 or 2 Expected Benefit: The goal of this project is to improve the management of chronic conditions and identify symptoms earlier, while preventing complications and managing utilization of acute and emergency care. Under this project, CHRISTUS expects to reach approximately 30% of the target population by DY. Therefore, CHRISTUS will endeavor to reach 2,500 patients by DY 3, 5,000 patients by DY 4, and 7,500 patients by DY 5.
Category 3 Outcome: Jasper expects an increase in the target population reached of 10% over the baseline by the end of DY and a reduction in the all-cause 30-day readmission rate of 2.5% in DY4 over DY3 and 2.5% in DY% over DY4. CHRISTUS believes this is a reasonable measure of

the success of this project because the management of chronic conditions is a contributing factor to the rate of re-admissions.

PROJECT DESCRIPTION:

This project will improve the overall health of the communities by targeting individuals with chronic diseases that can be controlled through healthy living habits and early intervention. The intended outcome will be a healthier community and reduced readmissions. The project will place Community Health Workers (CHWs) within the community to work with individuals with chronic diseases with the focus of educating and teaching those individuals how to manage and live a productive, healthy life. Additionally, the CHWs will coordinate community based education programs targeting at risk individuals to prevent chronic diseases and to live a healthier life. The CHWs will work with CHRISTUS Jasper Memorial Hospital (Jasper) and its sister hospital CHRISTUS Hospital in Jefferson County to identify at risk individuals and those that would benefit most from chronic disease management.

Project goal(s):

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.

Challenges:

A major challenge will be reaching all the at-risk populations and having the ability to educate and to improve the lifestyles of those populations. Because the hospital and CHWs are unable to effectuate behavioral changes in the at risk population, the project is focused on outreach and education for the needy in the community.

5-year Expected Outcome(s) for Performing Provider and Patients:

The five-year target goals are to increase the number of patients reached by the evidenced based care management model by 10% over the baseline year and reduce the all cause 30 day readmission rate by 2.5%. It is anticipated that by end of DY5 17,500 Medicaid and indigent patients will be reached.

Relationship to Regional Goals:

- A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

STARTING POINT/BASELINE:

Currently, no comprehensive network of CHWs is available in the area. It will be imperative to begin the program by educating CHWs and creating the network, working with all local resources available. Community education will be significant to reach a nucleus of at-risk persons.

RATIONALE:

Economics, culture, and history are all causal factors in the poor health outcomes of the service region. With an ever-changing demographic in the community, we are seeing the population growing in ethnicity and in age. Approximately 31% of the community population is sedentary and nearly 25% are smokers. 23% of the population earns below the federal poverty level. The population also has a high rate of preventable hospital stays, at nearly 1,400 per 100,000 days. Further, the area has a poverty rate of 22.6% and an uninsured rate of 25.2%—both of which are higher than the respective state and national rates. There is no county hospital district and only one FQHC serving the region. The region has been continuously served by religious-sponsored, not-for-profit hospitals for over 100 years. Texas is one of the most litigious areas in the United States, and for many years recruiting and retaining physicians was nearly impossible. These factors have created a cycle in which chronic diseases go undiagnosed and/or untreated until patients are so ill that they must access services at the most costly point of care, the emergency departments of local hospitals. The severity of the illnesses and lack of coordination among medical services has led to a downward spiral for many patients. Jefferson County and Jasper County residents have a higher rate of physical inactivity, obesity, adult smoking, hypertension, and poor physical health days than the statewide average, each of which increases a patient's risk of CHF and being high-risk. Jefferson County and Jasper County have a higher rate of mortality from aortic aneurysm, diseases of the heart, COPD, cerebrovascular conditions, chronic liver disease, and hypertension than the statewide average. Additionally, Jefferson County and Jasper County residents have a higher rate of adult-smoking, obesity, physical inactivity, and poor physical health days than the statewide average, each of which puts residents at risk for common chronic diseases.

Chronic disease management initiatives using population-based approaches to create practical, supportive, evidence-based interactions between patients and providers have been shown to improve the management of chronic conditions and identify symptoms earlier, while preventing complications and managing utilization of acute and emergency care. Specifically, chronic disease management through CHWs has been successful in improving the health and lifestyle of a community. Therefore, we selected this project in an effort to effectuate similar changes in Jasper and Jefferson Counties.

Rationale/Evidence: I-21 Improvements in access to care of patients receiving chronic care management services using innovative project option. This metric speaks to the efficacy of the innovative project in reaching its targeted population.

Relation between Project Choices and Community Needs:

In Region 2, more than 50% of the region is designated as Health Professional Shortage Areas in Primary Care and/or Mental Health. The region has a severe shortage of primary care providers with a ratio of PCP's to 100,000 population of 54.6 (TX=69.5; US=91.0). The region is also short mental health professionals (psychiatrist, psychologist) and other specialty doctors (specialty physician ratios). Further, due in part to a lack of access to primary care services, Region 2 patients are forced to inefficiently rely on the ED for primary care and behavioral health services. Consequently, Region 2 has a very high ED utilization rate and has some of the highest health care costs in the U.S.

One month after Hurricane Ike struck the area in 2008, Beaumont's only FQHC closed its doors. Additionally, with the implementation of Managed Care in Jefferson County, many providers have opted out of participating in Medicaid. Thus, the addition of two primary care clinics in Medicaid-heavy areas will have a substantial impact on the availability of primary care services to low-income and uninsured community members.

Unique Community Need Identification numbers:

- CN.10 - High ED Utilization Rates
- CN.11 - 30 Day Readmission Rates
- CN.12 - Chronic Diseases: Diabetes
- CN.13 - Chronic Diseases: Obesity
- CN.14 - Chronic Diseases: Heart & Vascular Related Diseases & Disorders
- CN.15 - Chronic Diseases: Pulmonary Diseases

Expansion or enhancement

This project significantly expands the existing healthcare delivery system by adding two new FQHC satellite clinics that will be able to provide a comprehensive array of primary care, dental and behavior health care, along with supportive services such as case management and transportation assistance to patients in the Jefferson County community.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD-3: Potentially Preventable Re-Admissions—30 day Readmission Rates; IT-3.1: All cause 30 day readmission rate. According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving care coordination through the use of electronic medical records and computerized provider order entry systems. A measurable reduction in CHRISTUS' all-cause 30-day readmission rate will indicate that CHRISTUS has made progress towards these goals. In order to record this reduction, CHRISTUS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

RELATIONSHIP TO OTHER PROJECTS:

This project is part of CHRISTUS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, it

complements CHRISTUS's Chronic Disease Management Clinics project and Palliative Care Program project; all of these projects will result in better management of the healthcare challenges facing their respective target populations, and more appropriate utilization of healthcare services.

This project's focus on chronic disease management and education and emphasis on use of Community Health Workers ties to these Category 1 and 2 projects in our RHP: 112671602.2.1, 112706003.2.1, 138296208.2.1, 094092602.2.6, 094148602.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of chronic care management models along with these other Category 2 projects in our RHP: 094148602.2.1-Expand chronic care management models; 112671602.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 112706003.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 138296208.2.1-Expanding chronic care management models (high risk healthcare needs).

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as

well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This particular project will manage the chronic conditions for patients in Region 2. This project has a strong correlation to all three aims of the Waiver because it: (1) increases the access to care for individuals with chronic conditions; (2) increases the quality of care for these patients by giving them coordinated holistic care; and (3) lowers costs of care by delivering care in the right setting and managing chronic conditions before they lead to acute health problems which are expensive to treat.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

112706003.2.1	2.2	2.2.2	Apply evidence-based care management model to patients identified as having high-risk health care needs	
CHRISTUS Jasper Memorial Hospital				TPI - 112706003
Related Category 3 Outcome Measure(s):	112706003.3.1	IT-3.1	All cause 30 day readmission rate.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: Milestone: P-3 Develop a comprehensive care management program Metric 1: P-3.1 Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Submit completed program materials Data Source: Program materials Milestone 1 Estimated Incentive Payment: $805,263	**Milestone 2**: Milestone: P-2 Train new Community Health Workers staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 2: P-2.1 Increase percent of Community Health Workers staff trained Baseline/Goal: Train 100% of new community health workers staff. Data Source: HR, training program materials Milestone 2 Estimated Incentive Payment: $757,895		**Milestone 3**: I-21 Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 3: I-21.1 Increase percentage of target population reached. Goal: Make at least a total of 5,000 contacts with Medicaid and indigent Data Source: Documentation of target population reached, as designated in the project plan. Milestone 4 Estimated Incentive Payment: $769,737	**Milestone 4**: I-21 Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 4: I-21.1Increase percentage of target population reached. Goal: By end of DY 5 this program should have made a total of 7,500 contacts with Medicaid and indigent patients Data Source: Documentation of target population reached, as designated in the project plan. Milestone 4 Estimated Incentive Payment: $585,000
Year 2 Estimated Milestone Bundle Amount:: $805,263	Year 3 Estimated Milestone Bundle Amount: $757,895		Year 4 Estimated Milestone Bundle Amount: $769,737	Year 5 Estimated Milestone Bundle Amount: $585,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $2,917,895				

PROJECT OPTION: 2.10.1: Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 112706003.2.2
PERFORMING PROVIDER NAME/TPI: CHRISTUS Jasper Memorial Hospital/TPI: 112706003

Provider: Located 65 miles north of Beaumont, **CHRISTUS Jasper Memorial Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. This project is being performed under the collaborative option with two other sister hospital CHRISTUS Hospital-St. Mary and CHRISTUS Hospital-St. Elizabeth. **CHRISTUS Hospital-St. Elizabeth,** a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatrics. **CHRISTUS Hospital-St. Mary,** a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. These three hospitals are collaborating on DSRIP projects with a combined service area that extends to the southeast coast of the state, to the southeast border with Louisiana, and northward into East Texas, and area which includes a catchment area of more than 585,000 individuals. The collaborative nature of this project is necessary for the project to reach a broad enough array of patient care and patient population to be truly transformative.
Interventions: Jasper and CHRISTUS Hospital will work together to implement a dedicated palliative care team in the inpatient acute care setting with emphasis in the ICU, Oncology, and Emergency departments. While an entire palliative care team currently exists and is available to deliver palliative care in the inpatient setting, this project will expand the team to outpatient and emergency department settings.
Need for the Project: There is a high incidence of poor healthcare literacy in this community and a disparity of access to palliative care in this region. Access to palliative care for hospitals of 300 or more beds is only 50% in Region 2, compared to 65% in other regions of Texas. Finally, there is a shortage of palliative medicine specialists, not only in Region 2, but nationally.
Target Population: CHRISTUS Health Southeast Texas receives at least 400 patients a year in need of palliative care, with current capability to respond to 300. The local population is made up of 39% on Medicaid or uninsured. Approximately, 39% of 600 patients a year, or 234, would be Medicaid or uninsured. Jasper and CHRISTUS Hospital will implement an ongoing education program targeting physicians, nurses, and the community to improve the delivery of services to this population.
Category 1 or 2 Expected Benefit: The goals of this project are to increase quality and reduce caregiver burden for the terminally ill patients and their families, and to improve access to palliative care sooner in chronic disease states, using an intra-disciplinary approach.
Category 3 Outcome: Expected outcomes include a steady increase in the number of palliative care referrals beginning in FY 3 and continuing an upward trend through FY5 to reach goal of 600 patients seen. A decrease in time spent in the ICU in the last 6 months of life as reflected in the Dartmouth Atlas, and earlier access to hospice. The percentage of inpatient deaths with

palliative care consults will decrease each year. Improved scores - patient/family satisfaction scores (HCAHPS willingness to recommend, HCAHPS hospital rating) FY3, FY4, FY5.

PROJECT DESCRIPTION:

In collaboration with its sister hospital in the region, CHRISTUS Hospital, Jasper Memorial Hospital (Jasper) will encourage providers to establish clear patient-centered treatment goals as illnesses progress and as patients move from one healthcare setting to another; doing so will ensure higher-quality care and reduce patient and hospital costs, and Medicare expenditure (especially in the last month of life). The project will promote the education of clinicians, health professionals, patients, and caregivers about supportive care, advanced care planning, and hospice in a non-threatening fashion for outpatient hospital settings, inpatient hospital settings, and community settings.

Jasper and CHRISTUS Hospital will work together to implement a dedicated palliative care team in the inpatient acute care setting with emphasis in the ICU, Oncology, and Emergency departments. An entire palliative care team currently exists and is available to deliver palliative care in the inpatient setting. Together with CHRISTUS Hospital, Jasper will expand the team from acute care inpatient to outpatient and emergency department settings.

Jasper and CHRISTUS Hospital will also implement an ongoing education program targeting physicians, nurses, and the community. This program will use End of Life Education Course (EPEC) modules, along with End of Life Palliative Education Resource Center (EPERC) materials, as ongoing education tools. Jasper will assist CHRISTUS Hospital in renewing ELNEC certification certificate for the palliative care team and nursing staff. By DY4, Jasper and CHRISTUS Hospital anticipate the certification of the palliative care program and its eventual expansion to include an inpatient palliative care unit in DY5. Jasper will assist in the implementation and coordination of an HPNA (Hospice and Palliative Nurses Association) chapter serving several counties in the East Texas region.

CHRISTUS Hospital and Jasper intend to work with other local hospital palliative care programs, community hospice agencies, nursing homes, and nurses in Outpatient Cardiac Rehabilitation and Oncology Clinics to address knowledge deficits and misconceptions about palliative care among healthcare professionals, patients and families.

Project goal(s):

The goals of this project are to increase quality and reduce caregiver burden for our seriously ill patients and their families, and to improve access to palliative care sooner in chronic disease states, using an intra-disciplinary approach.

Challenges:

Due to the sensitivity surrounding end-of-life care, a major challenge facing the successful implementation of a hospice or palliative care program is properly educating patient populations about the goals and benefits of a palliative approach to end-of-life care. This project will address this challenge primarily by focusing its educational efforts on providers, who will then be able to educate patients directly regarding palliative care in general and the specific palliative care options available in the East Texas community.

The 5-year expected outcome(s):
Expected outcomes include improved patient and family satisfaction, an increase in the number of palliative care referrals, and more appropriate timing of palliative care referrals.

Relationship to Regional Goals:

- A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management

STARTING POINT/BASELINE:
CHRISTUS Hospital currently uses the Solo Practitioner Model (one FTE = full time employee) to deliver palliative care as a consultative service to patients in the acute care setting. The number of consults seen has remained consistent over the past 3 years, with numbers staying around 400 consults per year. CHRISTUS Hospital and Jasper will expand palliative care beyond the acute care setting, to reach patients early on in their illness. The starting point will include adding a FTE NP and 0.1 physicians to begin rounding with an RN on patients (as opposed to meeting once a week during IDT meetings). CHRISTUS Hospital and Jasper will obtain a dedicated social worker (0.5 FTE) and additional chaplain support within this fiscal year, and an outpatient heart failure clinic will open, which will requires palliative care training as part of the applicable Heart Failure Society guidelines and Commission on Cancer guidelines.

RATIONALE:
There is a high incidence of poor healthcare literacy in this community (according to Region 2 Health Partnership report for Liberty, Hardin, Orange, and Jefferson counties), and a disparity of access to palliative care in this region. According to CAPC, access to palliative care for hospitals of 300 or more beds is only 50% here, compared to 65% in other regions of Texas. Thus this region has the lowest of an already lower rate of access to palliative care, when compared nationally to northern regions of 85% access. Workforce challenges exist due to a national shortage of palliative medicine specialists. A recent study estimates a shortfall of 2,800 to 7,500 FTE physicians just to meet the needs of existing hospices and hospital palliative care programs (Expert Voices In Health Care Policy, "Improving Health Care Value Through Increased Access to Palliative Care," Diane Meier, MD, April 2012, NIHCM Foundation).

Core Components:
This project will include the following core components:

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

- CHRISTUS will address this core component by involving key stakeholders to develop a business case for sustained quality and growth of program. A planning committee of clinicians, administrators in finance, quality and ethics will use the "Top Tools for Palliative Care Programs" from CAPC as a guide. Tools from CAPC will be used as follows-

- Hospital Global Assessment Tool
- Palliative Care Program Planning Tool
- Estimating Consult Volume and Cost Avoidance
- Dartmouth Atlas Data for Hospital Comparison (for a baseline assessment of how we compare to other hospitals regarding hospital utilization)
- Identified key stakeholders will attend the CAPC National seminar

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility

- CHRISTUS will address this core component by ensuring the timely and thorough communication of patient goals of care, preferences of treatments, existential and psycho-social issues, as well as meticulous documentation of symptoms that need to be managed as patient moves from one setting to another. A nurse to nurse report will address the above mentioned topics, as well as CAPC clinical care tools that will be sent with patient as they move through healthcare settings, to ensure that the entire team caring for patient understands the current patient centered goals of care and issues that receiving team needs to address. It is imperative to note that people's needs evolve as illness progresses, a well-trained team will ensure that patient and family needs are met, across the healthcare continuum. CAPC clinical care tools will be implemented and used as follows, as patient moves from one setting to another-
- CAPC Rounding tool and Daily Clinical Instrument
- Palliative Care Consultative Report
- Patient/ Family Meeting Record
- Patient Care Inpatient Progress Note (will be used when we implement an inpatient unit)

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

- CHRISTUS will address this core component by the use of the modified Edmonton Symptom Assessment Scale (ESAS) to measure, document and track trends on patient's pain, dyspnea and constipation in a timely, safe and effective

manner that is acceptable to both patient and family. Palliative care will use the CAPC Clinical Rounding Tool and Daily Clinical Instrument using a spreadsheet for data extraction.

- FAMCARE Scale is a family satisfaction tool that we will use to assess family satisfaction with care- we will implement this by FY 4 and compare at the end of the year after FY5 after implementation of having an inpatient unit.

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.

- CHRISTUS will address this core component by calculating cost savings from CAPC program evaluation tools. This will provide a retrospective analysis of our program's impact. Our hospital finance staff will assist in a retrospective financial impact review at the end of DY3, DY4 and DY5 using method A "before-and-after" analysis.

We will also use the Dartmouth Atlas Data to track trends on decreased hospital utilization.

Relation between Project Choices and Community Needs:

In Region 2, more than 50% of the region is designated as Health Professional Shortage Areas in Primary Care and/or Mental Health. The region has a severe shortage of primary care providers with a ratio of PCP's to 100,000 population of 54.6 (TX=69.5; US=91.0). The region is also short mental health professionals (psychiatrist, psychologist) and other specialty doctors (specialty physician ratios). Further, due in part to a lack of access to primary care services, Region 2 patients are forced to inefficiently rely on the ED for primary care and behavioral health services. Consequently, Region 2 has a very high ED utilization rate and has some of the highest health care costs in the U.S.

Early palliative care referrals have shown clinically significant improvements in quality of life, mood and longevity in patients with NSCLC (metastisis). Hospital palliative care programs have been shown to improve both physical and psychological symptom management, caregiver and well-being and family satisfaction.

Unique Community Need Identification numbers:

CN.3 Primary Care Physician Shortage

CN.10 High ED Utilization Rates

Expansion or enhancement:

This project significantly expands the existing healthcare delivery system by making palliative care services available to patients in the East Texas community who previously did not have access to those services.

RELATED CATEGORY 3 OUTCOME MEASURES:

OD-13: Palliative Care; IT-13.3: Proportion with more than one emergency room visit in the last days of life. This outcome measure was selected for DY4 and DY5 because the successful implementation of this palliative care project will result in lower utilization of emergency resources during the last days of life.

RELATIONSHIP TO OTHER PROJECTS:

This project is part of CHRISTUS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. For those with advanced care needs, palliative care provides both more appropriate care and more appropriate use of resources.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of a palliative care program along with these other Category 2 projects in our RHP: 094092602.2.10- Implement a Palliative Care Program to Address Patient with End-of-Life Decisions and Care Needs.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also

considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. The palliative care project interfaces with several important areas of valuation. The primary goal is to enhance quality of life for our patients who have serious illness. The palliative care team works with both the patient and their family to promote patient centered goals of care during illness. The essence of the palliative care team is communication and education; with patients and families, with HCP (Health Care Providers), and with caregivers in the community that care for palliative care patients. This is an evidenced based, integrated effort with the purpose of maximizing quality and minimizing the stress and pain (physical, psycho-social, spiritual) that often accompanies chronic, serious illness. The need for earlier intervention is key, to provide a coordinated effort that will produce positive trends in quality of life.

As shown in the community needs assessment, current access to palliative care is about 50% compared to national 85%. Palliative care has demonstrated significant cost savings for Medicare, hospitals, patients and families through cost avoidance and capturing patients who prefer less aggressive treatments as they reach the end of their lives. Most people prefer to be at home with family when they have a terminal illness. Palliative care increases quality with a focus on quality for whatever the prognosis is.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.

- Severity--Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

112706003.2.2	2.10	2.10.1	Comprehensive Palliative Care Program	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	**112706003.3.2**	**IT-13.3**	**Proportion with more than one emergency room visit in the last days of life**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-5 Implement/expand a palliative care program. Metric 1: P-8.1 Implement comprehensive palliative care program. Goal: Expand palliative care to inpatient settings. Data Source: Palliative care program. Milestone 1 Estimated Incentive Payment: $738,158	**Milestone2:** P-8 Document the number of consults for palliative care. Metric 1: P-8.1 Number of consults for which palliative care is consulted. Goal: Increase the number of consults for which palliative care is consulted by 5 % over baseline. Data Source: EHR Milestone 2 Estimated Incentive Payment: $694,737		**Milestone 3**: I-10 Among patients who died in the hospital, increase the proportion of those who received a palliative care consult. Metric 1: I-10.1 Percent of total in-hospital deaths who had a palliative care consult. Goal: 15% improvement over baseline. Data Source: EHR Milestone 3 Estimated Incentive Payment: $705,592	**Milestone 4**: I-10 Among patients who died in the hospital, increase the proportion of those who received a palliative care consult. Metric 1: I-10.1 Percent of total in-hospital deaths who had a palliative care consult. Goal: 20% improvement over baseline. Data Source: EHR Milestone 4 Estimated Incentive Payment: $536,250
Year 2 Estimated Milestone Bundle Amount: $738,158	Year 3 Estimated Milestone Bundle Amount: $694,737		Year 4 Estimated Milestone Bundle Amount: $705,592	Year 5 Estimated Milestone Bundle Amount: $536,250
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,674,737				

PROJECT OPTION: 2.9.2: "Other" Project Option: Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized Health Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 112706003.2.3
PERFORMING PROVIDER NAME/TPI: CHRISTUS Jasper Memorial Hospital/TPI 112706003

Provider: Located 65 miles north of Beaumont, **CHRISTUS Jasper Memorial Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. This project is being performed under the collaborative option with two other sister hospital CHRISTUS Hospital-St. Mary and CHRISTUS Hospital-St. Elizabeth. **CHRISTUS Hospital-St. Elizabeth,** a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatrics. **CHRISTUS Hospital-St. Mary,** a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. These three hospitals are collaborating on DSRIP projects with a combined service area that extends to the southeast coast of the state, to the southeast border with Louisiana, and northward into East Texas, and area which includes a catchment area of more than 585,000 individuals. The collaborative nature of this project is necessary for the project to reach a broad enough array of patient care and patient population to be truly transformative.
Interventions: CHRISTUS will establish a program wherein a Regional Outreach Coordinator will provide support to at-risk patient populations who are likely to have trouble navigating the health care system, have limited access to primary care clinicians and who have high rates of ED/inpatient hospital use.
Need for the Project: Jefferson County and Jasper County residents have a higher rate of physical inactivity, obesity, adult smoking and hypertension than the statewide average, each of which increases a patient's risk of being high-risk which can lead to acute episodes requiring hospitalization. Of the ED visits at Jasper and CHRISTUS Hospital, (totals 103,363 annually), approximately 28% (28,941) are either for non-emergent services or for patients with high rates of hospital service usage. Virtually all of those are Medicaid or uninsured. Approximately 31% of the community population is sedentary and nearly 25% are smokers. 23% of the population earns below the federal poverty level. The project is designed to work with this at-risk population in coordination with other types of providers in the community to improve utilization of health services at the appropriate level of care.
Target Population: It is estimated that 11% of CHRISTUS's catchment area patients have been diagnosed with high-risk illnesses, of which 39% are Medicaid or uninsured.
Category 1 or 2 Expected Benefit: The goal in implementing this Patient Care Navigation program is to improve at-risk patients' experience of the healthcare delivery system. By connecting with patients at the appropriate level of care, Jasper hopes to improve the patient experience and improve patients' long- and short-term health outcomes and quality of life.
Category 3 Outcome: Jasper expects a 10% reduction in non-emergent Emergency Room visits by the end of DY4 (2,894) and a 15% reduction in non-emergent Emergency Room visits by the end of DY5. (4,341). The reduction in emergency room visits is an appropriate measure of the success of this project because patients with care that is uncoordinated or patients with little

access to primary care are far more likely to use the ED for non-emergent health issues. Therefore, by providing proper access to coordinated care, CHRISTUS expects to see decreased non-emergent ER admissions.

PROJECT DESCRIPTION:

This project will establish a program wherein a Regional Outreach Coordinator will provide support to at-risk patient populations who are likely to have trouble navigating the health care system, and who have high rates of ED/inpatient hospital use. As part of this project, CHRISTUS will draft a job description and recruit a qualified coordinator; identify populations to target for outreach; reach out to the identified at-risk populations to provide navigational support and to facilitate use of the health care system before a condition becomes acute or emergent. The project will involve systematically identifying at-risk patients and then successfully reaching out to those communities and individuals. Challenges in implementing the project will include low literacy levels (specifically with regard to health, injury, and prevention), and recruiting and identifying a qualified candidate to act as Regional Outreach Coordinator.

Project Goals/Five Year Expected Outcome:

The goal in implementing this Patient Care Navigation program is to improve at-risk patients' experience of the healthcare delivery system by demystifying the often lengthy process of diagnosis and treatment, by assisting with scheduling appointments and keeping up with treatment regimens, and by providing professional support to patients and their families where and when needed. By improving the patient experience, CHRISTUS hopes to improve patients' long- and short-term health outcomes and quality of life. Another goal of this project is to decrease the systemic cost of treating at-risk patients by streamlining the process and making sure providers, patients, and their caregivers are all on the same page about the best treatment options to pursue at particular stages of disease. Finally, the more specific goals of the program are to reduce the number of ED visits by at-risk patients enrolled in the patient navigation program for non-emergencies – CHRISTUS hopes that enrolled patients will visit the ED 10% fewer times than non-enrolled at-risk patients in DY4, and 15% fewer times than non-enrolled at-risk patients in DY5.

Challenges:

The expected challenges in implementing and operating this project include training staff on best practices and protocols for coordinating care, engaging patients who are overwhelmed in addressing their health condition, and obtaining the cooperation of the medical providers in keeping the coordinators in the loop about patients' needs and treatment regimens. CHRISTUS will address these challenges by using evidence-based procedures that will prove to patients and providers how beneficial participation in the program can be.

Relationship to Regional Goals: Region 2 desires to transform the healthcare delivery process by making it more patient-centered and cost effective, which this project addresses. Supporting chronically ill patients with care coordination and navigation (such as at-risk patients) is proven to reduce the overall treatment costs and improve patient outcomes and satisfaction.

STARTING POINT/BASELINE:

40-50% of trauma admissions to the region are falls by patients over 65 years of age, and regional statistical data suggests a higher percentage rate of obesity, DM, and hypertension than the rest of the State, resulting in increased risk and mortality for strokes. This data

suggests that if these populations had more support through earlier interventions and access to all the programs and interventions the healthcare system has to offer, these emergencies and/or chronic conditions could be reduced, or at least that they could lead to fewer acute episodes.

RATIONALE:

Region 2 suffers from higher-than-average at-risk rates when compared to the statewide average. Coordination of care for the at-risk patient, from screening and early detection to end of life and survivorship care, improves patient quality of life and healthcare cost effectiveness with decreased emergency room visits, decreased hospital length of stay, and decreased end-of-life hospital admissions.

Milestones and Metrics:

CHRISTUS chose the two process milestones it did in order to train patient navigators and develop the program during the early years of the Waiver. Subsequently, the improvement milestones are meant to reflect improvements in enrolled patients' conditions by showing a lower rate of ED visits for enrolled at-risk patients than non-enrolled at-risk patients.

Ties to Unique Community Needs: CN.10, CN.18

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD-9: Right Care, Right Setting; IT-9.2: ED appropriate utilization. CHRISTUS chose this outcome measure because this patient-centered program is expected to result in increased patient awareness and understanding, leading to improved utilization of the proper form of care forth the patients' condition.

RELATIONSHIP TO OTHER PROJECTS:

This project is part of CHRISTUS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, it complements CHRISTUS's Chronic Disease Management Clinics project that is intended to identify at-risk populations and provide them with information and support which will reduce improper or ineffective utilization of healthcare services.

This project's focus on helping at-risk populations navigate the health care system and emphasis on use of a regional outreach coordinator ties to these Category 1 and 2 projects in our RHP: 131030203.1.3, 094092602.1.4, 094092602.1.5, 138296208.2.1, 094092602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on providing navigation services to targeted patients who are at high risk of disconnect from institutionalized health care. There are no other related Category 2 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Emergency Department care is the most expensive care, and for those who are non-emergent and frequent users, it is also inappropriate care. Virtually all of these in the CHRISTUS service area (28,941) are Medicaid or uninsured. A reduction of this number by 15% (2,894) by DY5 is a significant improvement in utilization of services, both cost effective and providing more appropriate preventive care in a medical home setting rather than an emergency room.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

112706003.2.3	2.9	2.9.2.	Regional Outreach Coordinator & Patient Care Navigation Program	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	112706003.3.3	IT-9.2	ED Appropriate Utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Establish the health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care, including program to train the navigators, develop procedures and establish continuing navigator education. **Metric** [P-2.1]: Number of people trained as care navigators. **Baseline/goal**: To train a Regional Care Coordinator and at least 3 staff members to be assigned to identified at-risk patients as Care Navigators. **Data source:** workforce development plan for patient navigator recruitment, training and education Milestone 1 Estimated Incentive Payment: $ 1,006,579	**Milestone 2** [P-3]: Provide care management/navigation services to targeted patients. **Metric** [P-3.1]: Increase the number or percent of targeted patients enrolled in the program. **Baseline/goal:** Currently, there is no navigation program generally for at risk patients. The program will serve an estimated __ patients with patient navigator services. Numerator: number of targeted patients enrolled in the program Denominator: total number of targeted patients identified **Data source:** enrollment reports Milestone 2 Estimated Incentive Payment: $ 947,368		**Milestone 3** [I-9]: Additional outcome metrics. **Metric** [I-9.1]: Improved clinical outcomes of target population, which can be intermediate or end result. **Baseline/goal:** 10% fewer (2,894) non-emergent ED visits by at-risk patients enrolled in the patient navigator program when measured against the number of all at-risk patients' ED visits during the same time period (DY4) **Data source:** hospital admission data Milestone 3 Estimated Incentive Payment: $962,171	**Milestone 4** [I-9]: Additional outcome metrics. **Metric** [I-9.1]: Improved clinical outcomes of target population, which can be intermediate or end result. **Baseline/goal:** 15% (4,341) fewer non-emergent ED visits by at-risk patients enrolled in the patient navigator program when measured against the number of all at-risk patients' ED visits during the same time period (DY5) **Data source:** hospital admission data Milestone 4 Estimated Incentive Payment: $731,250
Year 2 Estimated Milestone Bundle Amount: $1,006,579	Year 3 Estimated Milestone Bundle Amount: $947,368		Year 4 Estimated Milestone Bundle Amount: $962,171	Year 5 Estimated Milestone Bundle Amount: $731,250
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,647,368				

PROJECT OPTION*:* 2.9.1-Establish/Expand a Patient Care Navigation Program

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: **112706003.2.4-Pass 2**
PERFORMING PROVIDER NAME/TPI: CHRISTUS Jasper Memorial Hospital/112706003

Title of project: Oncology Navigation Program
Provider: . Located 65 miles north of Beaumont, **CHRISTUS Jasper Memorial Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. This project is being performed under the collaborative option with two other sister hospital CHRISTUS Hospital-St. Mary and CHRISTUS Hospital-St. Elizabeth. **CHRISTUS Hospital-St. Elizabeth,** a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatrics. **CHRISTUS Hospital-St. Mary,** a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. Together their service area extends to the southeast coast of the state, to the southeast border with Louisiana, and northward into East Texas, and area which includes a catchment area of more than 585,000 individuals. The collaborative nature of this project is necessary for the project to reach a broad enough array of patient care and patient population to be truly transformative.
Interventions: Jasper will implement a program to help and support cancer patients navigate through the continuum of health care services, so that these patients can receive coordinated, timely services, with smooth transitions between health care settings. This project will provide individualized assistance to oncology patients, families, and caregivers; assist the patient in overcoming health care system barriers; and facilitate timely access to quality medical and psychosocial care, from pre-diagnosis through all phases of the patient's cancer treatment.
Need for the Project: There are higher-than-average cancer rates in the service area. The Region 2 Health Partnership Study showed that Hardin and Orange counties are in the bottom 10%, and Jefferson County is in the bottom 25%, of all Texas counties for all cancers.
Target Population: The target population for this project is residents of the Jasper catchment area diagnosed with cancer. It is estimated that 4.8% of Jasper's catchment area patients have been diagnosed with cancer, of which 39% are Medicaid or uninsured.
Category 1 or 2 Expected Benefit: The goal of this project is to improve the health of . the service are through a coordinated system of patient centered care that uses resources more efficiently. Approximately 228,150 patients in the service area are on Medicaid or uninsured, with higher than average cancer rates. Jefferson County, where most of the population resides, is in the bottom 25% of all Texas counties for all cancers. We expect in year 3 to enroll 125 patients with 625 interventions/encounters (243 Medicaid encounters), Year 4 to increase enrollment to 175 with 875 interventions/encounters (341 Medicaid encounters) and By Year 5 the project is expected to be providing management/navigation services to 200 oncology targeted patients with 1000 interventions/ encounters (390 Medicaid encounters) per year.
Category 3 Outcome: The goal is to improve patient satisfaction by 10% over baseline by the end of DY5. Fractured care is a large cause of patient dissatisfaction and non-compliance,

therefore CHRISTUS believes that patient satisfaction is an accurate measure of a project whose main purpose is to coordinate and more effectively manage care.

Project Description:

This project will help and support patients especially in need of coordinated care to navigate through the continuum of health care services, so that these patients can receive coordinated, timely services when needed, with smooth transitions between health care settings. Specifically, the project will provide individualized assistance to oncology patients, families, and caregivers; overcome health care system barriers; and facilitate timely access to quality medical and psychosocial care, from pre-diagnosis through all phases of the cancer experience. Under this project, CHRISTUS will develop an Oncology Navigation Program utilizing a collaborative team approach to care coordination to improve quality and effectiveness of cancer screening and follow-up. Patients that discover they are about to battle cancer can be frightened, confused, and overwhelmed. Navigation of the healthcare system can be complicated and affect patient compliance, timeliness of care, and treatment. Patients need assistance to address and overcome financial barriers (uninsured and under-insured patients), communication barriers (patients for whom English is not a first language), systemic barriers such as transportation problems and missed appointments, and the creation of a bridge between the medical culture and the patient culture.

Project goal(s):

Ensure that hospital discharges are accomplished appropriately and that care transitions occur effectively and safely. Dedicate full-time RNs to facilitate discharge for high-risk patients, in an effort to assure that these patients receive instructions and education about self-care, and support for social and emotional issues related to discharge; engage social workers to consult with high-risk patients, and their physicians and nurses, to review and identify needs at discharge; coordinate with local community groups to place patients after discharge, thus keeping track of the targeted patients subsequent to discharge to provide support and monitor health status; finding community members to coordinate the discharges with in the community.

Anticipated challenges:

Developing a well-planned-out support system which includes education for the patient/family/caregivers; promoting and incentivizing the patient population to utilize available services; hiring and training of staff; managing non-compliant patients; space allocation; establishing a more focused coordination between the hospital and affiliated medical group physicians; coordination of medical information from the specific HH companies with feedback to the patient's PCP and hospital CM staff if necessary.

How the Project Addresses those Challenges:

Care coordination will engage cancer patients at risk to take active and participative roles in their healthcare by establishing on-going relationships, providing health prevention and wellness education, facilitating appointments, health screenings and symptom management.

The 5-year expected outcome(s):

We expect to achieve a more comprehensive treatment plan for patients with cancer. We are expecting a reduction in cancer survivor rates, an increase in patient satisfaction, and an increase in awareness leading to better lifestyle and cancer prevention.

Regional goals:

- A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Starting Point/Baseline:

Breast navigation is currently established at CHRISTUS Hospital St. Elizabeth and St. Mary, providing healthcare navigation for patients from mammography screening through biopsy and diagnosis. Expansion of the existing program will assist patients with coordinated care, continuing through treatment, providing psychosocial care and survivorship for all tumor sites.

Rationale:

There are higher-than-average cancer rates in the service area. The Region 2 Health Partnership Study showed that Hardin and Orange counties are in the bottom 10%, and Jefferson County is in the bottom 25%, of all Texas counties for all cancers. Coordination of care for the cancer patient, from screening and early detection to end of life and survivorship care, improves patient quality of life and healthcare cost effectiveness with decreased emergency room visits, decreased hospital length of stay, and decreased end-of-life hospital admissions.

Traditionally, a hospital's care of patients ends the instant the patient is discharged. This has resulted in fragmented or overlapping care that is complicated for patients to access and navigate. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.

Relation between Project Choices and Community Needs:

The project option chosen is: 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

Unique Community Need Identification numbers:

CN.1
CN.5
CN.6

Expansion or enhancement

This project will establish a patient care navigator program. CHRISTUS will hire and train care navigators to target and manage high-risk patients with cancer. This new program will identify these patients and ensure that they are receiving the follow-up care, self-management instructions, and support they need in the community.

Core Components

The implementation of this project at CHRISTUS will accomplish the following core project components (a-e):

f) Identify frequent ED users and use navigators as part of a preventable ED reduction program.
   - CHRISTUS will train navigators to implement this project.

The ED component is not directly part of this program. The program for oncology purposes will focus on outpatients needing to pursue their treatment in the most efficient way.

g) Deploy case managers/workers as patient navigators.
   - Patient navigators will be assigned to patients to work closely with them.

h) Connect patients to primary and preventive care.
   - Patient navigators will be assigned to patients to work closely with them.

i) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
   - Patient navigators will be assigned to patients to work closely with them.

j) 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.
   - One of CHRISTUS' milestones in Year 4 is to implement a continuous quality improvement plan by establishing meeting with other RHP providers.

Related Category 3 Outcome Measures:

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

Relationship to other Projects:

This project's focus on patient care coordination and emphasis on care transitions ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on establishing/expanding patient care navigation programs along with these other Category 2 projects in our RHP: 121805903.2.1-Establish/expand a patient care navigation program; 094148602.2.2-Expand care transition program; 094092602.2.3-

Establish/expand a patient navigation program - community health program, chronic disease education; 112706003.2.4- Establish/Expand a Patient Care Navigation Program.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The valuation of each CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The project addresses community needs because so many residents in Jefferson County and the entire service area are at risk for cancer related illnessess and are at high-risk without appropriate treatment. This project will require a hefty investment in infrastructure, staffing,

training, community education, and creative solutions; however, the return on investment will make this project high value to the community and the Region.

112706003.2.4	2.9	2.9.1 (A-E)	ONCOLOGY NAVIGATION PROGRAM
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 3 Outcome Measure(s):	112706003.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Process P-X: Establish baseline for measures. This milestone will be a comprehensive assessment of all the baseline data that will be necessary to measure the future success of the project. Metric: Submission of baseline assessment documentation Goal: To establish baseline for future years. Data Source: Provider documentation of baseline study Estimated Milestone 1 Payment Amount: $230,245.50. **Milestone 2** [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric: Provide report identifying the following: ▪ Targeted patient population characteristics (e.g. patients with no PCP or medical home,	**Milestone 3** [P-3]: Provide care management/navigation services to targeted patients. Metric: Increase in the number or percentage of targeted patients enrolled in the program. Numerator: Number of targeted patients enrolled in the program. Denominator: Total number of targeted patients identified. Data Source: Enrollment reports. Estimated Milestone 3 Payment Amount: $157,250.66. **Unrelated to Oncology Navigation** **Milestone 4** [I-6.4]: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment. Metric: Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Estimated Milestone 4 Payment Amount:	**Milestone 6** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Estimated Milestone 6 Payment Amount: $234,582.50. **Milestone 7** [I-6.4]: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment. Suggest- Provide care management/navigation services to 175 oncology targeted patients with 875 interventions/encounters . Metric: Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program.	**Milestone 8** [I-6.4]: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment. Suggest- Provide care management/navigation services to 200 oncology targeted patients with 1000 interventions/encounters. Metric: Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Suggested: Number of patients enrolled in oncology navigation program Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Estimated Milestone 8 Payment Amount: $190,535.00. **Milestone 9** **CQI**: P-8 Participate in interactions with other providers and RHP to promote

112706003.2.4	2.9	2.9.1 (A-E)	ONCOLOGY NAVIGATION PROGRAM	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	112706003.3.5	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)
frequent ED utilization, homelessness, insurance status, low health literacy). ▪ Gaps in services and service needs. ▪ How program will identify, triage and manage target population (i.e. policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). ▪ Ideal number of patients targeted for enrollment in the patient navigation program. ▪ Number of Patient Navigators needed to be hired. ▪ Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment,	$157,250.66. **Milestone 5** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [P-10.4]: Improved health status and/or quality of life of target population as measured by score improvement on validated assessment tool administered pre and post navigator program. Goal: Patients enrolled in the navigator program will demonstrate an improvement in health status and/or quality of life from beginning of program to dis-enrollment or at class completion. Improvement will be measured by administering a validated assessment tool at the initial navigator interaction and comparing those results to the same tool administered at dis-enrollment from the navigator program or at time of class completion. Data Source: Baseline information will be collected by validated assessment tool (to be selected) at time of enrollment – data source will be patient record and assessment tool scores. Estimated Milestone 5 Payment Amount:	Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Estimated Milestone 7 Payment Amount: $234,582.50.	collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Estimated Milestone 9 Payment Amount: $190,535.00.

112706003.2.4	2.9	2.9.1 (A-E)	ONCOLOGY NAVIGATION PROGRAM	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	**112706003.3.5**	**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)**
and percentage of monolingual patients. Data Source: Program documentation, EHR, claims, needs assessment survey. Estimated Milestone 2 Payment Amount: $230,245.50.	$157,250.66			
Year 2 Estimated Milestone Bundle Amount: $460,491	Year 3 Estimated Milestone Bundle Amount: $471,752		Year 4 Estimated Milestone Bundle Amount: $469,165	Year 5 Estimated Milestone Bundle Amount: $381,070
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,782,478				

PROJECT OPTION*:* 2.6.1- Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: **112706003.2.5-Pass 2**
PERFORMING PROVIDER NAME/TPI: CHRISTUS Jasper Memorial Hospital/112706003

Title of project: Health Promotion and Disease Prevention
Provider: Located 65 miles north of Beaumont, **CHRISTUS Jasper Memorial Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. This project is being performed under the collaborative option with two other sister hospital CHRISTUS Hospital-St. Mary and CHRISTUS Hospital-St. Elizabeth. **CHRISTUS Hospital-St. Elizabeth,** a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatrics. **CHRISTUS Hospital-St. Mary,** a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. Together their service area extends to the southeast coast of the state, to the southeast border with Louisiana, and northward into East Texas, and area which includes a catchment area of more than 585,000 individuals. The collaborative nature of this project is necessary for the project to reach a broad enough array of patient care and patient population to be truly transformative.
Interventions: Jasper will implement a program to provide pre-diabetes education to prevent/delay the onset of type 2 diabetes. The project will involve group education classes at a community-based facility to promote healthy lifestyles (including physical activity and healthy eating), to reach an identified targeted population without insurance or for which insurance does not cover pre-diabetes education.
Need for the Project: Type 2 diabetes has been diagnosed in 10.9 % of the population in Jasper County, 11.4% of the population in Jefferson County, 11.0% of Orange County, and 11.6% of Hardin County. Promoting pre-diabetes education will assist in improving the financial burdens and overall health of the community, and prevent or delay onset of type 2 diabetes and its complications.
Target Population: The target population for this project is residents of the Jasper catchment area who are at-risk for type 2 diabetes or have been diagnosed with pre-diabetes. It is estimated that 10.9% of Jasper's catchment area patients have been diagnosed with pre-diabetes or determined at-risk for type 2 diabetes, of which 39% are Medicaid or uninsured.
Category 1 or 2 Expected Benefit: The goal of this project is to prevent or reduce the onset of type 2 diabetes by 15% through focused population education and diabetes awareness. Jasper will focus its efforts in those neighborhoods identified as having the greatest need for this type of education. As a result, Jasper expects diabetes related illnesses to decrease, a higher quality of life for the patient and a reduction in the consumption of medical resources. It is estimated 1440 participant visits DY2, with 1760 participant visits in DY3-DY5.

Category 3 Outcome: The goal is to reduce admission rates due to diabetes related illnesses by 15% by the end of DY5. CHRISTUS chose this particular outcome measure because it is highly

correlated with the goals of its associated Category 2 project. One of the direct consequences of poorly managed diabetes is an increase in the number of unnecessary hospital admissions. Therefore, a reduction in the number of hospital admissions associated with diabetes would be an accurate reflection of the success of this project.

Project Description:

This project will provide pre-diabetes education to prevent/delay the onset of type 2 diabetes. The project will involve group education classes at a community-based facility to promote healthy lifestyles (including physical activity and healthy eating), to reach an identified targeted population without insurance or for which insurance does not cover pre-diabetes education. Challenges include a high volume of uninsured people with pre-diabetes, lack of insurance coverage for pre-diabetes education, lack of patient awareness, and the coordination of a physician database for referrals.

The lifestyle education program consists of the following:

- A 16-session "core" lifestyle change class (lifestyle class) for participants. The class is taught by a trained "lifestyle coach." It follows an approved curriculum that has been shown to work and contains all of the elements included in the original Diabetes Prevention Program (DPP) Lifestyle Curriculum.
- At least six "post-core" follow-up sessions.
- For evaluation of performance, programs recognized by the Diabetes Prevention Recognition Program (DPRP) submit reports to the DPRP every 6 months with data on participants' progress in their classes.

The recognition program helps to assure that classes offered by local programs are based on the proven elements in the curriculum and are consistent throughout the United States. This consistent quality could help an individual deciding whether to participate, a health care professional considering whether to refer a patient, or an insurance provider considering whether to pay for the program. It is estimated 1440 participant visits DY2, with 1760 participant visits in DY3-DY5.

The following documentation (milestones) will be maintained on each participant:

- Documentation of body weight during the core phase
- Documentation of physical activity minutes during the core phase
- Weight loss achieved during the core phase
- Session attendance during the post-core phase
- Documentation of body weights during the post-core phase
- Weight loss achieved by the end of the post-core phase

A minimum of 3 core classes will be initiated; at 26 weeks from the start of these classes, a second group of core classes (minimum of 4) will be started. Note this will be during the post-core phase of the first group. Core classes will be started every 26 weeks for the duration through DY 4. A maximum class size will be 20 participants to encourage group participation.

There is a potential for family members of the core/post-core classes to obtain the benefits of these lifestyle changes as they may also make these changes, thus reducing their risk of developing type 2 diabetes.

Project goal(s):

Our goal is to focus on population specific health education and awareness through various community partnerships by holding demographically targeted events and aide in the redevelopment of evidence-based programs in an effort to promote proactive health screenings, early enrollment in prenatal care and reduction of childhood obesity among other health education components. These events will be strategically located in neighborhoods of greatest need as identified through a data breakdown by zip code. We will spotlight wellness, healthy lifestyles and disease self-management among populations most at risk or undereducated on such topics. Through partnership with the local community health clinics we will also better educate the underinsured and uninsured on affordable access to healthcare in our region.

Anticipated challenges:

Encouraging increased personal responsibility and self-accountability among populations living at or near poverty level where meeting basic needs can become priority over health awareness and education. Also determining the best method of communication to said population and creating effective incentives to encourage attendance.

How the Project Addresses those Challenges:

These challenges will be addressed with follow up, coordination of resources and an increase in patient satisfaction to resolve areas of gaps in service.

The 5-year expected outcome(s):

Reduced potentially preventable usage of the ED for diabetes related complications, better disease management and prevention through education and community screenings.

Regional goals

- A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and that uses resources more efficiently, effectively and equitably.
- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Starting Point/Baseline:
CHRISTUS Hospital has an established Diabetes Education program, but has no funds to promote prevention of type 2 diabetes. There is a growing population of pre-diabetes patients, for which education is generally not covered for those with without insurance, Medicare, or Medicaid.

Rationale:
There is a significant portion of the population that is obese and uninsured, or insured without insurance coverage for pre-diabetes education, suffering from pre-diabetes. According to the Texas Behavioral Risk Factor Surveillance System (BRFSS 2010), 5.2% of adults 18 years and older have been diagnosed with pre-diabetes (about 1 million adults); nationwide, 6.4% have been diagnosed (about 15 million adults). Type 2 diabetes has been diagnosed in 11.4% of the population in Jefferson County, 11.0% of Orange County, and 11.6% of Hardin County. Promoting pre-diabetes education will assist in improving the financial burdens and overall health of the community, and prevent or delay onset of type 2 diabetes and its complications. Although about 33% of U.S. adults have pre-diabetes, awareness of this risky condition is low. Fewer than 10% of U.S. adults with pre-diabetes report that they have ever been told that they have pre-diabetes. Progression to type 2 diabetes among those with pre-diabetes is not inevitable. Studies have shown that people with pre-diabetes can prevent or delay the onset of type 2 diabetes by losing 5%–7% of their body weight and getting at least 150 minutes per week of moderate physical activity. Because awareness of pre-diabetes is low, we anticipate that the percentage of people who are aware that they have pre-diabetes will rise as diabetes prevention efforts progress.
In the United States, diabetes is the leading cause of kidney failure, lower limb amputations, and new cases of blindness among adults. It is also a major cause of heart disease and stroke, and is the seventh leading cause of death in the United States. The Center for Disease Control and Prevention's 2011 estimates indicate that diabetes affects 25.8 million people, or 8.3% of the U.S. population. In the thirteen counties of the Texas Coastal Bend area, the prevalence is substantially higher at 47% of the population.
Relation between Project Choices and Community Needs:
Our most recent Community Needs Assessment has identified that our region, as compared to the state of Texas and the United States, has a higher percentage of adults who do not access most of the basic aspects of preventive care such as screenings and routine lab work due to lack of education and cost barriers. Patients, especially those that can be categorized as "at risk," need access to preventative care in order to avoid and/or track the onset of chronic diseases, which will ultimately lead to better patient outcomes and fewer preventable hospital admissions down the line. The continually increasing number of uninsured and underinsured patients presenting to our ED for primary care or potentially preventable diseases has created a financial burden on the hospital district, in addition to resulting in worse patient outcomes.
Unique Community Need Identification numbers:
CN.1
CN.5
CN.6

Expansion or enhancement

There has not been an emphasis on reaching out to patient populations with pre-diabetes. This program will address that.

Related Category 3 Outcome Measures:

OD-2: Potentially Preventable Admissions; IT-2.7: Diabetes Short Term Complication Admission Rate.

Relationship to other Projects:

This project is part of CHRISTUS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, it complements CHRISTUS's Chronic Disease Management Clinics project and Community Health Workers project; each of these projects is intended to identify at-risk populations and provide them with information and support which will reduce improper or ineffective utilization of healthcare services.

This project's focus on patient education and emphasis on diabetes ties to these Category 1 and 2 projects in our RHP: 112706003.2.5, 094092602.2.9, 096166602.2.8. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on implementing a health promotion program along with these other Category 2 projects in our RHP: 112706003.2.5- Implement Evidence-based Health Promotion Programs; 094092602.2.9- Engage in Population-Based Campaigns or Programs to Promote Healthy Lifestyles Using Evidence Based Methodologies including Social Media and Text Messaging in an Identified Population

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The valuation of each CHRISTUS projects use a method which ranks the importance of each projects based several key factors. First, CHRISTUS considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the

quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, CHRISTUS considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, CHRISTUS reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This particular project directly addresses the aims of the Waiver, in that it is transformational, patient-centered, and will result in a reduced systemic cost of providing care. The project addresses community needs because so many residents in Jefferson County and Jasper County are at risk for diabetes and/or already have diabetes and are at high-risk for hospitalization when their condition deteriorates due to a lack of self-management. This project will require a hefty investment in infrastructure, staffing, training, community education, and creative solutions; however, the return on investment will make this project high value to the community and the Region.

112706003.2.5	2.6.1	2.6.1	HEALTH PROMOTION AND DISEASE PREVENTION	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	112706003.3.6	IT-2.7	Diabetes Short Term Complication Admission Rate	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Process P-X: Establish baseline for measures. This milestone will be a comprehensive assessment of all the baseline data that will be necessary to measure the future success of the project. Metric: Submission of baseline assessment documentation Goal: To establish baseline for future years, beginning with 60 pre-screened patients deemed to be appropriate and entered into the program; 1440 visits DY2. Data Source: Provider documentation of baseline study Estimated Milestone 1 Payment Amount: $283,379.50 **Milestone 2** [P-3]: Define evidence-based practices as the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions. Metric: Document implementation strategy and testing outcomes.	**Milestone 3** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric: Increase percentage of target population reached. Numerator: Number of individuals of target population reached by the innovative project. Denominator: Number of individuals in the target population. Goal: Increase access by 5% over baseline Data Source: Documentation of target population reached, as designated in the project plan. Estimated Milestone 3 Payment Amount: $290,309 **Milestone 4** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email	**Milestone 5** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric: Increase percentage of target population reached. Numerator: Number of individuals of target population reached by the innovative project. Denominator: Number of individuals in the target population. Goal: Increase access by 10% over baseline Data Source: Documentation of target population reached, as designated in the project plan. Estimated Milestone 5 Payment Amount: $288,716.50 **Milestone 6** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email	**Milestone 7** [P-2]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, to be summarized at quarterly intervals. Estimated Milestone 7 Payment Amount: $234,505 **Milestone 8** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric: Increase percentage of target population reached. Numerator: Number of individuals of target population reached by the innovative project. Denominator: Number of individuals in the target population. Goal: Increase access by 15% over baseline Data Source: Documentation of target population reached, as designated in the

112706003.2.5	2.6.1	2.6.1	HEALTH PROMOTION AND DISEASE PREVENTION	
CHRISTUS Jasper Memorial Hospital				112706003
Related Category 3 Outcome Measure(s):	112706003.3.6	IT-2.7	Diabetes Short Term Complication Admission Rate	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider. Estimated Milestone 2 Payment Amount: $283,379.50	Estimated Milestone 4 Payment Amount: $290,309	Estimated Milestone 6 Payment Amount: $288,716.50	project plan. Estimated Milestone 8 Payment Amount: $234,505
Year 2 Estimated Milestone Bundle Amount: $566,759	Year 3 Estimated Milestone Bundle Amount: $580,618	Year 4 Estimated Milestone Bundle Amount: $577,433	Year 5 Estimated Milestone Bundle Amount: $469,010
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,193,820			

PROJECT OPTION: 2.2.2: Apply evidence-based care management model to patients identified as having high-risk healthcare needs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 138296208.2.1
PERFORMING PROVIDER NAME/TPI: CHRISTUS Hospital – St. Elizabeth/TPI 138296208

Provider: Located 65 miles north of Beaumont, **CHRISTUS Jasper Memorial Hospital** is a 59-bed general medical/surgical hospital with emergency, medical imaging, laboratory, inpatient rehabilitation, birthing, and rural clinics. This project is being performed under the collaborative option with two other sister hospital CHRISTUS Hospital-St. Mary and CHRISTUS Hospital-St. Elizabeth. **CHRISTUS Hospital-St. Elizabeth,** a 438-bed hospital in Beaumont, is the regional leader in spine and orthopedics, cardiology, oncology, general surgery, critical care and trauma, birthing, neonatal care, and bariatric. **CHRISTUS Hospital-St. Mary,** a 227-bed hospital, in Port Arthur provides a comprehensive array of services including orthopedics, cardiology, oncology, general surgery, emergency and trauma, birthing, and neonatal care. These three hospitals are collaborating on DSRIP projects with a combined service area that extends to the southeast coast of the state, to the southeast border with Louisiana, and northward into East Texas, and area which includes a catchment area of more than 585,000 individuals.
Interventions: CHRISTUS will establish team-based clinics to address complex chronic diseases such as congestive heart failure, diabetes, COPD and asthma. These clinics will offer intensive care management to optimize health and healthcare utilization, thus decreasing the cost and impact of these chronic diseases.
Need for the Project: Jefferson County residents have a higher rate of adult-smoking, obesity, physical inactivity, and poor physical health days than the statewide average, each of which puts residents at risk for common chronic diseases. Additionally, Jefferson County has a higher rate of mortality from aortic aneurysm, diseases of the heart, COPD, cerebrovascular conditions, chronic liver disease, and hypertension than the statewide average.
Target Population: The target population for this project is residents of the CHRISTUS catchment area who suffer from congestive heart failure, diabetes, COPD or asthma. It is estimated that 10.9% of the catchment area patients who suffer from congestive heart failure, diabetes, COPD or asthma. That would be 63,765, of which 39%, or 24,868, would be Medicaid or uninsured.
Category 1 or 2 Expected Benefit: The goal of this project is to provide the health and supportive resources needed in a community in one location to empower patients and their caregivers to take charge of their health and access and utilize services appropriately. These clinics will create a significant reduction in hospitalizations, readmissions, and inappropriate emergency department utilization among those served. From year 2 through year 5 some 1000 patients are expected to be reached. Services include medication reconciliation, titration, education, counseling, diagnosis and treatment of chronic disease
Category 3 Outcome: CHRISTUS expects to decrease the current 30-day all cause readmission rate of 24% for patients suffering from heart failure by 50% at the end of DY5. This is a reasonable measure of the success of the associated Category 2 project to manage chronic conditions because poor management of chronic conditions is a leading cause of unnecessary hospital re-admissions.

PROJECT DESCRIPTION:

CHRISTUS will establish innovative team-based clinics in the local community to address complex chronic diseases such as congestive heart failure, diabetes, COPD, asthma and combinations of these conditions. These clinics will offer intensive care management to optimize health and healthcare utilization.

Project Goals/Five Year Expected Outcome: The five-year target goals are to establish to complex care clinics in the community that serve 400 or more patients per year in need of intensive care coordination and interdisciplinary care resources by DY 4 and to complete a cost-effectiveness study of utilization and patient satisfaction by DY 5. The complex care clinics will serve a group of patients with chronic illness in resource-rich ambulatory settings supported by multidisciplinary teams. The teams will provide improved access to health and community resources, education, and self-management resources. Each clinic will be run by Nurse Practitioners, under the guidance of a leading specialist. The clinics will include the services of disease management navigators, LCSW, dieticians, financial counselors, exercise physiologists, RNs, CNAs, and respiratory therapists. The services of the mid-level providers will support the work of the specialists to empower high-risk individuals to take charge of their own health and to access the appropriate level of care. Using referrals from ED visits and hospitalizations, as well as direct referrals from both primary-care and specialty providers, the clinics will enroll patients identified as high risk for hospital admission/readmission, and who can benefit from intensive care coordination.

Challenges: The challenge for the clinics will be to provide intense patient-centered critical care coordination while limiting the duration of services. The program design is to bridge the gaps in the system for patients with chronic disease by equipping them with the education, skills and resources they and their families need to manage their disease. The model is then to return patients to regular primary care when they are no longer in need of intensive care coordination. Moving patients through the clinics in an efficient manner is essential to the enrollment of new patients.

Relationship to Regional Goals: This project is intended to transform the healthcare delivery system in our catchment area, which furthers the identical goal of Region 2. This project is patient-centered and aimed to reduce the systemic cost of providing care, and thus ties in with all other comparable projects in Region 2.

STARTING POINT/BASELINE:

For over one hundred years, CHRISTUS Health Southeast Texas has been meeting the needs of the community by providing a variety of services to ensure the health of a complex population with complex diseases. CHRISTUS Health Southeast Texas is currently implementing models of inpatient navigation for chronic diseases such as heart failure. CHRISTUS Hospital recently opened its first Chronic Disease Management Heart Failure Clinic in Beaumont. The clinic provides cardiac rehabilitation, but will be expanded to become a one-stop comprehensive heart failure management center. A second center will be explored for Port Arthur, Texas to meet the needs of that community by addressing cardiovascular disease, pulmonary disease, and diabetes. CHRISTUS Health Southeast Texas will explore other clinic locations based upon needs in surrounding communities. These centers will offer services that are currently unavailable in the region. These centers will be patient-centered, accountable, and results-oriented and will practice ongoing learning from one another. Use of a broad range of existing

community resources, staff trained to connect with these services, and the provision of follow-up care will empower patients to access the most appropriate and cost-effective resources for their conditions. It is our intention to perfect a high-quality, patient-centered model that may be adapted and replicated in areas with similar needs.

RATIONALE:

Economics, culture, and history are all causal factors in the poor health outcomes of the service region. The area has a poverty rate of 22.6% and an uninsured rate of 25.2%—both of which are higher than the respective state and national rates. There is no county hospital district and only one FQHC serving the region. The region has been continuously served by religious-sponsored, not-for-profit hospitals for over 100 years. Texas is one of the most litigious areas in the United States, and for many years recruiting and retaining physicians was nearly impossible. These factors have created a cycle in which chronic diseases go undiagnosed and/or untreated until patients are so ill that they must access services at the most costly point of care, the emergency departments of local hospitals. The severity of the illnesses and lack of coordination among medical services has led to a downward spiral for many patients. Jefferson County residents have a higher rate of physical inactivity, obesity, adult smoking, hypertension, and poor physical health days than the statewide average, each of which increases a patient's risk of CHF and being high-risk. Jefferson County has a higher rate of mortality from aortic aneurysm, diseases of the heart, COPD, cerebrovascular conditions, chronic liver disease, and hypertension than the statewide average. Additionally, Jefferson County residents have a higher rate of adult-smoking, obesity, physical inactivity, and poor physical health days than the statewide average, each of which puts residents at risk for common chronic diseases.

The goal of this project is to provide the health and supportive resources needed in a community in one location to empower patients and their caregivers to take charge of their health and access and utilize services appropriately. Based upon evidence from similar interventions, these clinics will create a significant reduction in hospitalizations, readmissions, and inappropriate emergency department utilization among those served.

Unique Community Needs:

CN.10, CN.11, CN.12, CN.13, CN.14, CN.15

RELATED CATEGORY 3 OUTCOME MEASURE(S):

OD-3, IT 3.2: Reduce CHF 30 day readmissions

CHRISTUS chose this outcome because the intended outcome of providing chronic disease management is to improve health outcomes for targeted patients upon discharge from the hospital, which should result in fewer PPRs for these patients. This outcome will result in increased patient satisfaction and reduced delivery system costs.

RELATIONSHIP TO OTHER PROJECTS:

This project is part of CHRISTUS's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care. Specifically, it complements CHRISTUS's Palliative Care Program project and Community Health Workers project; each of these projects is intended to identify at-risk populations and provide them with information and support which will reduce improper or ineffective utilization of healthcare services.

This project's focus on establishing team-based clinics to address and manage complex chronic disease and emphasis on intensive care management for diseases such as CHF, diabetes, COPD

and asthma ties to these Category 1 and 2 projects in our RHP: 112671602.2.1, 112706003.2.1, 138296208.2.1, 094092602.2.6,094148602.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the expansion of chronic care management models along with these other Category 2 projects in our RHP: 094148602.2.1-Expand chronic care management models; 112671602.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 112706003.2.1-Apply evidence based care management model to patients identified as having high risk health care needs; 138296208.2.1-Expanding chronic care management models (high risk healthcare needs).

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The valuation of each CHRISTUS project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree collaboration involved in the project, and the sustainability of the project. This particular project directly addresses the aims of the Waiver, in that it is transformational, patient-centered, and will result in a reduced systemic cost of providing care. The project addresses community needs because so many residents in Jefferson County are at risk for chronic disease and/or already have chronic diseases and are at high-risk for hospitalization when their condition deteriorates due to a lack of self-management. This project will require a hefty investment in infrastructure, staffing, training, community education, and creative solutions; however, the return on investment will make this project high value to the community and the Region.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

138296208.2.1	2.2	2.2.2	CHRISTUS Chronic Disease Management Clinics in SETX	
CHRISTUS Hospital – St. Elizabeth				138296208
Related Category 3 Outcome Measure(s):	**138296208.3.2**	**IT-3.2**	**CHF 30 Day Readmission Rate**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop a comprehensive care management program. **Metric** [P-3.1]: Documentation of Care management program. **Baseline/goal**: CHRISTUS will develop a comprehensive plan for addressing chronic disease management in the community, which will include strategies for identifying high-risk, chronically ill patients, plans for multi-disciplinary teams at local clinics to treat identified patients, and best practices for teaching patient self-management skills. **Data source**: program materials Milestone 1 : Clinic One is open and seeing a hundred patients first year. Decrease in HF readmissions by 10%. Milestone 1 Estimated Incentive Payment: $1,100,961	**Milestone 2** [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic care model or similar. **Metric** [P-4.1]: Increase the number of clinic sites with formalized multi-disciplinary teams. **Baseline/goal**: CHRISTUS will implement formalized teams to work with chronically ill patients in at least two (2) local clinics. **Data source**: clinic staffing records and internal documentation Milestone 2 : Clinic Two is open and seeing 50 patients first year for total patients seen of 200 patients annually. Decrease HF admissions by 20%. Milestone 2 Estimated Incentive Payment: $1,126,021		**Milestone 3** [I-17]: Apply the chronic care model to targeted chronic diseases, which are prevalent locally. **Metric** [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease. **Baseline/goal**: Through the two local clinics with formalized teams to provide complex care, at least 200 chronically ill patients will be treated under the care management program developed in DY2 **Data source**: patient records, electronic health records, data created/maintained by the clinic Milestone 3: Both clinics seeing 300 patients total annually. Decrease HF readmissions by 30%. Milestone 3 Estimated Incentive Payment: $1,124,275	**Milestone 4** [I-19]: Implement disease-specific medical home. **Metric** [I-19.3]: Patient engages in disease appropriate preventative intervention. **Baseline/goal**: CHRISTUS will work with patients suffering from congestive heart failure to create and maintain a low-fat, low-sodium diet; at least 30% of identified patients will engage in this disease appropriate intervention. Numerator: Number of individuals with CHF in past year who are following the recommended diet Denominator: number of individuals treated with CHF in the past year **Date source:** patient records Milestone 4: All clinics up and running. Seeing 400 patients annually. Easily reproducible model . Decrease in HF readmissions by 50%. Milestone 4 Estimated Incentive Payment: $907,800
Year 2 Estimated Milestone Bundle Amount: $1,100,961	Year 3 Estimated Milestone Bundle Amount: $1,126,021		Year 4 Estimated Milestone Bundle Amount: $1,124,275	Year 5 Estimated Milestone Bundle Amount: $907,800
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,259,057				

PROJECT OPTION: 2.15.1 Integrate Primary and Behavioral Health Care Services

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 135222109.2.1
PERFORMING PROVIDER/TPI: Gulf Coast Center/135222109

Provider: The Gulf Coast Center (GCC) is the mental health authority and substance abuse recovery provider through the Texas Department of State Health Services (DSHS) for Galveston and Brazoria Counties. The Center is one of 39 community mental health centers in the State of Texas through the auspices of the Texas Department of State Health Services. Serving Galveston and Brazoria Counties, the Gulf Coast Center provides a complete array of services to those with mental health, recovery and intellectual and developmental disability needs. The Gulf Coast Center adult services are currently charged with serving 1759 adults, although currently serving more than 2400 adults. Service sites include four adult mental health clinics (two in Galveston County and two in Brazoria County). This project focuses on the Center's mental health adult population age 18 and older. Galveston County covers 873 square miles and is divided into three distinct geographic areas: the mainland, Galveston Island, and Port Bolivar. As one of the largest counties in Texas, Brazoria County covers 1386 square miles.
Intervention: Project will co-locate outpatient physical health services in its adult mental health facilities so as to integrate primary care and behavioral health care services in order to improve access to needed services.
Need for project: At this time, primary care services are not included on the Gulf Coast Center's comprehensive service array. This project will provide much needed primary care services for those individuals with co-existing behavioral health and primary care diagnoses.
Target population: The target population includes Galveston and Brazoria County clients with co-occurring physical health needs whom have not yet been assigned a designated medical home. Approximately 50% of our patient population is Medicaid eligible or indigent uninsured.
Category 2 expected patient benefit: The project seeks to increase the number of individuals who receive primary health care services following the co-location of primary care providers at Gulf Coast Center mental health adult clinics. Starting enrollment into the program near the end of DY2 our goals by DY4-5 is to have 40% -50% respectively, integrated health care available at Gulf Coast Center identified locations.
Category 3 Outcomes: By DY4-5 our goal is to have 40% -50% respectively, integrated health care available at Gulf Coast Center established locations. Realization of the integrated health care goal will result in a measured increased in overall quality of life for those we serve.
PROJECT DESCRIPTION:
Gulf Coast Center will co-locate outpatient physical health clinics in its adult mental health facilities. Following evidenced-based practices to improve health status, including the Texas Resilience and Recovery (TRR) model and the use of the Four Quadrant Clinical Integration Model, this grant will allow a GCC nurse care manager to establish baseline and track vital health indicators gathered at regularly scheduled psychiatric visits, conduct primary screening assessments, document presence of co-occurring mental health and substance dependence, refer clients to other medical providers for more extensive medical needs and assure access to secondary and tertiary care where necessary, and track health outcomes over time. The Gulf

Coast Center will also assign a nurse care manager to the Intellectual and Developmental Disabilities (IDD) program to administer assessments, provide wellness and disease education, link with community medical resources and monitor wellness progress.

Project goal(s)

The goal is to integrate primary care and behavioral health care services in order to improve care and access to needed services.

The concept of a medical home that can address the needs of the whole person is increasingly recognized as a key in improving both access to care, continuity of care and improved outcomes. The importance of simultaneously addressing the physical health needs and the behavioral health needs of individuals has become recognized over the past three decades.

A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems … the effects of atypical antipsychotic medications, which exacerbate this predisposition, individuals with schizophrenia have especially high rates of diabetes. Cardiovascular diseases are also very prevalent among people with mental illnesses. Again, psychiatric medications exacerbate the problem because they are associated with obesity and high triglyceride levels, known risk factors for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment… Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.[1]

Expanding the capacity of primary care to better accommodate the needs of the Gulf Coast Center clients through a nurse care management approach to improve the overall wellness and physical health status of consumers with intellectual and developmental disabilities and adult clients with serious mental illnesses served by the Gulf Coast Center in Galveston County and Brazoria County, Texas, by providing screening, wellness education, data management and a collaboration with the FQHC and other county resources that can facilitate wellness through GCC's mental health clinic based medical home. The additional inclusion of counseling and

1 Bazelon Center for Mental Health Law (2004), GET IT TOGETHER How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

therapy professionals to provide support services both within GCC Center facilities and off-site for individuals not qualifying for GCC Cognitive Behavioral Therapy services is also a goal of the project. The benefit of initial counseling sessions being in a Center facility is to start establishing rapport and to transition then to sessions off-site within the community. This facilitates the total discharge from Center services for those with minimal support needs from the Center; hence, freeing-up capacity for those with qualifying, intensive behavioral health service needs. For IDD consumers, counseling supports are much needed especially for those with dual diagnosis of IDD and depression.

Challenges:

Health clinics that serve indigent populations frequently do not have capacity to accept more patients. Even with the help of local primary care providers, the recruitment process for securing physicians and nurse practitioners can be challenging in light of the shortage of licensed primary care practitioners. Although the Center as well as other local stakeholders is currently participating in a Health Information Exchange Initiative, equally challenging will be the development of the shared Electronic Health Record for information exchange between behavioral health and primary care clinicians. Finally, work space within the Center's behavioral health facilities is limited, so locating available space will be especially challenging.

The 5-year expected outcome(s):

Within the 5 year project timeline, the Gulf Coast Center will co-locate and integrate outpatient physical health clinics within its adult mental health facilities. As we establish a baseline of those clients utilizing both primary and behavioral health care, we will initiate regular Quality of Life (QOL) assessments using the evidence-based, validated tools. We expect Quality of Life scores to significantly increase across our client population with access to our planned Integrated Primary and Behavioral Health Care project. Behavioral health clients have a high incidence of high blood pressure, cholesterol, obesity, and diabetes, shortening their life spans by 25 years compared to the general public. Many of these clients do not have access to physical health care because they are uninsured or lack funds to pay for these services. Health clinics that serve indigent populations frequently do not have capacity to accept more patients. As these physical health issues are addressed it is expected that overall health and well being will improve, thus improving perceived QOL.

Relationship to Regional goals:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

Of the 2411 adult mental health clients GCC currently service each month 788 (33%) are diagnosed with schizophrenia/schizoaffective disorder, 896 (37%) have bipolar disorder, 693 (29%) have major depressive disorder, and 34 (1%) have other related disorders; 57% are females and 43% are males. Non-Hispanic Whites make up 61% of the clients and the remainder are African American (24%), Hispanic (13%), and other (2%). Of these clients, 1111 reported physical illnesses and conditions, with the highest number associated with

hypertension, diabetes, hepatitis and hepatic/Biliary conditions. The collaboration and partnership with FQHC providers will afford the two service delivery systems (BH/IDD), the opportunity to improve quality of care, thus reducing hospitalization rates, emergency department visits and improving the quality of life for those with chronic health disparities.

At this time, primary care services are not included on the Gulf Coast Center's comprehensive service array. This project will provide much needed primary care services for those individuals with co-existing behavioral health and primary care diagnoses. Transitional supports including counseling services in the community or counseling services co-located and/or integrated with the Center's outpatient behavioral health clinics in partnership with partnering FQHC are integral to the project.

RATIONALE:

Relation between Project Choices and Community Needs:

Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. As Community Needs Assessment indicated: a shortage of Mental/Behavioral Health providers; a shortage of Mental Health/Behavioral Health Related Mortality and Morbidity; it was felt that co-locating Primary and Behavioral Health Care would be an important step in decreasing overall health issues and thus increasing quality of life.

The Integration of Primary and Behavioral Health Care project components are in 10 parts, several of which have already been completed. They are as follows:

a) Identify sites for integrated care projects.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include: Joint meetings to take place with FQHC primary health clinicians.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice. Revise/update existing legal agreements.

h) Arrange for utilities and building services for these settings.

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.

j) Conduct quality improvement for project using methods such as rapid cycle improvement.

The Integrate Primary and Behavioral Health Care Services program will implement the following Process Measures: P-2 : Identify existing clinics or other community-based settings where integration could be supported (initial clinic setting will start in DY2 then expansion clinics will be identified in DY3; P-3: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa (initial standards will be developed in DY2 and revised in DY3 as additional clinics sites are implemented); P-10 Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. GCC will participate in meetings with other community health centers participating in the waiver through our regional collaborative ETBHN to discuss similar projects. The Improvement Measure will be I-8: Integrated Services with

I-8.1. Metric: 40% of individuals receiving both physical and behavioral healthcare at the established locations by end of DY4 and 50% in DY5

Unique Community Need Identification numbers:

CN.3. Primary Care Physician Shortage (Physicians per 100,000: 7.0-97.2, Number of Primary Care HPSAs: 9, Number of Primary Care Partial HPSAs: 6, Preventable Hospital Admissions: 896.6-2459.1) Texas Medical Board, US Department of Health and Human Services (HHSC), Health Resources and Services Administration (HRSA)

CN.5. Mental/Behavioral Health Provider Shortage Health Resources Services Administration (HRSA), Area Resource File (ARF), US HHSC, Health Professions Workforce Center, TX Department of State Health Services

CN.16 Mental/Behavioral Health Related Mortality (Accident Mortality Rate per 100,000: 45.4-32.2, Intentional Self Harm Mortality Rate per 100,00:10.8-18.7) Texas Department of State Health Services Death Statistics

CN. 17 Mental/Behavioral Health Related Morbidity (Alcohol related admissions per 100,000: 313.7) Texas Department of State Health Services Admissions data

Expansion or Enhancement:

The CNA for RHP 2 has identified the need for expanded physical health care in RHP 2. Currently, primary care services are not available within the GCC services array. By co-locating a primary care nurse practitioner in our behavioral health clinics, individuals with mental health disorders will have access to outpatient primary care assessments and rapid referrals for more intensive medical treatment and IDD consumers will have access to much needed assessments and medical monitoring. The Gulf Coast Center does not currently receive state or federal funding for this project.

RELATED CATEGORY 3 OUTCOME MEASURES:

The Outcome Domain 10 – Quality of Life/Functional Status supports the project as evidenced in IT-10.1. Project planning to include engaging stakeholders, identification of current capacity/ needed resources, determining timelines and documentation of implementation process.

Additionally, establishing baseline rates, developing and testing data systems, conduct 'plan do study act' (PDSA) cycles to improve date collection and intervention.

RELATIONSHIP TO OTHER PROJECTS:

Some relationship to Psychiatric Telemedicine Expansion project as individuals who present to the Emergency Department for physical health needs when mental health worker is present have increased probability of follow-up with nurse practitioner following discharge; thus, minimizing the frequency of visits to local emergency department for chronic healthcare issues.

This project's focus on co-locating physical and behavioral health services and emphasis on use of a nurse care manager ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

The Gulf Coast Center will be a Performing Provider in partnership with local FQHC. This project focuses on the integration of primary and behavioral health care services along with these other Category 2 projects in our RHP: 135222109.2.1- Integrate primary and behavioral health care services in Brazoria/Galveston county; 109372601.2.2 - Expanding integrated primary care and behavioral/mental health care access using APC; 136367307.2.2- Design, Implement and Evaluate Projects that Provide Integrated and Behavioral Health Care Services.

PLAN FOR LEARNING COLLABORATIVE:

We will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Population Affected: Upon completion of the proposed project, the planned services will be available in both Galveston and Brazoria county Center adult clinics; and almost all will be either uninsured or on Medicaid. Within the Center's MH Adult services, over 75% are reported to have serious physical health issues (such as diabetes, high blood pressure, and heart problems) in addition to their serious mental health diagnosis. Despite such extensive medical

needs, adults with serious mental illnesses often do not receive treatment. Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.[2]

Score: Total of 4 points for relatively large population affected (3) and the number of uninsured/Medicaid population to be served (1).

Severity: Within the Region 2 CNA, the average number of poor mental health days and poor physical health days both averaged 3 days in both the Galveston and Brazoria counties. Additionally it was reported in the CNA, a total average of over 35% of survey respondents in both the Galveston (31%) and Brazoria (42%) counties did not consider themselves healthy. Compounding that was the identified lack of community resources including specific identification of the lack of preventive services and mental health care. The proposed project will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and access the physical health care not currently available.

Score: Total of 5 points for strong support on Community Needs Assessment (2) and will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and access the physical health care not currently available (3).

Cost-Effectiveness: It is projected that over the four year period, the total cost of the proposed project is estimated to be approximately $2.6 million; with projections of affecting over 2,000 individuals over the period of time for an approximate costs of $1,300/person...considered to be very cost effect considering the services provided, the persons served, and the expected positive impact on their overall physical and mental health.

Score: Total of 5 points for a very low cost per person.

Community Benefit: The proposed project will improve access to the physical health services sooner; improve overall quality of the service received and more importantly improvement to the quality of life; improve long term costs by reducing un-necessary hospital admissions or extensive medical care resulting from untreated medical issues; is a transformative initiative for behavioral health services in the Galveston and Brazoria county areas by integrating mental and physical health care to those who otherwise would have limited access; and will work in collaboration with other community resources specifically local community health care and FQHC's.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves long term costs (1), transformative (1), and collaboration (1).

---

2 Bazelon Center for Mental Health Law (2004), GET IT TOGETHER How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

135222109.2.1	2.15.1	2.15.1 (A-J)	Integrate Primary and Behavioral health care services in Galveston and Brazoria County
Gulf Coast Center		135222109	
Related Category 3 Outcome Measure(s):	135222109.3.6	IT-10.1	OD-10 Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-2 Milestone: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both either in new settings or for physicians to share their office space with behavioral health practitioners. P-2.1. Metric: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations in both Brazoria and Galveston County. In partnership with FQHC's, identify primary care practitioners to be embedded with GCC behavioral health service delivery areas; including counselors, nurse practitioner (and supervising MD), nurse for IDD assessments as well as nurse care coordinator(s). a. Data Source: Information from persons interviewed. Meeting minutes, attendance records,	**Milestone 3** P-2 Milestone: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both either in new settings or for physicians to share their office space with behavioral health practitioners. P-2.1. Metric: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations in both Brazoria and Galveston County. In partnership with FQHC's, identify primary care practitioners to be embedded with GCC behavioral health service delivery areas; including counselors, nurse practitioner (and supervising MD), nurse for IDD assessments as well as nurse care coordinator(s). a. Data Source: Information from persons interviewed. Meeting minutes, attendance records,	**Milestone 6** Improvement Milestone: I-8 Integrated Services I-8.1. Metric: 40% of individuals receiving both physical and behavioral healthcare at the established locations. Baseline/Goal: Integrated health care available at all MH adult treatment sites including administration of nursing assessments for MH/IDD as well as ongoing wellness monitoring. Milestone 6 Estimated Incentive Payment: $588,189	**Milestone 7** Improvement Milestone: I-8 Integrated Services I-8.1. Metric: 50% of individuals receiving both physical and behavioral healthcare at the established locations. Baseline/Goal: Integrated health care available at all MH adult treatment sites including administration of nursing assessments for MH/IDD as well as ongoing wellness monitoring. Milestone 7 Estimated Incentive Payment: $485,896

135222109.2.1	2.15.1	2.15.1 (A-J)	Integrate Primary and Behavioral health care services in Galveston and Brazoria County
Gulf Coast Center		135222109	
Related Category 3 Outcome Measure(s):	135222109.3.6	IT-10.1	OD-10 Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
program progress report. Baseline/Goal: No integrated health care currently available within GCC treatment facilities. Identify 1 GCC Behavioral Health Clinic for implementation. Update/revise existing MOU's with FQHC as appropriate. Milestone 1 Estimated Incentive Payment (maximum amount): $330,461 **Milestone 2** **P-3 Milestone:** Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. P-3.1 Metric:Number and types of referrals that are made between providers at that location. a)Data Sources: Survey of providers to determine the degree and quality of information sharing; review of referral data and survey results P-3.2.Metric: Number of referrals that are made outside of that location	program progress report. Baseline/Goal: Expand primary care clinic operations to other GCC Behavioral Health Clinics, thus increasing primary care volume. An estimated 150 individuals will be served by the end of DY3. Update/revise existing MOU's with FQHC as appropriate. Milestone 3 Estimated Incentive Payment (maximum amount): $263,918 **Milestone 4** **P-3 Milestone:** Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. P-3.1 Metric: Number and types of referrals that are made between providers at that location. a)Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results P-3.2.Metric: Number of referrals that are made outside of the location		

135222109.2.1	2.15.1	2.15.1 (A-J)	Integrate Primary and Behavioral health care services in Galveston and Brazoria County
Gulf Coast Center		135222109	
Related Category 3 Outcome Measure(s):	135222109.3.6	IT-10.1	OD-10 Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
a)Data Sources: Survey of providers to determine the degree and quality of information sharing; Review of referral data and survey results. Baseline/Goal: Referral process between providers is partially established. In partnership with providers, will finalize referral process. Baseline/Goal: Currently no standards for integrated health care services. Estimated service to 78 individuals by end of DY2 Milestone 2 Estimated Incentive Payment (maximum amount): $270,048	a)Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results. Baseline/Goal: Referral process between providers is partially established. In partnership with providers, will finalize referral process. Baseline/Goal: Compared to the baseline established in year 2, the number of referrals will increase. Milestone 4 Estimated Incentive Payment: $ 205,270 **Milestone 5:** P-10 Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1.Metric: Participate in semi-annual face-to-face meetings or		

135222109.2.1	2.15.1	2.15.1 (A-J)	Integrate Primary and Behavioral health care services in Galveston and Brazoria County
Gulf Coast Center		**135222109**	
Related Category 3 Outcome Measure(s):	**135222109.3.6**	**IT-10.1**	**OD-10 Quality of Life/Functional Status**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	seminars organized in the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers Milestone 5 Estimated Incentive Payment (maximum amount): $117,297		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $600,839	Year 3 Estimated Milestone Bundle Amount: $586,485	Year 4 Estimated Milestone Bundle Amount: $588,189	Year 5 Estimated Milestone Bundle Amount: $485,896
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $ 2,261,409			

PROJECT OPTION: 2.13.2 Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e. the criminal justice system, ER, urgent care, etc.) CAT, WRAP, CET

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 135222109.2.2 Pass 2
PERFORMING PROVIDER NAME/TPI: Gulf Coast Center/135222109

Summary: Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting-- CAT, WRAP, CET.
Provider: The Gulf Coast Center (GCC) is the mental health authority, intellectual and developmental disability authority and substance abuse recovery provider through the Texas Department of State Health Services (DSHS) and Department of Aging and Disability Services (DADS) for Galveston and Brazoria Counties. The Gulf Coast Center provides a complete array of services to those with mental health, recovery and intellectual and developmental disability needs. The Gulf Coast Center adult mental health services are currently charged with serving 1759 adults, although currently serving more than 2400 adults. Galveston County covers 873 square miles and Brazoria County covers 1386 square miles.
Intervention: Gulf Coast Center will provide innovative evidence-based services to the targeted adult behavioral health population using increased training of the behavioral health workforce including professionals, paraprofessionals, peer-to-peer specialists, and peer-to-peer volunteers trained in Cognitive Adaptation Training ("CAT"), Wellness Recovery Action Plan™ ("WRAP®") facilitator and patient training, and Cognitive Enhancement Therapy ("CET"). The CAT, CET and WRAP components are comprehensive and multispecialty community-based interventions.
Need for project: People with severe mental illness (schizophrenia, bipolar disorder and major depression) often have multiple concomitant issues such as substance use, traumatic injuries, homelessness, cognitive challenges, and lack of daily living skills and lack of natural supports. The goal of this project is to promote wellness and adherence to behavioral health treatments and recovery in the community, and avert negative outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals and state behavioral health facilities and to avert disruptive and deleterious events such as criminal justice system involvement.
Target population: The target population of this project is adults with severe mental health diagnoses who reside in Brazoria County or Galveston County. Approximately 50% of persons seen are either Medicaid eligible or low income uninsured individuals and have limited access to behavioral health care training, peer support, or therapy.
Category 2 expected patient benefit: The expected outcome of this program by the end of demonstration year 5 is to strengthen the recovery of our patients; reduce general and psychiatric hospital recidivism; decrease criminal justice system involvement with clients; and emergency department usage. Through the early intervention and retraining incorporated in CET, patients who would otherwise be considered "disabled" under Social Security Supplemental Income guidelines may obtain employment and become self-sufficient within three years, reducing their dependence on Federal support.
Category 3 Outcomes: OD-10 Quality of Life, which will demonstrate improvement in quality of life scores as measured by evidence based and validated assessment tools for the target

population. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health.

Category Project Area:

2.13.2 Implement an evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.

Project Description:

Gulf Coast Center will provide innovative services to the targeted behavioral health population using increased training of the behavioral health workforce including professionals, paraprofessionals, peer-to-peer specialists, and peer-to-peer volunteers trained in Cognitive Adaptation Training ("CAT"), Wellness Recovery Action Plan™ ("WRAP®") facilitator and patient training, and Cognitive Enhancement Therapy ("CET").

Project goal(s):

Provide specialized services to people with a severe mental illness diagnosis. These populations often have multiple concomitant issues such as substance use, traumatic injuries, homelessness, cognitive challenges, and lack of daily living skills and lack of natural supports. The goal of this project is to avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals and state behavioral health facilities; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community.

Anticipated challenges:

Gulf Coast Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression. Funding limitations inhibit our ability to provide additional services. All new programs/services have significant start-up costs. DSRIP funding would allow implementation of innovative evidence-based programs that are focused on adaptive training, peer support, and cognitive rehabilitation for our behavioral health clients.

The 5-year expected outcome(s):

The expected outcome of this program by the end of demonstration year 5 is to strengthen the recovery of our patients; reduce general and psychiatric hospital recidivism; decrease criminal justice system involvement with clients; and emergency department usage.

Starting Point/Baseline:

Of the 2411 adult mental health clients GCC serves each month 788 (33%) are diagnosed with schizophrenia/schizoaffective disorder, 896 (37%) have bipolar disorder, 693 (29%) have major depressive disorder, and 34 (1%) have other related disorders; 57% are females and 43% are males. Non-Hispanic whites make up 61% of the clients and the remainder is made up of African American (24%), Hispanic (13%), and other (2%).

We have systems in place to initiate implementation of this project, including scheduling, intake and assessment, electronic health records, and other computer capabilities. Space in our existing facilities has been identified for offices, meeting rooms and computer areas for the following project focus:

- CAT: We currently have one professional staff trained in service delivery methods centered on the CAT model. That identified staff would facilitate the implementation and expansion of the service.

- WRAP: Currently we have identified individuals who have the potential to become trained and certified as peer support specialist through a grant offered by the Hogg Foundation.
- CET: Based on current job duties, Gulf Coast Center is assessing all professionally licensed staff to determine feasibility of training and certification in CET service delivery.

Rationale

Relation between Project Choices and Community Needs:

The Community Needs Assessment for Region 2 notes that physical and mental/behavioral health are not integrated and that mental health related ED visits are increasing. Increased training of the behavioral healthcare workforce in these evidenced-based practices will support the physical/mental health integration and is expected to reduce the hospital recidivism and emergency department usage for behavioral health clients.

The behavioral health training proposed in this plan relates to community needs CN.5, CN.10, CN.16 and CN.17.

This project represents a new initiative for the Gulf Coast Center. No U.S. Department of Health and Human Services funding is received for these programs. They will enhance the behavioral health services we currently provide.

Components of the project include the following:

- Cognitive Adaptive Training (CAT) is a National Institute of Mental Health (NIMH) sponsored clinical trial study through the University of Texas Health Science Center in San Antonio, Texas. This evidenced-based practice provides comprehensive use of environmental supports to improve multiple areas of adaptive functioning. The CAT training for staff professionals, paraprofessionals, peer-to-peer specialists, and volunteers will be provided initially onsite in Brazoria County and Galveston County. As new staff and certified peer specialists are hired and more volunteer peer-to-peers are secured, training will be coordinated. After the training, staff will provide clients with weekly treatments in their homes to address medication adherence (reminders), symptomology (early warning signs), adaptive functioning (successful daily routines), and coordination of behavioral and physical health needs.
- Peer support – Wellness Recovery Action Plan (WRAP®) has been designated by SAMHSA as an evidenced-based practice. WRAP utilizes an individualized system of planned action strategies that help patients monitor and respond to mental health and physical health challenges and negative symptoms with the goal of achieving their highest level of wellness (develop effective action plans for identified warning signs or triggers). The goal is to train six WRAP facilitators and three advanced facilitator Champions by the end of four years. WRAP facilitators are client peers as well as paraprofessionals. Through increasing the specialized training of behavioral health workforce paraprofessionals, peer specialist, and peer-to-peer volunteers, the expected outcome is to develop a pool of facilitators necessary to meet the volume of patients who will benefit from their WRAP plan. This evidenced-based practice integrates behavioral and physical health needs.
- Cognitive Enhancement Therapy (CET) is a recovery-oriented, SAMHSA 2011 Science and Service Award winning, evidence-based practice that helps clients to develop and enhance the mental capacities that produce the awareness for self-directed social

interactions that are wise, appropriate, and effective. CET utilizes a combination of cognitive rehabilitation-based computer training exercises in addition to structured group exercises with individual counseling and homework assignments (skills to improve attention, memory and problem solving skills). CET staff coaches will be hired and trained in CET techniques. After the training, they will lead patients in a 45-week program that includes weekly computer exercises, group process rehabilitation skills training, and individual therapy to improve social and vocational deficits and to decrease the overuse of hospital emergency departments and inpatient services. Through the early intervention and retraining incorporated in CET, patients who would otherwise be considered "disabled" under Social Security Supplemental Income guidelines may obtain employment and become self-sufficient within three years, reducing their dependence on Federal support.

- Results of all three of these training programs will be evaluated at time intervals appropriate to each program to determine the effectiveness. Adjustments to the programs will be made as needed based on "lessons learned'.

For demonstration year 2, the process milestone is to design the project plans and begin the initial phases that include coordinating the initial CAT training for staff, peers, interns, and volunteers; training WRAP facilitators; acquiring the CET software and beginning CET coach training.

In demonstration years 3-5, the improvement milestones will be the increase in the number of professionals, peers and volunteers trained to provide CAT, CET, and WRAP services. Because the CET program is designed for 45 weeks, no new enrollments will occur during year 5 unless funding is procured to sustain continuation of program.

The CAT, CET and WRAP components are comprehensive and multispecialty community-based interventions. Process milestones to include 1) Identifying community-based specialized interventions for target populations 2) Enrolling and serving individuals with targeted complex needs 3) Evaluate and continuously improve interventions and 4) Participating in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Identified improvement milestone will focus on Functional Status and the percentage of individuals receiving specialized interventions who demonstrate improved functional status on identified standardized assessment instrument(s).

Unique Community Need Identification numbers:

CN.3. Primary Care Physician Shortage (Physicians per 100,000: 7.0-97.2, Number of Primary Care HPSAs: 9, Number of Primary Care Partial HPSAs: 6, Preventable Hospital Admissions: 896.6-2459.1) Texas Medical Board, US Department of Health and Human Services (HHSC), Health Resources and Services Administration (HRSA)

CN.5. Mental/Behavioral Health Provider Shortage Health Resources Services Administration (HRSA), Area Resource File (ARF), US HHSC, Health Professions Workforce Center, TX Department of State Health Services

CN.10. High ED Utilization Rates HRSA Area Resource File (Rates calculated using population data from US Census Bureau's Population Estimates Program)

CN.16 Mental/Behavioral Health Related Mortality (Accident Mortality Rate per 100,000: 45.4-32.2, Intentional Self Harm Mortality Rate per 100,000:10.8-18.7) Texas Department of State Health Services Death Statistics

CN. 17 Mental/Behavioral Health Related Morbidity (Alcohol related admissions per 100,000: 313.7) Texas Department of State Health Services Admissions data

Expansion or Enhancement

Gulf Coast Center currently has staff trained in CAT. If this project is funded, it is expected that several additional staff would participate in CAT training and certification. We are also involved in a Hogg Foundation grant that is providing funding for WRAP training. We have identified several clients who have expressed interest in participating in that training. Identified licensed staff will be considered for CET training should funding become available. It is expected that a large portion of Gulf Coast Center client population would benefit from a minimum of at least one of the identified innovative services.

This proposed program would represent a new initiative for Gulf Coast Center.

No U.S. Department of Health and Human Services funding is received for these programs. It will greatly enhance the behavioral health services we currently provide. It is anticipated that we would serve approximately 50 individuals by the end of DY2 and over 100 by the end of DY5.

Related Category 3 Outcome Measures:

Gulf Coast Center has selected improvement outcome measure IT-10.1, Quality of Life, which will demonstrate improvement in quality of life scores as measured by evidence based and validated assessment tools for the target population. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. Additionally, processes for establishing baseline rates, developing and testing data systems, conduct 'plan do study act' (PDSA) cycles to improve data collection and intervention would be initiated.

Relationship to other Projects:

Gulf Coast Center has also proposed a project that would integrate primary and behavioral health care services (2.15). These projects would work concurrently to improve the overall health and quality of life for the targeted population in our service community.

This project's focus on behavioral health and emphasis on peer to peer support ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP:096166602.2.2-Youth respite/residential treatment; 096166602.2.3 - Community behavioral crisis services; 096166602.2.4 - Behavioral health training; 096166602.2.5 - Inpatient detox services; 096166602.2.6 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.5- "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Population Affected: Upon completion of the proposed project, the planned services will be available in both Galveston and Brazoria counties; and almost all those served by the proposed project will be either uninsured or on Medicaid.

> Score: Total of 4 points for relatively large population affected (3) and the number of uninsured/Medicaid population to be served (1).

Severity: Within the Region 2 CNA, the average number of poor mental health days and poor physical health days both averaged 3 days in both the Galveston and Brazoria counties. Additionally it was reported in the CNA, a total average of over 35% of survey respondents in both the Galveston (31%) and Brazoria (42%) counties did not consider themselves healthy. Compounding that was the identified lack of community resources including specific identification of the lack of preventive services and mental health care. As the proposed project will work concurrently with the Center's proposed integrated healthcare project, there will be a significant and lasting impact on both the mental and physical health of those to be served within the proposed project. Plus it will provide appropriate intervention options to minimize unnecessary incarcerations or ER use; and improve the overall quality of service.

> Score: Total of 5 points for strong support on Community Needs Assessment (2) and will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and provide appropriate intervention options to minimize unnecessary incarcerations or ER use (3).

Cost-Effectiveness: It is projected that over the four year period, the total cost of the proposed project is estimated to be approximately $1.5 million; with projections of affecting over 2,000 individuals over the period of time for an approximate costs of $755/person...considered to be very cost effect considering the services provided, the persons served, and the expected positive impact.

Score: Total of 5 points for a very low cost per person.

Community Benefit: The proposed project will provide appropriate intervention options to minimize unnecessary incarcerations or ER use; improve overall quality of the service received and more importantly improvement to the quality of life; improve long term costs by reducing un-necessary hospital admissions or extensive medical care resulting from untreated medical issues; is a transformative initiative for behavioral health services in the Galveston and Brazoria county areas; will work concurrently with the proposed integrating mental and physical health care project; and will work in collaboration with other community resources specifically local community health care and FQHC's.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves long term costs (1), transformative (1), and collaboration (1)

135222109.2.2	2.13.2	2.13.2	Provide an intervention for a targeted behavioral health population
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	**135222109.3.7**	**IT-10.1**	**OD-10 Quality of Life/Functional Status**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2 Milestone: Identify community – based specialized interventions for target population: CAT, WRAP, CET. Hire/train staff; procure computer hardware/software to facilitate implementation. Metric: P-2.1 Project plans based on evidence/experience and which address the project goals. Personnel records, procurement documentation. Data Source: Project documentation Baseline/Goal: No CAT, WRAP, CET, intervention services for a targeted behavioral health population are currently available within GCC services array. Those services will be offered to appropriate population, and baseline number of individuals served will be tracked. It is anticipated that we will serve approximately 50 individuals by the end of DY2. Milestone 1 Estimated Incentive Payment: $ 287,686	**Milestone 2** P-3 Milestone: Enroll and serve individuals with targeted complex needs Metric P-3.1 Number of targeted individuals enrolled/served in the project Data Source: Project documentation Baseline/Goal: Number of individuals served in Year 2 will serve as baseline for Year 3. Goal is to increase the number served to 60 individuals. Milestone 2 Estimated Incentive Payment: $ 117,886 **Milestone 3** P-7 Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Each participating provider should publicly commit to implementing these improvements. P-7.1.Metric: Participate in semi-annual face-to-face meetings or seminars organized in the RHP.	**Milestone 5** P-3 Milestone: Enroll and serve individuals with targeted complex needs Metric P-3.1 Number of targeted individuals enrolled/served in the project Data Source: Project documentation Baseline/Goal: Number of individuals served in Year 2 will serve as baseline for Year 3. Goal is to increase the number served by 20% Milestone 5 Estimated Incentive Payment : $ 95,816 **Milestone 6** P-4 Milestone: Evaluate and continuously improve interventions Metric P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Data source: PDSA documentation, intervention tracking documentation. Baseline/Goal: Baseline determined in year 3, goal is identified improvement Milestone 6 Estimated Incentive Payment : $ 95,816	**Milestone 8** P-3 Milestone: Enroll and serve individuals with targeted complex needs Metric P-3.1 Number of targeted individuals enrolled/served in the project Data Source: Project documentation Baseline/Goal: Number of individuals served in Year 4 will serve as baseline for Year 5. Goal is to increase the number served by an additional 20% Milestone 8 Estimated Incentive Payment: $ 72,880 **Milestone 9** P-4 Milestone: Evaluate and continuously improve interventions Metric P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Data source: PDSA documentation, intervention tracking documentation. Baseline/Goal: Baseline determined in year 4, goal is identified improvement Milestone 9 Estimated Incentive Payment : $ 72,880 **Milestone 10**

135222109.2.2	2.13.2	2.13.2	Provide an intervention for a targeted behavioral health population
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	**135222109.3.7**	**IT-10.1**	**OD-10 Quality of Life/Functional Status**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 3 Estimated Incentive Payment : $ 117,886 **Milestone 4** P-4 Milestone: Evaluate and continuously improve interventions Metric P-4.1 Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. Data source: PDSA documentation, intervention tracking documentation. Baseline/Goal: Baseline determined in year 2, goal is identified improvement Milestone 4 Estimated Incentive Payment : $ 117,886	**Milestone 7** **Improvement Milestone** I-5.1 Milestone: Functional Status I-5.1 Metric: 40% of individuals receiving specialized interventions who demonstrate improved functional status on the standardized Adult Needs and Strengths Assessment instrument and/or the DLA assessment tool a. Numerator: % individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. b. Denominator: the number of individuals receiving specialized interventions c. Data source: Standardized functional assessment instruments d. Rationale/Evidence: see project goal Milestone 7 Estimated Incentive Payment: $ 95,815	**Improvement Milestone**: I-5.1 Milestone: Functional Status I-5.1 Metric: The % of individuals receiving specialized interventions who demonstrate improved functional status on the standardized Adult Needs and Strengths Assessment instrument and/or the DLA assessment tool a. Numerator: 100% individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. b. Denominator: the number of individuals receiving specialized interventions c. Data source: Standardized functional assessment instruments d. Rationale/Evidence: see project goal Milestone 10 Estimated Incentive Payment:$ 72,880
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $287,686	Year 3 Estimated Milestone Bundle Amount: $353,658	Year 4 Estimated Milestone Bundle Amount: $ 287,447	Year 5 Estimated Milestone Bundle Amount: $ 218,460

135222109.2.2	2.13.2	2.13.2	Provide an intervention for a targeted behavioral health population
Gulf Coast Center			135222109
Related Category 3 Outcome Measure(s):	135222109.3.7	IT-10.1	OD-10 Quality of Life/Functional Status
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,147,251			

PROJECT OPTION: 2.12.1 Implement/Expand Care Transitions Programs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 139172412.2.1
PERFORMING PROVIDER NAME/TPI: Memorial Medical Center of East Texas-Lufkin/139172412

Provider: Memorial Medical Center of East Texas—Lufkin ("Memorial") is a 271 bed acute care facility in Lufkin, Texas, which has the largest emergency room (32 private patient rooms) in the East Texas area. Memorial serves a three county primary service area with a population of approximately 142,268 and a nine county secondary service area with a population of approximately 239,338.

Intervention(s): We will implement an inter-disciplinary and inter-provider team to standardize post-discharge planning and support processes across the continuum of care. This will include conducting an assessment and establishing linkages with community-based organizations to create a support network for targeted patients post-discharge. Additionally, this will include the development and implementation of validated risk assessment tool and patient identifications system for hospital admissions

Need for the project: When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. By concentrating on a coordinated approach by health care providers and providing tools to enable successful adoption of desired compliance, patients will have a greater chance of succeeding in adhering to the discharge plan and thus avoiding readmission. No patients currently receive the standardized evidence based intervention that will be implemented through this project and the baseline 30 day all cause readmission rate is 20%.

Target population: Target population is adults age 18 and over with multiple chronic medical conditions who reside in Memorial's service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. Memorial had approximately 87,700 patient encounters last year, and approximately 30% of these encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients benefiting from this project will be Medicaid and uninsured patients. Additionally, the validated risk assessment tool and patient identifications system that will be developed and implemented for this project focuses on Medicaid admissions; thus 100% of the patients benefiting from this aspect of the project will be Medicaid patients.

Category 1 or 2 expected patient benefits: By DY5, 75% of patients in the target population will receive the standardized evidence based intervention according to the clinical protocols and guidelines developed for this project.

Category 3 outcomes: All cause 30 day all cause readmission rate will be reduced to 18% by year 4, and reduced to 16% by year 5.

PROJECT DESCRIPTION:

We will implement an inter-disciplinary and inter-provider team to standardize processes across the continuum of care to reduce 30 day acute care re-admissions. Target population is adults age 18 and over with multiple chronic medical conditions who reside in Memorial Health System of East Texas' service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. When used as a reference, the Texas Medical Foundation data defines the "Lufkin Community" as the following zip codes: 75834, 75845, 75864, 75901, 75902, 75903, 75904, 75915, 75926, 75929, 75934, 75936, 75939, 75941, 75944, 75949, 75960, 75969, 75976, and 75980.

Through the implementation of standardized screenings to identify which patients being discharged from the hospital are in the target population and are potentially at risk of needing acute care services within 30 - 60 days, we estimate that this project will serve approximately 6,000 – 9,000 patients each year in DY3 – DY5. Through the administration of standardized, evidence-based interventions, per approved clinical protocols and guidelines, for target population patients identified by the screenings, we estimate that this project will serve approximately 250 – 400 patients in DY4 and approximately 450 – 600 patients in DY5, as measured by the number of patients projected to require and receive interventions per approved clinical protocols and guidelines. In the previous year, approximately 30% of Memorial's patient encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients served/benefiting from this project will be Medicaid and uninsured patients.

The project includes all of the following required core project components:

a) Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.). This review is being completed by a committee made of representatives of Case Management, Rehab Services, Pharmacy, Homecare and Nursing. Based on the preliminary results of this review, we expect that inpatients will be utilizing RED, area Nursing Homes will be using INTERACT and/or SBAR and hospitalists will be using BOOST.

b) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews. We are using the modified LACE tool to complete reviews on 10 patients who were readmitted within 30 days to determine common drivers of readmission. Additionally, we are using the

Institute of Healthcare Improvement, 2009 root cause analysis tool, to complete patient interviews on 10 patients to determine underlying reasons for readmission from the patient's point of view.

c) Integrate information systems so that continuity of care for patients is enabled. By implementing the Paragon system in March 2013, we will automate the completion of the LACE tool as a part of the Nursing admission assessment. The score will auto generate referrals to appropriate hospital service departments.

d) Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days. The LACE tool score will be communicated on the transfer form to the next downstream provider of care. We are conducting community in-services with 18 area Nursing Homes to provide education on the meaning of the LACE tool score.

e) Implement discharge planning program and post discharge support program. We are revising the discharge planning/support form materials and will be educating all nursing staff on use of the revised discharge planning/support form materials by mid-January 2013 This discharge planning/support form materials incorporate elements of RED and highlight the LACE tool score.

f) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers. There will be a cross-continuum team called the Forest County Healthcare Collaborative with representation from all 4 area acute care hospitals, nursing homes, home health agencies and retail pharmacies. The team will be conducting meetings with area Home Health Agencies and Nursing Homes who receive patients from Memorial Health System of East Texas to educate them on the readmission goals for this project.

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 this project to a broader patient population, and identifying key challenges associated with expansion of this project, including special considerations for safety-net populations. A readmissions team will be meeting every Monday at 11 a.m. to review progress from the past week. Additionally, each morning we will generate reports for readmitted patients in the past 24 hours and these reports will be discussed during 7 a.m. meetings with Hospitalists, 8 a.m. meetings with Case Managers, and 9 a.m. meetings with Nurse Managers.

Project Goal(s):

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Safe, effective, and efficient care

transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmissions. The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Challenges:

4. Misaligned incentives - readmission penalties are in effect for some, but not all, providers. Response will be a community education and outreach effort to these providers to demonstrate mutual benefit.
5. Cooperation among traditionally competing entities will be required. Nursing Homes, Home Health Agencies, Hospice, Inpatient and Outpatient Rehab Pressure for lowered hospital length of stay. Response will be to form a core group of providers from all levels of care to meet quarterly to review progress of project, share experiences and offer input to the process.
6. New IS system install scheduled for March 2012. Response will be to use a four person team to develop the tools in time for them to be built into the system, or to build "placeholders" in the system until the tools are done.

The 5-Year Expected Outcome(s):

By DY5, 75% of patients in the target population will receive the standardized evidence based intervention according to the clinical protocols and guidelines and all cause readmission rate will be reduced to 16%.

Regional Goals:

Region Wide 2 Goals

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce.

STARTING POINT/BASELINE:

No patients currently receive the standardized evidence based intervention and the baseline 30 day all cause readmission rate is 20%.

RATIONALE:

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients

cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home- and community-based services, etc. Patients with limited resources have a difficult time adhering to discharge prescription and other provisions due to limited resources. By concentrating on a coordinated approach by health care providers and providing tools to enable successful adoption of desired compliance, patients will have a greater chance of succeeding in adhering to the discharge plan and thus avoiding readmission. According to the Texas Region 2 Health Partnership, Angelina, Polk and San Augustine Counties have higher than State average rates for adult smoking, obesity, physical inactivity and preventable hospitalizations.

Unique Community Need Identification Numbers:

- CN.1 Access Barriers: Lack of Personal Resources
- CN.2 Access Barriers: Lack of Insurance
- CN.3 Primary Care Physician Shortage
- CN.4 Specialty Care Physician Shortage
- CN.8 Mid-Level Provider Shortage
- CN.9 Pharmacist Shortage
- CN.10 High ED Utilization Rates
- CN.11 30 Day Readmission Rates
- CN.12 Chronic Diseases: Diabetes
- CN.13 Chronic Diseases: Obesity
- CN.14 Chronic Diseases: Heart & Vascular Related Diseases & Disorders
- CN.15 Chronic Diseases: Pulmonary Diseases
- CN.18 Cancer Incidence

Expansion or Enhancement:

A limited project was done in 2011 focused entirely on Medicare FFS patients with CHF as a primary diagnosis. This project was limited to identification of physician champions, implementation of best practices regarding testing on admission, utilization of the current IT system and standardized teaching of the patient/family using a pre-recorded nurse instructor. With this limited intervention, the 30 day re-hospitalization rate decreased from 2010 baseline of 31.4% to 20% in 2012q1. This project significantly enhances the existing and very limited system reform initiative.

RELATED CATEGORY 3 OUTCOME MEASURE(S):

IT-3.1 All Cause 30 day readmission rate reduction. This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible

condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from th e volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. The measure was developed for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. The following was used: the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.

Category 3 Outcome Measures are:
Year 2 Process Milestone 1 is P-1 Project Planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
Year 3 Process Milestone 2 is P-2 Establish baseline rates and P-3 Develop and test systems.
Year 4 IT-3.1 All Cause 30 day readmission rate reduction.
Year 5 IT-3.1 All Cause 30 day readmission rate reduction.

The reduction of all-cause 30 day readmissions is a priority because it is potentially avoidable patient harm. Use of models such as the Coleman CYI model have reduced readmissions as much as 44% in high risk populations.

RELATIONSHIP TO OTHER PROJECTS:

2.12.2 This project relates to 2.12.2 in that it will use some of the same interdisciplinary teams and coalition of downstream providers in both projects.
This project's focus on expanding primary care capacity through standardized clinical protocols and emphasis on care transitions and receiving care at the right time in the right setting ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation/expansion of care transitions programs along with these other Category 2 projects in our RHP: 139172412.2.1-Develop, implement and evaluate standardized clinical protocols and evidence - based care delivery model to improve care transitions; 094092602.2.4-Develop and implement a transitional care program between hospital, nursing home, and home health care home via a care transition coordinator; 094092602.2.7-Implement/expand care transitions programs (Obstetrics/STORK); 094092602.2.5 - Implement a care transitions program care management registry.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the

region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

2.12.1 Standardize Clinical Protocols for Care Transitions

I. Population Affected
   - Measure: All adults over 18 years with multiple chronic medical conditions.
   - Score: 3 points awarded for significant population affected, and 1 extra point for Medicaid/Uninsured population.

J. Severity
   - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.

K. Cost Effectiveness
   - Score: 4 points awarded for a low cost per person.

L. Community Benefit
   - Score: 4 points awarded; 1 for quality; 1 for cost; 1 for transformative; 1 for collaborative.

139172412.2.1	2.12.1	2.12.1 (A-G)	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions.
Memorial Medical Center of East Texas-Lufkin			139172412
Related Category 3 Outcome Measure(s):	139172412.3.3	IT- 3.1	IT- 3.1 Potentially Preventable Re-Admissions-30 day Readmission Rates (PRPs)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-4 Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge. P-4.1 Metric**:** Care transitions assessment Baseline/Goal: Submission of care transitions assessment and resource planning documents. Data Source: Care Transitions assessment, resource planning documents, and coalition meeting minutes Milestone 1 Estimated Incentive Payment (maximum amount): $514,887	**Milestone 2** P-5 Using a validated risk assessment tool, create a patient identifications system. P-5.1. Metric: Patient stratification system. Baseline/Goal: Development and implementation of validated risk assessment tool and patient identifications system for Medicaid admissions Data Source: Risk assessment tool and patient stratification report and description of provider utilization of report findings. Milestone 2 Estimated Incentive Payment: $561,714	**Milestone 3I**-11 Improve the percentage of patients in the defined population receiving standardized care according to the approved clinical protocols and guidelines I-11.1. Metric: Number over time of those patients in the target population receiving standardized, evidence-based interventions per approved clinical protocols and guideline Baseline/Goal: 50% of patients in the target population receive standardized, evidence-based interventions per approved clinical protocols and guideline Data Source: Registry or EHR report/analysis Milestone 3 Estimated Incentive Payment: $563,347	**Milestone 4I**-11 Improve the percentage of patients in the defined population receiving standardized care according to the approved clinical protocols and guidelines I-11.1. Metric**:** Number over time of those patients in the target population receiving standardized, evidence-based interventions per approved clinical protocols and guideline Baseline/Goal: 75% of patients in the target population receive standardized, evidence-based interventions per approved clinical protocols and guideline Data Source: Registry or EHR Milestone 4 Estimated Incentive Payment: $465,374
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $514,887	Year 3 Estimated Milestone Bundle Amount: $561,714	Year 4 Estimated Milestone Bundle Amount: $563,347	Year 5 Estimated Milestone Bundle Amount: $465,374
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,105,321			

PROJECT OPTION: 2.12.2 Implement One or More Pilot Interventions in Care Transitions Targeting one or more patient care units or a Defined Patient Population.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 139172412.2.2
PERFORMING PROVIDER NAME/TPI: Memorial Medical Center of East Texas-Lufkin/139172412

Provider: Memorial Medical Center of East Texas—Lufkin ("Memorial") is a 271 bed acute care facility in Lufkin, Texas, which has the largest emergency room (32 private patient rooms) in the East Texas area. Memorial serves a three county primary service area with a population of approximately 142,268 and a nine county secondary service area with a population of approximately 239,338.

Intervention(s): We will develop and implement evidence-based protocols for effective communication with patients and families during and post discharge to improve adherence to discharge and follow up care instructions. Additionally, we will establish a process for hospital based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education which address activity, diet, medications, follow up care, weight, and worsening symptoms; and where appropriate, additional patient education and/or coaching as identified during discharge.

Need for the project: When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. No patients currently receive the care according to the standardized care transitions process that will be developed and implemented for this project. For the period 2011Q2 through 2012Q1 AMI 30 day readmission rate for Memorial, Lufkin was 9.09%, 14.29%, 14.29%, 30% and 22.73% respectively, for a cumulative readmission rate of 19% for the 6 month period.

Target population: The target population is non-Medicare adults age 18 and over with multiple chronic medical conditions who reside in Memorial's primary service area and secondary service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. Memorial had approximately 87,700 patient encounters last year, and approximately 30% of these encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients benefiting from this project will be Medicaid and uninsured patients.

Category 1 or 2 expected patient benefits: By DY5, 90% of the specified patient population will receive care according to the standardized care transitions process on discharge.

Category 3 outcomes: The Acute Myocardial Infarction (AMI) 30 day readmission rate will be reduced to 17% by year 4, and 15% by year 5.

PROJECT DESCRIPTION:

We will develop and implement evidence-based protocols for effective communication with patients and families during and post discharge to improve adherence to discharge and follow up care instructions. Additionally, we will establish a process for hospital based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education which address activity, diet, medications, follow up care, weight, and worsening symptoms; and where appropriate, additional patient education and/or coaching as identified during discharge. The target population is non-Medicare adults age 18 and over with multiple chronic medical conditions who reside in Memorial Health System of East Texas' service area. The primary service area is Angelina, Polk and San Augustine Counties. The secondary service area is Houston, Trinity, San Jacinto, Tyler, Jasper, Newton, Sabine, Shelby and Nacogdoches Counties. When used as a reference, the Texas Medical Foundation data defines the "Lufkin Community" as the following zip codes: 75834, 75845, 75864, 75901, 75902, 75903, 75904, 75915, 75926, 75929, 75934, 75936, 75939, 75941, 75944, 75949, 75960, 75969, 75976, and 75980. Through the implementation and administration of evidence-based care coordination protocols/processes for communication with patients and families during and post discharge from the hospital, we estimate that this project will serve approximately 6,000 – 7,200 patients in DY4 and 6,300 – 7,500 patients in DY5, as measured by the projected number of patients in the target population that will receive the standardized care transitions protocol/process during or post discharge from the hospital. In the previous year, approximately 30% of Memorial's patient encounters were with Medicaid and uninsured patients. Therefore, we are expecting that a similar percentage of the patients served/benefiting from this project will be Medicaid and uninsured patients.

Project Goal(s):

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Challenges:

1. Misaligned incentives - readmission penalties are in effect for some, but not all, providers. Response will be a community education and outreach effort to these providers to demonstrate mutual benefit.

2. Cooperation among traditionally competing entities will be required. Nursing Homes, Home Health Agencies, Hospice, Inpatient and Outpatient Rehab Pressure for lowered hospital length of stay. Response will be to form a core group of providers from all levels of care to meet quarterly to review progress of projects, share experiences and offer input to the process.
3. New IS system install scheduled for March 2012. Response will be to use a four person team to develop the tools in time for them to be built into the system, or to build "placeholders" in the system until the tools are done.

The 5-Year Expected Outcome(s):

By DY5, 90% of the specified patient population will receive care according to the standardized care transitions process on discharge, and the Myocardial Infarction (AMI) readmission rate will be reduced by 4%.

Regional Goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce.

STARTING POINT/BASELINE:

No patients currently receive the care according to the standardized care transitions process on discharge. For the period 2011Q2 through 2012Q1 AMI 30 day readmission rate for Memorial Health System of East Texas, Lufkin was 9.09%, 14.29%, 14.29%, 30% and 22.73% respectively, for a cumulative readmission rate of 19% for the 6 month period.

RATIONALE:

Relation Between Project Choices and Community Needs:

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home- and community-based services, etc. Patients with limited resources have a difficult time adhering to discharge prescription and other provisions due to limited resources. By concentrating on a coordinated approach by health care providers and providing tools to enable successful adoption of desired

compliance, patients will have a greater chance of succeeding in adhering to the discharge plan and thus avoiding readmission. According to the Texas Region 2 Health Partnership, Angelina, Polk and San Augustine Counties have higher than State average rates for adult smoking, obesity, physical inactivity and preventable hospitalizations. Further, Heart Failure and Shock DRGs 292 and 291 account for 51.3% of all 30 day readmissions in the Lufkin Community.

Unique Community Need Identification Numbers:

- CN.1 Access Barriers: Lack of Personal Resources
- CN.2 Access Barriers: Lack of Insurance
- CN.3 Primary Care Physician Shortage
- CN.4 Specialty Care Physician Shortage
- CN.7 Dentist Shortage
- CN.8 Mid-Level Provider Shortage
- CN.9 Pharmacist Shortage
- CN.10 High ED Utilization Rates
- CN.12 Chronic Diseases: Diabetes
- CN.13 Chronic Diseases: Obesity
- CN.14 Chronic Diseases: Heart & Vascular Related Diseases & Disorders
- CN.15 Chronic Diseases: Pulmonary Diseases

Expansion or Enhancement:

A limited project was done in 2011 focused entirely on Medicare FFS patients with CHF as a primary diagnosis. This project was limited to identification of physician champions, implementation of best practices regarding testing on admission, utilization of the current IT system and standardized teaching of the patient/family using a pre-recorded nurse instructor. With this limited intervention the 30 day re-hospitalization rate decreased from 2010 baseline of 31.4% to 20% in 2012q1.This project significantly enhances an existing and very limited system reform initiative.

RELATED CATEGORY 3 OUTCOME MEASURES:

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[1] Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates.

Process Milestone P-1 Project Planning

Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation.

Process Milestone P-2 Establish baseline rates.

Process Milestone 3

P-3 Develop and test systems.

---

[1] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75-91.

Outcome Improvement Target 1 [IT-1.1]:
IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure).
Outcome Improvement Target 2 [IT-1.1]:
IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure).

Heart Failure and Shock DRGs 292 and 291 account for 51.3% of all 30 day readmissions in the Lufkin Community. Standardized discharge processes including timely physician follow up, accurate medication reconciliation and follow up phone calls will reduce re- hospitalization rates in these patients.

RELATIONSHIP TO OTHER PROJECTS:

Many of same processes and interdisciplinary teams developed for the implementation of 2.12.2 will also be used in the implementation of 2.12.1. These are synergistic projects.

This project's focus on care transitions and coordination of care and emphasis on inpatient to outpatient, post-acute care and home care settings ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of one or more pilot intervention(s) in care transitions targeting a defined patient population along with these other Category 2 projects in our RHP: 139172412.2.2- Implement one or more pilot interventions in care transitions targeting one or more patient care units; 094092602.2.6 - Implement care transitions program; 109372601.2.1-Implement EpicCare link to improve clinical communication between UTMB and referring providers.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and

improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

2.12.2 Implement Pilot Interventions in Care Transitions

A. Population Affected
   - Score: 1 point awarded for relatively small population affected, and 1 extra point for Medicaid/Uninsured population.

B. Severity
   - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.

C. Cost Effectiveness
   - Score: 4 points awarded for a low cost per person.

D. Community Benefit
   - Score: 4 points awarded; 1 for quality; 1 for cost; 1 for transformative; 1 for collaborative.

139172412.2.2	2.12	2.12.2	Implement One or More Pilot Interventions in Care Transitions Targeting one or more patient care units or a Defined Patient Population	
Memorial Medical Center of East Texas-Lufkin				139172412
Related Category 3 Outcome Measure(s):	139172412.3.4	IT-3.5	Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-1 Develop or implement best practices or evidence-based protocols for effective communication with patients and families during and post discharge to improve adherence to discharge and follow up care instructions. Metric 1: P-1.1 Care Transitions protocols. Submission of protocols Baseline/Goal: Development and submission of consistent process/protocols based on identified best practices. Data Source: Protocols, Care transitions program materials. Milestone 1 Estimated Incentive Payment (maximum amount): $454,312	**Milestone 2**: P-3 Establish a process for hospital based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education which address activity, diet, medications, follow up care, weight, and worsening symptoms; and where appropriate, additional patient education and/or coaching as identified during discharge. Metric 2: P-3.1 Care Transitions protocols. Submission of protocols Baseline/Goal: Develop and implement a consistent process based on identified best practices. Data Source: Care Transitions program materials. Milestone 2 Estimated Incentive Payment: $495,630		**Milestone 3**: I-14 Implement standard care transition processes in specified patient populations. Metric 3: I-14.1 Measure adherence to processes Goal: 85% of the specified patient population receive standardized Care Transitions Process on discharge. Data Source: EHR, training materials. Milestone 3 Estimated Incentive Payment: $497,071	**Milestone 4**: I-14 Milestone: Implement standard care transition processes in specified patient populations. Metric 4: I-14.1 Measure adherence to processes Goal: 90% of the specified patient population receive standardized Care Transitions Process on discharge. Data Source: EHR, training materials. Milestone 4 Estimated Incentive Payment: $410,624
Year 2 Estimated Milestone Bundle Amount:$454,312	Year 3 Estimated Milestone Bundle Amount: $495,630		Year 4 Estimated Milestone Bundle Amount: $497,071	Year 5 Estimated Milestone Bundle Amount: $410,624
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,857,637				

PROJECT OPTION: 2.6.2 Implement Evidence-Based Health Promotion Programs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 131030203.2.1
PERFORMING PROVIDER NAME/TPI: Nacogdoches Memorial Hospital (MH)/TPI: 131030203

Provider: Nacogdoches Memorial Hospital is a 216 bed hospital serving as the county hospital district in Nacogdoches. Nacogdoches serves as the county seat for Nacogdoches County. It is one of the largest towns in the region with a population of 32,996 individuals. Nacogdoches County is a 946.5 square mile area and has a population totaling 64,524 reported by the Census Bureau for 2010.
Intervention(s): This project will implement an evidence-based self-management program to improve primary and preventative care to the Medicaid and underserved populations of Nacogdoches County.
Need for the project: Currently a comprehensive chronic disease self-management program is not available to the underserved population in Nacogdoches County. This project will allow Medicaid and underserved patients to manage their chronic disease and prevent them from receiving care in the emergency room, when the chronic disease has evolved into an acute medical emergency.
Target population: The target population is Medicaid and uninsured patients in Nacogdoches and surrounding counties who have one or more chronic conditions.
Category 1 or 2 expected patient benefits: The project seeks to provide chronic disease self-management education to approximately 225 patients with one or more chronic conditions in DY2-DY5.
Category 3 outcomes:
IT-1.1: Our goal is to increase the percentages of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 5% in DY2, by 10% in DY4 and by 15% in DY5.

PROJECT DESCRIPTION:
Implement an evidence-based self-management program to improve primary and preventive care to the indigent and underserved populations of Nacogdoches County.

Project goal(s):
Implement an evidence-based disease self-management program in Nacogdoches County for one or more patient populations diagnosed with selected chronic disease(s) or with Multiple Chronic Conditions (MCCs). The program will be led by community health workers (CHWs) in community settings and will enable patients to manage their chronic disease, promote healthy lifestyles and navigate the healthcare system for better patient compliance.

The 5-year expected outcome(s):
The 5-year expected outcome for the project: Establish Self-Management Programs for Health Promotion is to impact the health of diabetics by improving blood pressure control. The

effectiveness of this project will be measured by the reduction of patients 18-75 years of age with diabetes (type 1 or type 2) who have controlled blood pressure.

Anticipated challenges:

According to the Behavioral Risk Factor Surveillance System, chronic disease and associated risk factor prevalence is high in Nacogdoches County: 9.3% have diabetes, 27.5% have high blood pressure, 43 0% have high cholesterol, 30.8% are smokers and 31.8% are obese. Challenges associated with implementing the project include the low rates of health literacy among Nacogdoches residents and the nature of East Texans to live sedentary lifestyles and consume high fat convenience foods. Educating patients on the importance of healthy lifestyles, increasing their capacity to make healthy choices and enabling them to take responsibility for their health will be important factors in chronic disease self management.

Regional goals:

This project contributes to the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

Currently a comprehensive chronic disease self-management program is not available to the underserved population in Nacogdoches County. Patients diagnosed with chronic disease or associated risk factors receive limited education from healthcare providers due to a lack of time and resources. Individuals who have Medicare or private insurance can be seen by primary care physicians in their offices. In this setting, the patient is seen for approximately 15 minutes and then scheduled for a follow up appointment several months later. Whereas the, uninsured patients or those with Medicaid are even less fortunate due to their sole means of receiving care is from the emergency room, when the chronic disease has evolved into an acute medical emergency. Few, if any, patients receive education related to managing their disease or necessary precautions to improve and maintain good health.

RATIONALE:

Relation between Project Choices and Community Needs:

The self-management program led by community health workers is an evidence based strategy improving health status among individuals with chronic disease. This education program along with services available at the primary care clinic (i.e., care management, social services, chronic disease management registry) will enhance the quality and consistency of the primary and preventive care provided, while reducing preventable hospitalizations and readmissions.

Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

To properly implement this project the following milestones and metrics have been selected: In Year 2 the process milestone is Memorial Hospital will implement, document and test an evidence-based self-management program for a target population. The metrics, baseline and goal have been chosen to reasonably meet this goal in Year 2. In Year 3, the process milestone will be further implement, document and test the evidence-based self-management program. In Year 4, the improvement milestone will be to identify at least 100 members of the target population (MH clinic patients with one or more chronic disease or related risk factor) and enroll them in the self-management program. In Year 5, the improvement milestone will be to identify at least 125 members of the target population (MH clinic patients with one or more chronic disease or related risk factor) and enroll them in the self-management program. A quality improvement process milestone has been selected for the project: in Years 3-5, community health workers will attend 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. In Years 4-5, the staff will implement the "raise the floor" improvement initiatives established at the semiannual meetings.

Unique Community Need Identification numbers:

CN.2, CN.3, CN.10, CN.11, CN.12

Expansion or enhancement

This project is a new initiative for Memorial Hospital, currently serving as a provider who primarily focuses on disease-focused care and switching to provide more health-focused care. Implementing an efficient and effective self-management program for health promotion will treat patients on a patient-centered disease management model. This project will collaborate with the entire Memorial Hospital system of care to ensure that patients are provided the right care in the right setting.

No part of this DSRIP project is currently funded by DHHS.

RELATED CATEGORY 3 OUTCOME MEASURES:

The Outcome Measure chosen for this project is [IT-1.11]: Diabetes Care: Blood pressure control. The following Process and Outcome Improvement milestones have been selected:

P-2-Establish baselines of the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure control (<140/80 mm Hg).

IT-1.11- Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg).

This outcome measure was chosen because of the high diabetes death rate and the amount of complications among diabetics in Nacogdoches County. Measuring the improvements in blood pressure control among diabetics will enable Memorial Hospital to see how effectively the community health workers are implementing the self-management program.

RELATIONSHIP TO OTHER PROJECTS:

This DSRIP project proposal, Establish Self-Management Programs for Health Promotion, relates to the other Memorial Hospital projects through the project Expand Primary Care Capacity (131030203.1.1), which establishes a primary care clinic that will serve as the central hub for DSRIP projects. The project, Expand Primary Care Capacity- Perinatal Care (131030203.1.2) will serve as a referral source for mothers and children to receive primary care once their postpartum care is complete. The project, Implement a Chronic Disease Management Registry (131030203.1.3), will ensure a continual and efficient management of the primary care clinic's patients with chronic disease. The case management of clinic patients will be documented in the care registry. Clinic patients with chronic disease will be referred to this project for health education and training on chronic disease self-management.

This project's focus on establishing a disease self-management program for chronic disease in Nacogdoches County and emphasis on using Community Health workers ties to these Category 1 and 2 projects in our RHP: 112671602.2.1, 112706003.2.1, 138296208.2.1, 094092602.2.6, 094148602.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation of evidence based disease self management program in Nacagdoches County for one or more patient populations with selected chronic diseases. There are no other related Category 2 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will

establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). The new primary care clinic will provide approximately 60,060 patient visits over the four year project timeframe. Based on clinic usage in Memorial Hospital's current clinics, 25% of the patients served will be expected to have one or more chronic conditions. The project is expected to cost $639,554 over the four year timeframe. If the project enrolls at least 225 patients, the project cost will be approximately $2,842 per patient. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, is transformative and will be a collaborative approach to healthcare improvement in Nacogdoches.

131030203.2.1	2.6	2.6.2	Establish Self-Management Programs for Health Promotion	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	131030203.3.5	IT 1.11	Diabetes care: Blood Pressure control	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-3]: Implement, document and test an evidence-based self-management program for a target population. Metric 1 [P-3.1.]: Document implementation strategy and testing outcomes. Baseline/Goal: In 2012, there is not an evidence-based self-management program in the MH system of care; goal of self-management program in place for health promotion. Data Source: Documentation of program implementation. Milestone 1 Estimated Incentive Payment: $155,987	**Milestone 2** [P-3]: Implement, document and test an evidence-based self-management program for a target population. Metric 1 [P-3.1.]: Document implementation strategy and testing outcomes. Baseline/Goal: Year 2 implementation of an evidence-based self-management program; goal of improvements and further implementation of self-management program in place for health promotion. Data Source: Documentation of program implementation. Milestone 2 Estimated Incentive Payment: $77,481.50 **Milestone 3 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: In Y2, community health workers (CHWs) have not	**Milestone 4** [I-6]: Identify at least 100 members of target population (MH clinic patients with one or more chronic disease or related risk factor) enrolled in the evidence-based self management program. Metric 1 [I-6.1]: Measured by the number of patients enrolled in the evidence-based self-management program. Baseline/Goal: Number of patients enrolled in the program in Year 3; Goal of 100 patients enrolled in Year 4. Data Source: Program records, and patient chronic care registry Milestone 4 Estimated Incentive Payment: $93,858.50 **Milestone 5 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: In Y3, CHWs	**Milestone 6** [I-6]: Identify at least 125 members of target population (MH clinic patients with one or more chronic disease or related risk factor) enrolled in the evidence-based self management program. Metric 1 [I-6.1]: Measured by the number of patients enrolled in the evidence-based self-management program. Baseline/Goal: Number of patients enrolled in the program in Year 4; Goal of 125 patients enrolled in Year 5. Data Source: Program records, and patient chronic care registry Milestone 6 Estimated Incentive Payment: $70.443.50 **Milestone 7 [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. Metric 1 [P-8.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: In Y4, CHWs

131030203.2.1	2.6	2.6.2	Establish Self-Management Programs for Health Promotion	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	131030203.3.5	IT 1.11	Diabetes care: Blood Pressure control	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	participated in collaborative learning meetings; goal of participation in at least two collaborative learning meetings per year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment $77,481.50		participated in at least two collaborative meetings; goal of implementing the "raise the floor" improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 5 Estimated Incentive Payment: $93,858.50	participated in at least two collaborative meetings and implemented improvement initiatives; goal of implementing additional "raise the floor" improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 Estimated Incentive Payment: $70,443.50
Year 2 Estimated Milestone Bundle Amount: $155,987	Year 3 Estimated Milestone Bundle Amount: $154,963		Year 4 Estimated Milestone Bundle Amount: $187,717	Year 5 Estimated Milestone Bundle Amount: $140,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $639,554				

PROJECT OPTION: 2.4.1-Redesign to Improve Patient Experience

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 131030203.2.2-Pass 2
PERFORMING PROVIDER NAME/TPI: Nacogdoches Memorial Hospital/131030203

Category Project Area*:* 2.4 – Redesign to Improve Patient Experience
Provider: Nacogdoches Memorial Hospital is a 216 bed hospital serving as the county hospital district in Nacogdoches. Nacogdoches serves as the county seat for Nacogdoches County. It is one of the largest towns in the region with a population of 32,996 individuals. Nacogdoches County is a 946.5 square mile area and has a population totaling 64,524 reported by the Census Bureau for 2010.
Intervention(s): This project will improve the patient experience by implementing improvement processes. Components include organizational integration and prioritization of patient experience, data and performance measurement, implementation of processes to improve patient's experience in getting through to the clinical practice, and development of 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.
Target population: The target population is Medicaid and uninsured patients served by Nacogdoches Memorial Hospital.
Category 1 or 2 expected patient benefits: The project seeks to improve the experience for all patients who receive care at Memorial Hospital.
Category 3 outcomes: IT- 4.5: Improve the patient fall rate by 5% over baseline in Year 4 and by 10% over baseline in Year 5.

Project Description:

This project will implement processes that will redesign the Memorial Hospital (MH) system of care to improve the patient experience.

Project goal(s):

To implement patient improvement processes including a nurse-nurse and nurse-patient/family communication system at Memorial Hospital. Project components will include: organizational integration and prioritization of patient experience, data and performance measurement, implementation of processes to improve patient's experience in getting through to the clinical practice, and development of 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.

Anticipated challenges:

Memorial Hospital recognizes that this project will require an organizational and cultural change for nursing services. It will be necessary for nursing staff to embrace this technology to benefit the patients and their family members. To overcome this challenge, the organization will dedicate time to training nurses to ensure user confidence and familiarity with the new communication technology. Nursing administration will need to invest time in reporting data from the communication system to monitor nurse compliance and response times to patient calls. In addition to system monitoring, administration will also provide ongoing feedback to floor nurses facilitating ongoing training.

The 5-year expected outcome(s):

The 5-year expected outcome for Redesign to Improve Patient Experience is to reduce the Patient Fall Rate at Memorial Hospital. The project expects to improve patient satisfaction with the nurses' response time to the bedside. If nurses are able to respond to the patients in a timely manner, it will prevent patients from getting out of the bed without nurse assistance and reduce falls.

Regional goals:

This project contributes to the following regional goals:

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

Starting Point/Baseline:

In recent years Memorial Hospital Customer Service Initiatives have been launched to improve the patient experience. In the last two years, intense efforts to improve customer service awareness within our employee ranks have been facilitated by a marketing consultant. House-wide customer service forums were facilitated by the consultant in October 2010 and follow up seminars were provided to new employees hired after that date in 2012.

Memorial Hospital established three different committees to engineer our customer service efforts on a monthly to a bimonthly basis. The Advisory Council (a multidisciplinary employee committee) meets to discuss issues that affect employee morale, in an effort to head off problems. The Care Committee was formed to celebrate successes in customer service and to reward departments for improvement. The Care Committee also notifies departments when patients write favorable reviews to the local newspaper and creates celebratory banners when certain goals are met on Press Ganey. The Wow Committee seeks to highlight random acts of kindness performed by employees who go above and beyond their expected duties by providing great customer service moments, whether it be taking care of a patient, a visitor or fellow employee. These Wow Moments are featured on Facebook, billboards, and the hospital website.

Customer service meetings with individual departments and various nursing units have addressed topics such as how to transition patients effective through our systems, how to improve our discharge processes and how to inspire team spirit among staff. Director have been trained to navigate the Press Ganey website as a resource for customer service improvement.

Rationale:

Relation between Project Choices and Community Needs:

A recent review of hospital performance data (HCAHPS-Survey Dimensions) reveals that Memorial Hospital has work do to improve the patient experience. In survey data from October 2010 to September 2011, the Overall Rating of the Hospital was 64, while the National Threshold was 66.02. Memorial did perform slightly over national thresholds in six of the

categories: Communication with Nurses (76), Communication with Doctors (82), Responsiveness of Hospital Staff (65), Pain Management (70), Communication about Medications (59), and Cleanliness and Quietness (63). The rating for Discharge Information (79) was less than the National Threshold (81.93).

Falls account for a significant portion of injuries in hospitalized patients. One of the outcome improvements of this DSRIP project is to reduce the patient fall rate. This objective of this is to reduce the risk of patient harm resulting from falls. A look at Memorial Hospitals' recent assessment of falls shows us that in FY 2012 (July 2011 – June 2012) there were 80 falls, with an average of 2.7 falls/1000 patient days. The goal is to maintain less than 3 patient falls/1000 patient days. Four months out of the measurement period the fall rate did not meet the goal.

Based on the CNA, Nacogdoches has a higher percentage of Medicaid clients than the Texas average and also has populations that are federally designated as Medically Underserved Populations. A significant amount of the patients seen by Memorial Hospital are Medicaid or underserved clients. An improved patient experience at MH will provide these and all clients with quality health care.

To properly implement this project the following milestones and metrics have been selected.
In Year 2 the process milestone is:

> P-1: Appoint an executive accountable for experience performance or create a percentage of time in an existing executive position for experience performance.

In Year 3, the process milestone is:

> P-12: Implement and sustain at least one organization strategy aimed at improving patient, family and/or employee experience.

The metrics, baseline and goal have been chosen to reasonably meet this goal in Year 2.
In Year 4, the process milestone is:

> P-12: Continue implementation of organizational strategy aimed at improving patient, family and/or employee experience.

The selected metrics, baseline and goals (as detailed in Table A) will document the ongoing implementation of organizational strategies for improved patient experience.
In Year 5, the improvement milestones are:

> I-18: Develop regular organizational displays of patient experience data and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients.

A quality improvement process milestone (P-18) has been selected for the project: in Years 3-5, hospital performance improvement staff will attend 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. In Years 4-5, the staff will implement the "raise the floor" improvement initiatives established at the semiannual meetings.

Required core project components:

a) Organizational integration and prioritization of patient experience. This project will be integrated throughout the hospital, with an emphasis on implementing the nurse-nurse and nurse-patient/family communication system on all direct patient care units. Improving the

patient experience has been an ongoing project of system improvement to best serve the patient. This project will allow for additional resources to be directed towards a consistent quality experience for the patient.

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. The hospital currently utilizes the Press Ganey monitoring system to collect HCAHPS measures. Throughout this project Memorial Hospital will continue to utilize this system or similar product to collect data on the patient experience.

c) Implementing processes to improve patient's experience in getting through to the clinical practice. As detailed in the selected process milestones for this project, in Years 2-4, the Hospital will implement a systems-wide approach of organizational strategies to improve the patient experience.

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. Memorial Hospital currently utilizes the Press Ganey monitoring system as an independent survey vendor to collect HCAHPS measures. Throughout this project Memorial Hospital will continue to utilize this system or similar product to collect data on the patient experience.

Unique Community Need Identification numbers:

CN.11

Expansion or enhancement

The nurse-patient communication system is a new initiative for Memorial Hospital. Recently, the Hospital has been implementing a patient satisfaction improvement project; however, lack of funding has reduced the Hospital's ability to invest in implement innovative processes to improve the patient experience. The Hospital is at a point where resources are needed for technology improvements for the nurse-patient communication system that will enhance the patient experience.

Currently, there are no related projects funded by the U.S. DHHS. No part of this DSRIP proposal is currently funded by DHHS.

Related Category 3 Outcome Measures:

The Outcome Measure chosen for this project is [IT-4.5] Patient Fall Rate. The following Process and Outcome Improvement milestones have been selected:

Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Process Milestone 2 [P-2]: Establish baseline rates.

Outcome Improvement Target 1 & 2 [IT-4.5]: In Year 4, improve the patient fall rate by 5% over baseline and in Year 5, by 10% over baseline. This outcome measure was chosen because of the relationship between hospital readmissions and quality of care being well documented.

Relationship to other Projects:

This DSRIP project proposal Redesign to Improve Patient Experience will link with the other Nacogdoches DSRIP projects. The project will improve patient experience through effective communication and education to the patient provided by the nurse. The project, Expand

Primary Care Capacity (131030203.1.1) will serve as the central hub for all Memorial Hospital projects. Clinic primary care providers will refer patients to specialists for the Expand Specialty Care Capacity (131030203.1.4) and which will be located within the same clinic. The project, Implement a Chronic Disease Management Registry (131030203.1.3), will ensure a continual and efficient management of the clinic's patients with chronic disease. The case management of clinic patients will be documented in the care registry.
This project's focus on improving communication and emphasis on the patient and family's experience ties to these Category 1 and 2 projects in our RHP: 131030203.2.2, 1363814.5.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:
This project focuses on improving the patient experience along with these other Category 2 projects in our RHP: 1363814.5.2.1- Implement Processes to Measure and Improve Patient Experience; 131030203.2.2- Redesign to Improve Patient Experience

Plan for Learning Collaborative:
Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.
To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:
The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3%. This project has the potential to reach all patients served by Memorial Hospital. The project is expected to cost approximately $2 million over the four years. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, is transformative and will be a collaborative approach to healthcare improvement in Nacogdoches.

131030203.2.2	2.4.1	2.4.1 (A-D)	Redesign to Improve Patient Experience	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	**131030203.3.7**	**IT 4.5**	**Patient Fall Rate**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Appoint an executive accountable for experience performance or create a percentage of time in an existing executive position for experience performance. Metric 1 [P-1.1.]: Documentation of an executive assigned the responsibility of experience performance. Baseline/Goal: Currently there is not an executive at MH assigned directly to experience performance. Goal: Appoint an executive responsible for experience performance. Data Source: Organization Chart or job description Milestone 1 Estimated Incentive Payment: $509,904	**Milestone 2** [P-12]: Implement and sustain at least one organizational strategy aimed at improving patient, family and/or employee experience. Metric 1 [P-12.1]: Number of experience improvement initiatives conducted. Baseline/Goal: The number of organizational strategies in Y2; Goal to implement at least one organizational strategy to improve patient experience. Data Source: Documentation of strategy implemented. Milestone 2 Estimated Incentive Payment: $264,852.50 **Milestone 3 [P-18]:** 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. Metric 1 [P-18.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: In Y2, hospital performance improvement staff have not participated in collaborative	**Milestone 4** [P-12]: Continue implementation of organizational strategy aimed at improving patient, family and/or employee experience. Metric 1 [P-12.1]: Number of experience improvement initiatives conducted. Baseline/Goal: The number of organizational strategies in Y3; Goal to implement or expand at least one organizational strategy to improve patient experience. Data Source: Documentation of strategy implemented. Milestone4 Estimated Incentive Payment: $273,913.50 **Milestone 5 [P-18]:** 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. Metric 1 [P-18.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meetings. Baseline/Goal: In Y3, hospital performance improvement staff	**Milestone 6** [I-18]: Develop regular organizational displays of patient experience data and provide updates to employees on the efforts the organization is undertaking to improve the experience of the patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays about the organization's performance in the area of patient/family experience and CEO communication on experience improvement work. Baseline/Goal: The number of organization-wide displays about the organization's performance in the area of patient/family experience and CEO communication on experience improvement work in Y4; Goal of at least one display and one CEO communication distributed per quarter. Data Source: Documentation of display and internal communication. Milestone6 Estimated Incentive Payment: $217,813.50 **Milestone 7 [P-18]:** Participate in face-to-face learning (i.e. meetings or

131030203.2.2	2.4.1	2.4.1 (A-D)	Redesign to Improve Patient Experience	
Nacogdoches Memorial Hospital (MH)				131030203
Related Category 3 Outcome Measure(s):	**131030203.3.7**	**IT 4.5**	**Patient Fall Rate**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	learning meetings; goal of participation in at least two collaborative learning meetings per year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment*:* $264,852.50		participated in at least two collaborative meetings; goal of implementing the "raise the floor" improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 5 Estimated Incentive Payment*:* $273,913.50	seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-18.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meetings. Baseline/Goal: In Y4, hospital performance improvement staff participated in at least two collaborative meetings; goal of implementing the "raise the floor" improvement initiatives. Data Source: Documentation of "raise the floor" improvement Initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 Estimated Incentive Payment*:* $217,813.50
Year 2 Estimated Milestone Bundle Amount: $509,904	Year 3 Estimated Milestone Bundle Amount: $529,705		Year 4 Estimated Milestone Bundle Amount: $547,827	Year 5 Estimated Milestone Bundle Amount: $ 435,627
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,023,063				

PROJECT OPTION: 2.15.2 Implement other evidence-based project to integrate primary and behavioral health care services in an innovative manner

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.1
PERFORMING PROVIDER NAME/TPI: Spindletop Center/TPI 096166602

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop will co-locate primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. In addition, a mobile clinic will be purchased and equipped to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. The mobile clinic could also be used to provide physical and behavioral health services during disasters such as hurricanes. To supplement the benefits of integrating primary care with behavioral health services, Spindletop will implement Individualized Self Health Action Plan for Empowerment ("In SHAPE"), a wellness program for individuals with mental illness.

Need for project: The Region 2 Community Needs Assessment has identified the need for expanded physical health care in our area. Spindletop Center has determined further that many of our behavioral health clients do not have access to physical health care because they are uninsured or lack funds to pay for these services. Health clinics that serve indigent populations frequently do not have capacity to accept more patients and charge a fee higher than many clients are able or willing to pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits. Co-locating primary care providers in our behavioral health facilities and coordinating healthcare appointments will increase the likelihood that our clients will receive the physical health care they need.

Target: This project is targeted primarily to the more than 2200 "priority population" adult mental health clients that Spindletop serves. 54% of these clients are on Medicaid, with most of the remainder being uninsured indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: By integrating primary care with Spindletop's behavioral services, 1500 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of demonstration year 5. Addressing the physical health needs of clients will result in improved quality of life for these clients as well as reducing emergency

room visits and hospitalizations for more severe illnesses and diseases that occur when physical health is neglected.

- For demonstration year 2, the process milestone is to develop the integrated sites as reflected in the number of locations and providers participating in the integration project. In demonstration years 3-5, the improvement milestones will be the number of primary care appointments available. In DY3, the number of appointments will be 500; in DY4, appointments will be 1000; and in DY5, appointments will be 1500.
- Spindletop has selected improvement outcome measure OD-6 Patient Satisfaction, IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

PROJECT DESCRIPTION:

Goal: The goal of this project is to integrate primary care with the behavioral health care services Spindletop Center ("Spindletop") provides in order to improve care and access to needed health services for the clients we serve.

Description: Spindletop will co-locate primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. In addition, a mobile clinic will be purchased and equipped to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. The mobile clinic could also be used to provide physical and behavioral health services during disasters such as hurricanes.

To supplement the benefits of integrating primary care with behavioral health services, Spindletop will implement Individualized Self Health Action Plan for Empowerment ("In SHAPE"), a wellness program for individuals with mental illness. Behavioral health clients in the Jefferson, Orange, Hardin, and Chambers counties will receive proactive, ongoing care that keeps them healthy and empowers them to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care.

Challenges: Although Spindletop currently provides basic care such as labs and screenings for drugs, pregnancy, glucose and lipid profiles, we have not expanded other physical health care services due to funding limitations. The 1115 Waiver funds will allow Spindletop to provide more comprehensive physical health care services.

Hiring or contracting for primary care providers may be challenging as well. Initially, Spindletop will use one of its psychiatrists, who is a board-certified internal medicine doctor, to provide physical health care two days a week. As the program is expanded, Spindletop will contract or hire additional providers.

Outcomes: By integrating primary care with Spindletop's behavioral services, 1500 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of demonstration year 5. Addressing the physical health needs of clients will result in improved quality of life for these clients as well as reducing emergency room visits and hospitalizations for more severe illnesses and diseases that occur when physical health is neglected.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

Spindletop Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression. We have space in our existing facilities to co-locate primary care providers. A need has been identified to provide primary care for our clients in the same location that they receive behavioral health services. Scheduling, billing, and electronic health records systems are already in place for our clients and could be adapted for integration with primary care services.

RATIONALE:

Behavioral health clients have a high incidence of high blood pressure, cholesterol, obesity, diabetes, and other severe illnesses that shorten their life spans by 25 years compared to the general public. They are frequently high utilizers of hospital emergency departments because they do not have access to regular physical health care.

The Region 2 Community Needs Assessment has identified the need for expanded physical health care in our area. Spindletop Center has determined further that many of our behavioral health clients do not have access to physical health care because they are uninsured or lack funds to pay for these services. Health clinics that serve indigent populations frequently do not have capacity to accept more patients and charge a fee higher than many clients are able or willing to pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits. Co-locating primary care providers in our behavioral health facilities and coordinating healthcare appointments will increase the likelihood that our clients will receive the physical health care they need.

The primary care/behavioral health integration proposed in this plan relates to community needs CN.1, CN.2, CN.3, CN.10 and CN.12-15.

This project represents a new initiative for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Facilities will be adapted for co-locating primary care services.
- A mobile clinic will be purchased and equipped to provide primary and behavioral health care.
- Medical professionals and support staff will be hired or contracted to provide the primary care services.
- InSHAPE health mentors will be hired and trained to work one-on-one with behavioral health clients for education, planning, coaching, and measuring progress.
- For the InSHAPE program Spindletop will partner with local wellness and fitness centers to help behavioral health clients navigate the available opportunities to improve their health condition.
- Protocols will be established for joint scheduling, shared information and treatment plans, and referrals.
- Spindletop's existing electronic health record system will either be expanded to accommodate physical health data if primary care providers are hired as employees or will be integrated with outside systems if contracted providers are utilized for primary care.
- Spindletop's current medical staff meetings will be expanded to include primary care providers and discussions of primary care issues at least monthly.
- A system of reporting primary care utilization and outcomes will be developed.
- Ongoing quality assessments will be done to provide feedback for impact and improvements.

For demonstration year 2, the process milestone is to develop the integrated sites as reflected in the number of locations and providers participating in the integration project.

In demonstration years 3-5, the improvement milestones will be the number of primary care appointments available. In DY3, the number of appointments will be 500; in DY4, appointments will be 1000; and in DY5, appointments will be 1500.

RELATED CATEGORY 3 OUTCOME MEASURE:

Spindletop has selected improvement outcome measure OD-6 Patient Satisfaction, IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health. Public reporting of survey results will serve to enhance

accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

RELATIONSHIP TO OTHER PROJECTS AND MEASURES:

This project relates to Spindletop's project to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to this program. The project to provide specialty behavioral health care #096166602.1.1 is also related as more clients could receive primary care as well. Spindletop's project to provide an internet-based client health information portal #0962166602.1.11 will support this project.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS AND MEASURES:

This project's focus on co-locating primary and behavioral health services and emphasis on coordination of care and use of a mobile clinic ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10 096166602.2.11 , 096166602.2.6, 136367307.2.1, 109372601.2.2. All required reporting domains in Category 4 will be measured and reported on by the provider.

PROJECT VALUATION:

Spindletop 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.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

096166602.2.1	2.15	2.15.2	Integrate Primary and Behavioral Health Care Services	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.5**	**OD-6 IT-6.1**	**Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-5: Develop integrated sites reflected in number of locations and providers participating in the integration project Metric 1 P-5.2: Goal: Number of primary care providers newly located in behavioral health settings Baseline/Goal: 1 primary care provider Data Source: Employment records and/or contracts Milestone 1 Estimated Incentive Payment : $809,525	**Milestone 2** I-X: Expand primary care available appointments Metric 1 [I-X.1]: Baseline/Goal: 500 primary care appointments available Data Source: Scheduling records Milestone 3 Estimated Incentive Payment: $888,954		**Milestone 3** I-X: Expand primary care available appointments Metric 1 [I-X.1]: Baseline/Goal: additional 500 primary care appointments available; 1,000 total appointments Data Source: Scheduling records Milestone 3 Estimated Incentive Payment: $950,943	**Milestone 4** I-X: Expand primary care available appointments Metric 1 [I-X.1]: Baseline/Goal: additional 500 primary care appointments available; 1,500 total appointments Data Source: Scheduling records Milestone 4 Estimated Incentive Payment: $918,830
Year 2 Estimated Milestone Bundle Amount: $809,525	Year 2 Estimated Milestone Bundle Amount: $888,954		Year 4 Estimated Milestone Bundle Amount: $950,943	Year 5 Estimated Milestone Bundle Amount: $918,830
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,568,252				

CATEGORY/PROJECT AREA: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting
PROJECT OPTION: 2.13.2 Implement an evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.
PROJECT TITLE: Community Behavioral Crisis Services
RHP PROJECT ID NUMBER: 096166602.2.2
PERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Spindletop will provide early intervention and intensive wraparound services and supports for IDD individuals who are in behavioral crisis by developing a mobile Community Behavioral Crisis (CBC) clinical team, with a Clinical Out-of-home Respite (COR) component to reduce the use of less clinically appropriate care, such as hospital ED's, for the targeted population in Jefferson, Orange, Hardin, and Chambers counties.
Need for project: Since there is not currently a resource in our area to treat IDD individuals in behavioral crises, this population is either underserved or sent to costly hospitals or jail. Developing a mobile clinical team to provide crisis intervention for these individuals will, in many cases, allow the individuals to remain in their homes or to go to short-term, less costly respite facilities. This provides more appropriate care and reduces overall health care costs.
Target: This program is targeted primarily to the almost 1000 "priority population" adult consumers with intellectual and developmental disabilities that Spindletop serves. Almost all of these are either indigent or in Medicaid programs, including HCS, Texas Home Living, and ICF/ID waiver programs. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.
Expected benefits: The expected outcome of this project is to decrease the number of individuals in the target population served in less clinically appropriate, more costly settings by the end of demonstration year 5.

- For demonstration year 2, the process milestone is to design the project plan. In demonstration years 3-5, the improvement milestones will be the number of IDD individuals served by the crisis team.
- Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.4 for this project. The measure will be the reduction in days in state behavioral health facilities, hospitals, and criminal justice facilities for individuals in the target population.

Project Description:

Goal: The goal of this project is to avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community for individuals with Intellectual and Developmental Disabilities (IDD) or Autism Spectrum Disorders (ASD).

Challenges: With the increasing number of individuals diagnosed with IDD/ASD, there is a lack of resources to address their behavioral crises within our region. Although Spindletop provides ongoing services for individuals with IDD and has a crisis team for clients with mental health issues, but it does not currently have crisis capability for IDD individuals due to lack of funding. Other existing community services lack the expertise to treat this specialty population. As a result, IDD individuals in crisis may be sent to state-supported living facilities, local hospitals or state mental health hospitals or if space is available, or they may be incarcerated. Often, the IDD individuals are left untreated, which may exacerbate the crisis condition. The 1115 Waiver funding will allow Spindletop to provide crisis services for IDD individuals.

Description: To address these challenges, Spindletop will provide early intervention and intensive wraparound services and supports for IDD individuals who are in behavioral crisis by developing a mobile Community Behavioral Crisis (CBC) clinical team, with a Clinical Out-of-home Respite (COR) component to reduce the use of less clinically appropriate care, such as hospital ED's, for the targeted population in Jefferson, Orange, Hardin, and Chambers counties.

Outcomes: The expected outcome of this project is to decrease the number of individuals in the target population served in less clinically appropriate, more costly settings by the end of demonstration year 5.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

As a starting point, Spindletop has identified an IDD/ASD patient population without access to community behavioral crisis interventions. We currently have one associate psychologist with the training and expertise necessary to treat this specialty population. By adding a team, we would increase the capacity within our region.

Rationale:

Since there is not currently a resource in our area to treat IDD individuals in behavioral crises, this population is either underserved or sent to costly hospitals or jail. Developing a mobile clinical team to provide crisis intervention for these individuals will, in many cases, allow the individuals to remain in their homes or to go to short-term, less costly respite facilities. This provides more appropriate care and reduces overall health care costs.

The primary care/behavioral health integration proposed in this plan relates to community needs CN.5, CN.6 and CN.10.

This new program is an expansion of IDD services Spindletop already provides. No U.S. Department of Health and Human Services funding is received for this program.

The CBC team that Spindletop is proposing for the major service delivery will combine office and field-based services to assess the patient in the problem environment and determine

where intervention should be delivered most effectively. Components of the project will include:

- Hiring and increasing training for professions (e.g., Licensed Psychological Associate, Registered Nurse/Nurse Practitioner, Psychiatrist, Psychologist) and paraprofessionals in IDD/ASD, Crisis Intervention, Risk Management, Behavior Intervention, data collection, and assessment tools
- Establishing an IDD/ASD CBC contact telephone line
- Providing behavioral crisis intervention services in a non-hospital environment that is more appropriate to meet the needs of individuals with IDD/ASD in crisis
- Engaging in population-based campaigns to promote awareness of CBC services
- Making appropriate referrals upon discharge in order to reduce the likelihood of future behavioral crises
- Developing reporting methodologies that will enable continuous quality improvement, including assessment of meeting the desired outcomes and consideration of expanding the program

For demonstration year 2, the process milestone is to design the project plan.
In demonstration years 3-5, the improvement milestones will be the number of IDD individuals served by the crisis team.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.4 for this project. The measure will be the reduction in days in state behavioral health facilities, hospitals, and criminal justice facilities for individuals in the target population. Various studies, including a March 2010 study by Texas A&M University, found that crisis services programs offer direct and measurable reductions in cost of services associated with crisis that more than cover the cost of the programs.

Relationship to Other Projects and Measures:

This project relates to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to the community behavioral crisis program.

This project's focus on residential treatment and respite for youth with mental illness and emphasis on reducing preventable inpatient admissions ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP:096166602.1.3-Youth respite/residential treatment; 096166602.2.2 - Community behavioral crisis services; 096166602.2.10 - Behavioral health training; 096166602.2.11 - Inpatient detox services; 096166602.2.4 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.5- "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, state-supported living centers, and criminal justice incarceration. A health economic study that included these factors was also used to value the project.

096166602.2.2	2.13.2	2.13.2	Community Behavioral Crisis Services	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.6**	**OD-9 IT-9.4**	**Right Care, Right Setting- Reduction in hospitalization, behavioral health stays, incarceration**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population (IDD individuals with behavioral crises) Metric 1 P-2.1: Goal: Project plans based on evidence/experience and which address the project goals Data Source: Project documentation Milestone 1 Estimated Incentive Payment *:* $165,907	**Milestone 2** I-X: Number of individuals in target population served by crisis team Metric 1 [I-X.1]: Baseline/Goal: 6 individuals served Data Source: Spindletop service records/EHR Milestone 2 Estimated Incentive Payment: $182,186		**Milestone 3** I-X: Number of individuals in target population served by crisis team Metric 1 [I-X.1]: Baseline/Goal: 12 individuals served Data Source: Spindletop service records/EHR Milestone 3 Estimated Incentive Payment: $194,891	**Milestone 4** I-X: Number of individuals in target population served by crisis team Metric 1 [I-X.1]: Baseline/Goal: 18 individuals served Data Source: Spindletop service records/EHR Milestone 4 Estimated Incentive Payment: $188,309
Year 2 Estimated Milestone Bundle Amount: $165,907	Year 3 Estimated Milestone Bundle Amount: $182,186		Year 4 Estimated Milestone Bundle Amount: $194,891	Year 5 Estimated Milestone Bundle Amount: $188,309
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $731,293				

PROJECT OPTION: 2.13.2 Implement an evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.3
PERFORMING PROVIDER/TPI: Spindletop Center/TPI 096166602

Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: This project will increase training of the behavioral health workforce including professionals, paraprofessionals, peer-to-peer specialists, and peer-to-peer volunteers in Cognitive Adaptation Training ("CAT"), Wellness Recovery Action Plan™ ("WRAP®") facilitator and patient training, and Cognitive Enhancement Therapy ("CET"). Each of these evidence-based programs is designed to improve the behavioral health and coordination of physical health for the behavioral health population Spindletop serves.

Need for project: The Community Needs Assessment for Region 2 notes that physical and mental/behavioral health are not integrated and that mental health related ED visits are increasing. Increasing the training of the behavioral healthcare workforce in these three evidenced-based practices will support the physical/mental health integration and will reduce the hospital recidivism and emergency department usage for behavioral health clients. Due to limited funding directed toward very specific diagnoses, Spindletop currently cannot provide all of this training.

Target: These training programs are targeted primarily to the more than 2,200 "priority population" adult mental health clients that Spindletop serves. 54% of these clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcomes of these programs by the end of demonstration year 5 are to strengthen the recovery of our patients, provide more coordination of physical and behavioral health, and reduce general and psychiatric hospital recidivism and emergency department usage.

For demonstration year 2, the process milestone is to design the project plans and begin the initial phases that include coordinating the initial CAT training for staff, peers, interns, and volunteers; trainings WRAP facilitators; acquiring the CET software and beginning CET coach

training. In demonstration years 3-5, the improvement milestones will be the increase in the number of professionals, peers and volunteers trained to provide CAT, CET, and WRAP services.

- Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (4) patient's involvement in shared decision making. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

PROJECT DESCRIPTION:

Goal: The goal of this project is to avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals and state behavioral health facilities; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community.

Description: Spindletop will achieve this goal through increased training of the behavioral health workforce including professionals, paraprofessionals, peer-to-peer specialists, and peer-to-peer volunteers in Cognitive Adaptation Training ("CAT"), Wellness Recovery Action Plan™ ("WRAP®") facilitator and patient training, and Cognitive Enhancement Therapy ("CET").

Challenges: Spindletop Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression; however, funding limitations inhibit our ability to provide additional services. All three of these programs have significant start-up costs. With DSRIP funding, we can implement innovative evidence-based programs that are focused on adaptive training, peer support, and cognitive rehabilitation for our behavioral health clients.

Outcomes: The expected outcomes of these programs by the end of demonstration year 5 are to strengthen the recovery of our patients, provide more coordination of physical and behavioral health, and reduce general and psychiatric hospital recidivism and emergency department usage.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention. The training program proposed by Spindletop provides patient-centered behavioral health care to improve both the mental and physical health of our clients.

STARTING POINT/BASELINE:

Spindletop currently provides outpatient behavioral health services for approximately 2,100 active clients. We have systems in place to begin these programs, including scheduling, intake and assessment, electronic health records, and other computer capabilities. Space in our existing facilities has been identified for meeting rooms and computer areas.

- CAT: We currently have a paraprofessional utilizing psychiatric rehabilitation methods of service delivery without the intensive engagement to wellness the CAT model can provide.
- WRAP: Currently we have two co-facilitators to instruct the WRAP classes which are limited to 12 patients per class. The WRAP facilitator consists of one Peer Specialist and one staff member to provide this service to 2,100 eligible patients who desire to develop their wellness and recovery plan.
- CET: A CET Referral Questionnaire has been distributed to the Outpatient MH Clinics to survey client interest and eligibility requirements for this project. A Request for Interest has been sent to Spindletop Center professionals, paraprofessionals, and private counseling providers for interest in becoming a CET coach.

RATIONALE:

The Community Needs Assessment for Region 2 notes that physical and mental/behavioral health are not integrated and that mental health related ED visits are increasing. Increasing the training of the behavioral healthcare workforce in these three evidenced-based practices will support the physical/mental health integration and will reduce the hospital recidivism and emergency department usage for behavioral health clients.

The behavioral health training proposed in this plan relates to community needs CN.5, CN.10, CN.16 and CN.17.

These training programs represent a new initiative for Spindletop. No U.S. Department of Health and Human Services is received for these programs. They will enhance the behavioral health services we currently provide.

Components of the project include the following:

- CAT is a National Institute of Mental Health (NIMH) sponsored clinical trial study through the University of Texas Health Science Center in San Antonio, Texas. This evidenced-based practice provides comprehensive use of environmental supports to improve multiple areas of adaptive functioning. The CAT training for staff professionals, paraprofessionals, peer-to-peer specialists, and volunteers will be provided initially onsite in Beaumont. As new staff and certified peer specialists are hired and more volunteer peer-to-peers are secured, training will be coordinated at the University of Texas Health Science Center in San Antonio, Texas. After the training, staff will provide

patients with weekly treatments in their homes to address medication adherence (reminders), symptomology (early warning signs), adaptive functioning (successful daily routines), and coordination of behavioral and physical health needs.

- WRAP® has been designated by SAMHSA as an evidenced-based practice. WRAP utilizes an individualized system of planned action strategies that help patients monitor and respond to mental health and physical health challenges and negative symptoms with the goal of achieving their highest level of wellness (develop effective action plans for identified warning signs or triggers). The goal is to train six WRAP facilitators and three advanced facilitator Champions by the end of four years. WRAP facilitators are patient peers as well as paraprofessionals. Through increasing the specialized training of behavioral health workforce paraprofessionals, peer specialist, and peer-to-peer volunteers, the expected outcome is to develop a pool of facilitators necessary to meet the volume of patients who will benefit from their WRAP plan. This evidenced-based practice integrates behavioral and physical health needs.

- CET is a recovery-oriented, SAMHSA 2011 Science and Service Award winning, evidence-based practice that helps patients to develop and enhance the mental capacities that produce the awareness for self-directed social interactions that are wise, appropriate, and effective. CET utilizes a combination of cognitive rehabilitation-based computer training exercises in addition to structured group exercises with individual counseling and homework assignments (skills to improve attention, memory and problem solving skills). CET staff coaches will be hired and trained in CET techniques. After the training, they will lead patients in a 45-week program that includes weekly computer exercises, group process rehabilitation skills training, and individual therapy to improve social and vocational deficits and to decrease the overuse of hospital emergency departments and inpatient services. Through the early intervention and retraining incorporated in CET, patients who would otherwise be considered “disabled” under Social Security Supplemental Income guidelines may obtain employment and become self-sufficient within three years, reducing their dependence on Federal support.

- For ongoing quality improvement, results of all three of these training programs will be evaluated at time intervals appropriate to each program to determine their effectiveness in meeting the goals of the project. Adjustments to the programs will be made as needed.

For demonstration year 2, the process milestone is to design the project plans and begin the initial phases that include coordinating the initial CAT training for staff, peers, interns, and

volunteers; trainings WRAP facilitators; acquiring the CET software and beginning CET coach training.

In demonstration years 3-5, the improvement milestones will be the increase in the number of professionals, peers and volunteers trained to provide CAT, CET, and WRAP services.

RELATED CATEGORY 3 OUTCOME MEASURE:

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (4) patient's involvement in shared decision making. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

RELATIONSHIP TO OTHER PROJECTS AND MEASURES:

This project relates to Spindletop's project to integrate primary care with behavioral health #096166602.2.1. The project to provide specialty behavioral health care #096166602.1.1 is also related as more clients could receive benefits from these training programs.

This project's focus on behavioral health and crisis and emphasis on avoiding inpatient admissions ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, , 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS AND MEASURES:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP:096166602.1.3-Youth respite/residential treatment; 096166602.2.2 - Community behavioral crisis services; 096166602.2.3 - Behavioral health training; 096166602.1.4- Inpatient detox services; 096166602.2.4 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.5- "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

PROJECT VALUATION:

Spindletop considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the overall health of behavioral health clients through peer support, cognitive and skills training should reduce the number of ED visits and the occurrences of hospitalizations.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

096166602.2.3	2.13.2	2.13.2	Behavioral Health Training	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.7**	**OD-6 IT-6.1 (4)**	**Percent improvement over baseline of patient satisfaction scores-Patients involvement in shared decision making**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized interventions for target population: CAT, WRAP, CET Metric 1 P-2.1: Goal: Project plans based on evidence/experience and which address the project goals; acquire and implement CET software, initial CAT, WRAP, CET training Data Source: Project documentation Milestone 1 Estimated Incentive Payment : $307,067	**Milestone 2** I-X: Number of professionals, peers, volunteers providing CAT, CET, WRAP services Metric 1 [I-X.1]: Goal: 40 professionals, peers, volunteers providing CAT, CET, WRAP services Data Source: Training records Milestone 2 Estimated Incentive Payment: $337,195		**Milestone 3** I-X: Number of additional professionals, peers, volunteers providing CAT, CET, WRAP services Metric 1 [I-X.1]: Goal: 20 additional professionals, peers, volunteers providing CAT, CET, WRAP services Data Source: Training records Milestone 3 Estimated Incentive Payment: $360,708	**Milestone 4** I-X: Number of additional professionals, peers, volunteers providing CAT, CET, WRAP services Metric 1 [I-X.1]: Goal: 25 additional professionals, peers, volunteers providing CAT, CET, WRAP services Data Source: Training records Milestone 4 Estimated Incentive Payment: $348,527
Year 2 Estimated Milestone Bundle Amount: $307,067	Year 3 Estimated Milestone Bundle Amount: $337,195		Year 4 Estimated Milestone Bundle Amount: $360,708	Year 5 Estimated Milestone Bundle Amount: $348,527
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $1,353,497				

PROJECT OPTION: 2.13.2-"Other" Project Option

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.10-Pass 3b
PERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

Project Title: Affordable Housing for People with Mental Illness
Project Area: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting
Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Existing buildings currently owned by Spindletop Center will be refurbished to create 7 new apartments in Beaumont and 12 new studio apartments in Orange for our behavioral health clients who are at risk of being homeless. Spindletop Center will manage referrals, applications and tenant occupancy for the apartments, which will be affordably priced for people on Social Security Disability Income due to their mental illness.
Need for project: There are currently over 1200 homeless people in our 4 county-region. It is estimated that at least 75-85% of the homeless population have severe mental illness and or a substance abuse diagnosis. Creating new and affordable apartments for individuals with mental illness will have a significant long-term benefit for the community since it has been shown to increase compliance with treatment and reduce ED visits and jail admissions.
Target: This program is targeted primarily to Spindletop's adult mental health clients who are at risk of being homeless. 54% of Spindletop's adult mental health clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.
Expected benefits: The expected outcome by the end of demonstration year 5 is to provide 7 additional apartments in Beaumont and 12 in Orange for people with behavioral health issues.

- For demonstration year 2, the process milestone is to engage an architect and contractor to remodel existing space. In year 3, the remodel will be completed, furnishings purchased, and screening of applicants will begin. In demonstration years 4-5, the improvement milestones will be the number of clients in apartments, beginning with 12 in year 4 and increasing to 16 in year 5.

- Spindletop has selected improvement outcome measure OD-10, Quality of Life/Functional Status, IT-10.7 Other Outcome Improvement Target. The measures will be reduced homelessness, increased employment, and improved compliance with behavioral health treatment plans for clients in the apartments. We chose outcome improvement IT-10.7 because the ultimate outcome of this project is improve the quality of life for homeless people with behavioral health issues, to promote wellness and adherence to behavioral health treatments, and to promote recovery in the community.

Project Description:

Goal: The goal of this project is to avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community. Residential options linked to a range of support services can effectively improve health outcomes and decrease hospitalizations, ED visits, and incarcerations for vulnerable individuals, such as the long-term homeless with severe mental illness. One such model in Colorado demonstrated a drastic 80 percent decrease in overnight hospital stays and a 76 percent decrease in nights in jail (*Wortzel, 2007).* Research indicates that among residents of permanent supportive housing:

- Rates of arrest and days incarcerated are reduced by 50%;
- Emergency room visits decrease by 57%;
- Emergency detoxification services decrease by 85%; and
- Nursing home utilization decreased by 50%.

(Lewis, D., Corporation for Supportive Housing, Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010).

Description: To achieve this goal, existing buildings currently owned by Spindletop Center will be refurbished to create 7 new apartments in Beaumont and 12 new studio apartments in Orange. Spindletop Center will manage referrals, applications and tenant occupancy for the apartments, which will be affordably priced for people on Social Security Disability Income due to their mental illness.

Challenges: Decent and affordable housing for people on a fixed income, or with no income at all has been a long-term challenge in Southeast Texas, but that was greatly exacerbated by Hurricanes Rita and Ike which destroyed many single and multi -family dwellings in Southeast Texas. Many people with mental illness who had been staying with their families became displaced and several boarding homes were damaged and never repaired so that people lost their place to live. Spindletop has already remodeled two buildings to provide housing for people with behavioral health issues, but a lack of funding inhibits our ability to expand the program. With funds from the 1115 Waiver, we can increase the housing units available for this targeted population.

We do not anticipate any significant challenges related to the remodel, furnishing, and leasing of additional housing units.

Outcomes: The expected outcome by the end of DY5 is to provide seven (7) additional apartments in Beaumont and 12 in Orange for people with behavioral health issues.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop Center has recently remodeled two of its existing buildings for 26 apartments for people with behavioral health issues. It has become apparent that the need far exceeds these 26 units as there is a constant waiting list and demand for these affordable units. Development of additional housing will serve clients in Jefferson, Orange, and Hardin Counties. Even with 19 new units, there will still be a very large number of homeless people in our area with a mental illness or substance abuse diagnosis.

Spindletop has existing buildings that can be used for the proposed apartments. Since the layouts would be similar to the apartments we have recently remodeled, we can recognize some economies in the planning and design parts of the project.

In addition to Spindletop's experience in providing housing, we offer mental health outpatient treatment and community support services such as assisting clients with free medications, rental assistance, and access to other social services. Combined with the affordable housing, this increases the likelihood of meeting the goals of the project.

Rationale:

There are currently over 1200 homeless people in our 4 county-region. It is estimated that at least 75-85% of the homeless population have severe mental illness and or a substance abuse diagnosis. Creating new and affordable apartments for individuals with mental illness will have a significant long-term benefit for the community since it has been shown to increase compliance with treatment and reduce ED visits and jail admissions. According to a report in the New England Journal of Medicine, homeless people spent an average of four days longer per hospital visit than comparable non-homeless people. This extra cost, approximately $2,414 per hospitalization, is attributable to homelessness. A study of hospital admissions of homeless people revealed that 1,751 adults were responsible for 564 hospitalizations and $4 million in admission costs. Their rate of psychiatric hospitalization was over 100 times higher than their non-homeless cohort. The researchers conducting the study estimate that the excess cost for treating these homeless individuals was $3.5 million or about $2,000 per person. Homelessness both causes and results from serious health care issues, including addiction, psychological disorders, HIV/AIDS, and a host of other ailments that require long-term, consistent care. Homelessness inhibits this care, as housing instability often detracts from regular medical attention, access to treatment, and recuperation. This inability to treat medical

problems can aggravate these problems, making them both more dangerous and more costly. According to a University of Texas two-year survey of homeless individuals, each person cost the taxpayer $14,480 per year, primarily for overnight jail. A typical cost of a prison bed in a state or federal prison is $20,000 per year.

The services proposed in this plan relate to community needs CN.1, CN.10, CN.16, and CN.17.

This project is an expansion of Spindletop's housing services for individuals with mental illness who are at risk for being homeless. No U.S. Department of Health and Human Services funding will be received for this program.

Components of the project include the following:

- Engaging an architect to design the remodeling needed.
- Contracting with vendors to do the remodeling.
- Purchasing needed furnishings.
- Screening applicants for apartments.
- Managing the daily operations of the apartments.
- As a quality improvement, results of the program will be measured annually to track the effectiveness of the program in reducing homelessness, increasing employment, and improving compliance with behavioral health treatment plans for clients in the apartments. Spindletop will measure these results based the SAMSHA Permanent Supportive Housing Evidence-Based Practices Kit as well as other internal statistics. For Spindletop's current housing project that opened in 2010, these statistics showed the following results for the 21 residents housed during the initial 2-year period:
    - 77% were homeless, by HUD definition, before moving into Spindletop's facility
    - After moving into our housing,
        - 24% sought and secured employment
        - 10% returned to school
        - 24% transitioned into permanent housing
        - <u>5% transitioned out of mental health services at Spindletop Center</u>
        - <u>100% of current residents are now compliant with mental health services at Spindletop Center</u>

For demonstration year 2, the process milestone is to engage an architect and contractor to remodel existing space. In year 3, the remodel will be completed, furnishings purchased, and screening of applicants will begin. In demonstration years 4-5, the improvement milestones will be the number of clients in apartments, beginning with 12 in year 4 and increasing to 16 in year 5.

<u>Related Category 3 Outcome Measure:</u>

Spindletop has selected improvement outcome measure OD-10, Quality of Life/Functional Status, IT-10.7 Other Outcome Improvement Target. The measures will be reduced homelessness, increased employment, and improved compliance with behavioral health

treatment plans for clients in the apartments. These statistics have been compiled for previous Spindletop housing projects to demonstrate the effectiveness of the project.

We chose outcome improvement IT-10.7 because the ultimate outcome of this project is improve the quality of life for homeless people with behavioral health issues, to promote wellness and adherence to behavioral health treatments, and to promote recovery in the community. Residential options linked to a range of support services can effectively improve health outcomes and decrease hospitalizations, ED visits, and incarcerations for vulnerable individuals, such as the long-term homeless with severe mental illness.

Process milestone P-1 was selected for DY2 to complete the plan, and process milestone 2 was selected for DY3 to establish baseline rates for measuring the outcome improvements in DY4-5.

Relationship to Other Projects and Measures:

This project is related to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan may be applied to this program. The project to integrate primary care with behavioral health #096166602.2.1 could also benefit clients who reside in these apartments. Spindletop's project to provide an internet-based client health information portal #0962166602.15 will support this project since residents in the housing units will have computer access to retrieve this information.

This project's focus on behavioral health and crisis and emphasis on avoiding inpatient admissions ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP: 096166602.1.3-Youth respite/residential treatment; 096166602.2.3 - Community behavioral crisis services; 096166602.2.3 - Behavioral health training; 096166602.2.5 - Inpatient detox services; 096166602.2.10 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.11- "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration. A health economic study measuring the monetary value for a health intervention was also used to value the project.

096166602.2.10	2.13	2.13.2	Affordable Housing for People with Mental Illness	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.17**	**OD-10 IT-10.7**	**Quality of Life/Functional Status, Other Outcome Improvement Target**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized interventions for target populations - engage an architect and contractors to remodel existing space Metric 1 P-2.1: Goal: Project plans which are based on evidence / experience and which address the project goals -architect and contractors engaged Data Source: Signed contracts with architect and contractors Milestone 1 Estimated Incentive Payment *:* $500,324	**Milestone 2** P-2: Design community-based specialized interventions for target populations - completion of remodel, purchase furnishings, screen applicants Metric 1 P-2.1: Goal: Project plans which are based on evidence / experience and which address the project goals - apartment remodels completed and furnished; applicants screened Data Source: Project documentation Milestone 2 Estimated Incentive Payment: $549,415		**Milestone 3** I-X: Number of clients in apartments Metric 1 [I-X.1]: Baseline/Goal: 12 clients in apartments Data Source: Spindletop rental records Milestone 3 Estimated Incentive Payment: $587,728	**Milestone 4** I-X: : Number of clients in apartments Metric 1 [I-X.1]: Number of clients in apartments Baseline/Goal: 15 clients in apartments Data Source: Spindletop rental records Milestone 4 Estimated Incentive Payment: $567,880
Year 2 Estimated Milestone Bundle Amount: $500,324	Year 3 Estimated Milestone Bundle Amount: $549,415		Year 4 Estimated Milestone Bundle Amount: $587,728	Year 5 Estimated Milestone Bundle Amount: $567,880
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,205,347				

PROJECT OPTION: 2.13.2 "Other" Project Option

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.11 Pass 3b
RHP PERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

Project Area: 2.13 Provides an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting
Project Title: Health and Wellness Program for Individuals with Intellectual and Developmental Disabilities
Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Spindletop will enhance its behavioral health care services by developing a health and wellness program for individuals with Intellectual and Developmental Disabilities (IDD) or Autism Spectrum Disorders (ASDs), utilizing swimming, exercise equipment, and aerobics to decrease cardiovascular risk factors for the targeted population in Jefferson, Orange, Hardin, and Chambers counties.
Need for project: With the increase in life-spans of individuals diagnosed with IDD/ASDs, they are more likely to have cardiac conditions, be more prone to obesity than the general population, and experience these conditions at an earlier age. A need exists for this population to have access to programs offering physical activities similar to those which are available to the non-IDD population; however, there is a lack of adequate available facilities in our area for individuals with IDD/ASDs to participate in recreational and physical activities that would allow them to maintain a healthier lifestyle.
Target: This program is targeted primarily to the 980 adult and child individuals with intellectual and developmental disabilities that Spindletop serves. About 80% of these clients are on Medicaid, including Medicaid waiver programs such as Home and Community-based Services (HCS), Texas Home Living, and Intermediate Care Facility/ID (ICF/ID) with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.
Expected benefits: The expected outcome of this project is to decrease cardiovascular risk factors by lowering resting heart rate and blood pressure and reducing total body fat for individuals with IDD/ASDs.

- For demonstration year 2, the Category 2 process milestone is to begin renovating the facilities, purchase additional equipment, hire the wellness team, and develop the health and wellness program. In demonstration years 3-5, the improvement milestones will be the number of individuals in the target population served by the health and wellness program. Goals are 50 for DY3, 100 for DY4, and 150 for DY5.

- Spindletop has selected Category 3 improvement outcome domain OD-10, Quality Of Life/Functional Status and measure IT-10.7 for this project. The measure will be improved cardiovascular health as demonstrated by lowered resting heart rate and blood pressure and reduced total body fat for individuals with IDD/ASDs who are in the Health and Wellness program.

Project Description:

Goal: The goal of this project is to avert outcomes such as potentially avoidable hospital inpatient and ED admissions and to promote wellness for individuals with Intellectual and Developmental Disabilities (IDD) or Autism Spectrum Disorders (ASDs).

Description: To meet this goal, Spindletop will enhance its behavioral health care services by developing a health and wellness program for individuals with IDD/ASDs, utilizing swimming, exercise equipment, and aerobics to decrease cardiovascular risk factors for the targeted population in Jefferson, Orange, Hardin, and Chambers counties.

Challenges: Lack of funding prevents Spindletop from offering expanded wellness programs for individuals with IDD/ASDs, but 1115 Waiver funding will allow Spindletop to enhance the provision of physical activity for these individuals.

Outcomes: The expected outcome of this project is to decrease cardiovascular risk factors by lowering resting heart rate and blood pressure and reducing total body fat for individuals with IDD/ASDs.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

As a starting point, Spindletop has identified a need for the IDD/ASDs population to increase physical activity. We currently have facilities including a pool and exercise equipment and employ a part-time lifeguard; however, the services we can provide with these facilities and part-time staff are limited

Rationale:

With the increase in life-spans of individuals diagnosed with IDD/ASDs, it is likely that a greater number of them will fall victim to disease and disability at an earlier rate than the general population. Physical inactivity is directly linked to many secondary health conditions such as coronary artery disease, congestive heart failure, hypertension, stroke, and some cancers. In addition, physical inactivity is known to contribute to obesity. The prevalence of obesity in individuals with intellectual disabilities is higher than that in the general population. Cardiac conditions are 3 to 4 times more likely in individuals with Down syndrome than in the general population. (Hall, Jamie M., and M. Janet Thomas. *"Promoting Physical Activity and Exercise in Older Adults With Developmental Disabilities."* Geriatric Rehabilitation 24.1 (2008): 64-73.)

A need exists for this population to have access to programs offering physical activities similar to those which are available to the non-IDD population; however, there is a lack of adequate available facilities in our area for individuals with IDD/ASDs to participate in recreational and physical activities that would allow them to maintain a healthier lifestyle. Creating a Health and Wellness program will give this population the same opportunity for increased physical activities as exist for the non-IDD population, thereby giving them the possibility for a healthier,

better quality of life and helping them avoid chronic illnesses that lead to increased health care needs and costs.

The Health and Wellness program proposed in this project relates to community needs CN.10, CN.12, CN.13, and CN.14.

This project is an expansion of a limited physical activity program Spindletop currently provides for individuals with IDD/ASDs. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Renovate pool facilities and update exercise equipment
- Hiring or contracting professionals (e.g., Recreational Technician, Aquatic Physical Therapist, Certified Lifeguard) for the wellness team
- Design physical activity programs, both general and individualized to client-specific needs
- Provide information to individuals in our IDD programs and encourage participation
- Establish baseline for cardiovascular risk factors
- Develop a system of monitoring changes in cardiovascular risk factors
- For quality improvement, assessments of program participants will be done at regular intervals to determine the project impact on improving the cardiovascular health of the target population. Physical activity programs will be adapted as needed to improve outcomes.

For demonstration year 2, the process milestone is to begin renovating the facilities, purchase additional equipment, hire the wellness team, and develop the health and wellness program.

In demonstration years 3-5, the improvement milestones will be the number of individuals in the target population served by the health and wellness program. Goals are 50 for DY3, 100 for DY4, and 150 for DY5.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome domain OD-10, Quality Of Life/Functional Status and measure IT-10.7 for this project. The measure will be improved cardiovascular health defined as the percentage of individuals with IDD/ASDs who are in the Health and Wellness program whose resting heart rate and blood pressure are lowered and total body fat is reduced.

Relationship to Other Projects and Measures:

This project relates to Spindletop's integration of primary care with behavioral health (#096166602.2.1) as some aspects of the InSHAPE program could be used in this program.

This project's focus on promoting health and wellness and emphasis on individuals with Intellectual and Developmental Disabilities ties to these Category 1 and 2 projects in our RHP: 135222109.1.5. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP: 096166602.1.3 -Youth respite/residential treatment; 096166602.2.2 - Community

behavioral crisis services; 096166602.2.3 - Behavioral health training; 096166602.2.5 - Inpatient detox services; 096166602.2.6 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.11 - "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for cardiovascular stays and emergency room visits.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.2.11	2.13	2.13.2	Health and Wellness Program	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.18**	**OD-10 IT-10.7**	**Quality of Life/Functional Status, Other Outcome Improvement Target—Improved Cardiovascular Health**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Develop the health and wellness program plan. Metric 1 P-X.1: Goal: Renovating the facilities, purchasing additional equipment, hiring the wellness team, and designing the health and wellness activity plans Data Source: Project documentation Milestone 1 Estimated Incentive Payment : $369,239	**Milestone 2** I-X: Number of individuals in target population served in wellness program Metric 1 [I-X.1]: Number of individuals in target population served in wellness program Baseline/Goal: 50 individuals served Data Source: Spindletop service records/EHR Milestone 2 Estimated Incentive Payment: $405,469		**Milestone 3** I-X: Number of individuals in target population served in wellness program Metric 1 [I-X.1]: Number of individuals in target population served in wellness program Baseline/Goal: 100 individuals served Data Source: Spindletop service records/EHR Milestone 3 Estimated Incentive Payment: $433,743	**Milestone 4** I-X: Number of individuals in target population served in wellness program Metric 1 [I-X.1]: Number of individuals in target population served in wellness program Baseline/Goal: 150 individuals served Data Source: Spindletop service records/EHR Milestone 4 Estimated Incentive Payment: $419,096
Year 2 Estimated Milestone Bundle Amount: $369,239	Year 3 Estimated Milestone Bundle Amount: $405,469		Year 4 Estimated Milestone Bundle Amount: $433,743	Year 5 Estimated Milestone Bundle Amount: $419,096
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,627,547				

PROJECT OPTION: 2.13.2 "Other" Project Option

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.6-Pass 2
PERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

Project Area: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting
Project Title: Mental Health Peace Officers
Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Spindletop will hire additional Mental Health Peace Officers ("MHPO's") and train them to stabilize mental health crisis situations with the aim of averting hospitalizations or criminal justice system involvement. MHPO's will assess the individuals in crisis to determine what level of care may be needed and facilitate the appropriate clinical treatment, including transporting individuals for screening, telemedicine services, or to a hospital unit if necessary.
Need for project: Teams made up of police officers and mental health workers have proven to be effective in both meeting the crisis needs of high-risk individuals in the community and reducing unnecessary hospitalization, ED usage, and incarceration. MHPO's will be able to direct these individuals to the most appropriate services. MHPO's can also decrease time spent by local law enforcement on individuals in a behavioral health crisis.
Target: This project program is targeted primarily to the 2300 adult behavioral health clients that Spindletop serves. 54% of these clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.
Expected benefits: The expected outcome is for the MHPO's to provide mental health crisis stabilization services and reduce admissions to hospitals, ED visits, and criminal justice system involvement.

- For demonstration year 2, the process milestone is to develop the implementation plan for MHPO crisis services. In demonstration years 3-5, the improvement milestones will be 100 MHPO crisis interventions for year 3, 200 MHPO crisis interventions for year 4, and 300 MHPO crisis interventions for year 5.
- Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting, IT-9.4, Other Outcome Target of decreasing the percentage of clients served by the MHPO's who have behavioral health admissions and readmissions to hospitals and criminal justice settings such as jails or prisons.

Project Description:

Goal: The goal of this project is to avert outcomes such as potentially avoidable inpatient admissions in settings including general acute and psychiatric hospitals and state behavioral health facilities; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the community.

Description: To achieve this goal, additional Mental Health Peace Officers ("MHPO's") will be hired and trained to stabilize mental health crisis situations with the aim of averting hospitalizations or criminal justice system involvement. MHPO's will assess the individuals in crisis to determine what level of care may be needed and facilitate the appropriate clinical treatment, including transporting individuals for screening, telemedicine services, or to a hospital unit if necessary.

MHPO's will work in conjunction with Spindletop's Mobile Crisis Outreach Team ("MCOT") to provide safety checks and enforcement of emergency detention procedures as appropriate. They will be available to ensure the safety of caseworkers during appointments with clients. MHPO's will also accompany local Homelessness Coalition caseworkers who are providing services to individuals in living environments that are not safe for unsupervised visits.

MHPO's will be dispatched through Spindletop's Crisis Hotline and will be available for requests for assistance from other law enforcement officers, hospitals, family service agencies, education officials, and others. Moreover, the MHPO's will provide monthly training to law enforcement and other community agencies about crisis and safety protocol.

Challenges: The major obstacle that we will face is initial staffing for the positions. An existing .5 FTE MHPO position is filled with off-duty law enforcement officers who work at two local police departments. We currently utilize these off duty-officers at maximum capacity. In order to increase the number of available hours, we need to change the way we staff the MHPO position. Several alternatives exist that we will utilize to meet this challenge:

- Increase officer use at the Port Arthur Police Departments
- Discuss adding additional officers with Sour Lake & Kountze Police Departments
- Discuss using on duty officers at Jefferson & Hardin County Sheriff's Departments

Outcomes: The expected outcome is for the MHPO's to provide mental health crisis stabilization services for 100 clients in DY3, 200 clients in DY4, and 300 clients in DY5 to reduce hospital recidivism, ED visits, and incarceration for this target population.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop currently has one .5 FTE position staffed by off-duty law enforcement officers that provides limited coverage for the MCOT team. This program will allow expansion of these services to other Spindletop mental health programs and for community awareness trainings.

Rationale:

Teams made up of police officers and mental health workers have proven to be effective in both meeting the crisis needs of high-risk individuals in the community and reducing unnecessary hospitalization, ED usage, and incarceration. MHPO's will be able to direct these individuals to the most appropriate services.

MHPO's can decrease time spent by local law enforcement on individuals in a behavioral health crisis. Often officers are diverted from other police matters for several hours to deal with a behavioral health crisis situation. In addition, law enforcement staff cannot always respond promptly to behavioral health emergencies if they are dealing with other urgent cases. This program would allow Spindletop's behavioral health rehabilitation and crisis staff to go into unsecured places safely, accompanied by an MHPO. Currently, staff can go only to places that are secure environments.

This expansion of an existing program addresses these needs by providing crisis services to individuals that previously could only be served in jail, psychiatric hospital facilities, or emergency rooms.
The Mental Health Peace Officers program proposed in this plan relates to community needs CN.6, CN.10, CN.16, and CN.17.
No U.S. Department of Health and Human Services funding is received for this program.
Components of the project include the following:

- Developing the MHPO implementation plan and training
- Hiring a part-time Qualified Mental Health Professional ("QMHP") to manage the MHPO program
- Hiring and training 2.0 FTE MHPO's, working with law enforcement agencies in Jefferson and Hardin counties
- Purchasing vehicles and equipment for the MHPO's
- For ongoing quality improvement, reviewing program results at monthly quality management meetings to determine the effectiveness of the program in meeting the goals of the project. Adjustments to the program will be made as needed.

For demonstration year 2, the process milestone is to develop the implementation plan for MHPO crisis services.
In demonstration years 3-5, the improvement milestones will be 100 MHPO crisis interventions for year 3, 200 MHPO crisis interventions for year 4, and 300 MHPO crisis interventions for year 5.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting, IT-9.4, Other Outcome Target of decreasing the percentage of clients served by the MHPO's who have behavioral health admissions and readmissions to hospitals and criminal justice settings such as jails or prisons.

Relationship to Other Projects and Measures:

This project relates to Spindletop's project to enhance behavioral health training (#096166602.2.3), extended crisis stabilization project (#096166602.1.2), detox project (#096166602.1.4), and primary care integration with behavioral health (#096166602.2.1).
This project's focus on behavioral health and emphasis on avoiding inappropriate care settings ties it to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1,

096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, , 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP:096166602.1.3-Youth respite/residential treatment; 096166602.2.2 - Community behavioral crisis services; 096166602.2.3 - Behavioral health training; 096166602.1.4- Inpatient detox services; 096166602.2.4 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.5- "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration. A health economic study that included these factors was also used to value the project.

096166602.2.6	2.13	2.13.2	Mental Health Peace Officers	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.11**	**OD-9 IT 9.4**	**OD-9, Right Care, Right Setting, IT-9.4, Other Outcome Target-Decrease % of Client Admissions to Hospitals & Criminal Justice Settings**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Develop implementation plans for needed MHPO crisis services. Metric 1 P-2.1: Goal: Project plans based on evidence/experience and which address the project goals Data Source: Project documentation Milestone 1 Estimated Incentive Payment : $322,209	**Milestone 2** I-X: Increase the number of clients served by MHPO's Metric 1 [I-X.1]: Number of clients served by MHPO's Baseline/Goal: 100 clients served Data Source: Electronic health record system Milestone 2 Estimated Incentive Payment: $353,824		**Milestone 3**: I-X: Increase the number of clients served by MHPO's Metric 1 [I-X.1]: Number of clients served by MHPO's Baseline/Goal: 200 clients served Data Source: Electronic health record system Milestone 3 Estimated Incentive Payment: $378,497	**Milestone 4**: I-X: Increase the number of clients served by MHPO's Metric 1 [I-X.1]: Number of clients served by MHPO's Baseline/Goal: 300 clients served Data Source: Electronic health record system Milestone 4 Estimated Incentive Payment: $365,714
Year 2 Estimated Milestone Bundle Amount: $322,209	Year 3 Estimated Milestone Bundle Amount: $353,824		Year 4 Estimated Milestone Bundle Amount: $378,497	Year 5 Estimated Milestone Bundle Amount: $365,714
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,420,244				

PROJECT OPTION: 2.18.2 "Other" Project Option

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.7-Pass 2
ERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

DSRIP Category/Project Area: 2.18 Recruit, train, and support consumers of mental health services to provide peer support
Project Title: Peer-to-Peer Support Services
Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Spindletop will implement Emotional CPR ("eCPR") to train mental health consumers in peer-to-peer engagement services to support and encourage participation in the development of a Wellness Recovery Action Plan™ ("WRAP®") and Peer Support Whole Health for our mental health clients.
Need for project: The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase. Consumers are more likely to create a healthier lifestyle when their focus is on their interests and personal strengths are encouraged and supported through a peer provider program. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness.
Target: This project program is targeted primarily to the more than 2,200 "priority population" adult mental health clients that Spindletop serves. "Priority population" consists of clients who are diagnosed with severe depression, schizophrenia, and bipolar disorder.54% of these clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.
Expected benefits: Through effective utilization and teaching eCPR techniques of connecting to the patient, peer providers will assist mental health consumers to engage in the ownership of their Whole Health plans to address physical and behavioral health wellness and recovery.

- For demonstration year 2, the process milestone is to hire and train initial staff, equip the office, and purchase a vehicle.
  In demonstration year 3, the improvement milestone is 150 participants receiving eCPR peer support services and developing a whole health plan to address physical and behavioral health wellness and recovery. The improvement milestone increases to 200 additional participants receiving eCPR peer support services and developing a whole health plan in demonstration year 4 and 250 additional participants in year 5.

- Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (4) patient's involvement in shared decision making. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Project Description:

Goal: The goal of this project is to use 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 peer support services. These services are supportive and not necessarily clinical in nature. Building on a project originally established under the State's Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training is provided to peers specialist providers in "whole health". With the whole health training, peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases and behavioral health symptoms.

Description: Spindletop will achieve this goal by implementing Emotional CPR ("eCPR") to train mental health consumers in peer-to-peer engagement services to support and encourage participation in the development of a Wellness Recovery Action Plan™ ("WRAP®") and Peer Support Whole Health. eCPR is an educational program designed to teach consumers of mental health services to assist others through an emotional crisis and engage in their own recovery by three simple steps: C = Connecting, P = emPowering, and R = Revitalizing. eCPR teaches listening skills, practicing presence, and creating a sense of safety for the person experiencing a crisis; the program engages an individual to resume or begin routines that support health and wellness which reinforces the person's sense of mastery and accomplishment. eCPR is based on the principles shared by a number of support approaches: trauma-informed care, counseling after disasters, peer support to avoid continuing emotional despair, emotional intelligence, suicide prevention, and cultural attunement. Through the successful engagement of consumers in the Peer Support Whole Health process, they are able to create a healthier life-style and reduce emergency interventions.

Challenges: In order to recruit consumers to become certified peer specialists and advance the physical and emotional wellness and recovery of our mental health patient population, proven and effective peer support engagement methods must be available. Currently, there is little funding for the non-reimbursable services needed to recruit and train peer providers. DSRIP funding will allow Spindletop to implement the eCPR and Peer Support Whole Health programs for peer provider training.

Outcomes: After recruiting and training peer providers, the expected outcome of this project is to serve 150 clients through this program in DY3 and 250 additional clients annually in DY4 and DY5. Through effective utilization and teaching eCPR techniques of connecting to the

patient, peer providers will assist mental health consumers to engage in the ownership of their Whole Health plans to address physical and behavioral health wellness and recovery.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop currently provides outpatient behavioral health services for more than 2,200 active adult clients. We have one certified peer specialist enrolled in the mentor train-the-trainer program for eCPR and two peer WRAP trainers.

Rationale:

The inability to engage consumers in their own recovery is often the result of poor communication skills, emotional crisis reactions, trauma reactions, and adverse childhood experiences. These areas contribute to a lack of commitment to improve their whole health wellness and management of recovery goals. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase. Consumers are more likely to create a healthier lifestyle when their focus is on their interests, and personal strengths are encouraged and supported through a peer provider program. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness. While peer provider training currently exists, very limited numbers of peers are trained due to resource limitations. Peer-to-peer support and engagement services are underfunded and non-reimbursable for non-certified Peer Specialists.

The Peer-to-Peer Support Services proposed in this plan relates to community needs CN.5, CN.10, CN.16 and CN.17.

This project represents a new initiative for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

Components of the project include the following:

- Develop the project plan
- Hire and train a peer support project manager
- Recruit eight part-time peer support providers who have completed WRAP training
- Equip office space for project manager
- Purchase a vehicle for the program
- Contract with eCPR program trainers to train peer providers
- Train peer providers in the Peer Support Whole Health program
- Have staff complete the mentor train-the-trainer program for eCPR
- For ongoing quality improvement, results of the programs will be evaluated quarterly to determine its effectiveness in meeting the outcomes. Adjustments to the program will be made as needed.

For demonstration year 2, the process milestone is to hire and train initial staff, equip the office, and purchase a vehicle.

In demonstration year 3, the improvement milestone is 150 participants receiving eCPR peer support services and developing a whole health plan. The improvement milestone increases to 200 additional participants receiving eCPR peer support services and developing a whole health plan in demonstration year 4 and 250 additional participants in year 5.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (4) patient's involvement in shared decision making. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Relationship to Other Projects and Measures:

This project relates to Spindletop's projects to enhance behavioral health training #096166602.2.3 as techniques implemented in that plan support the whole health of the patient served. The project to integrate primary care with behavioral health #096166602.2.1 is also related as peer-to-peer whole health encompasses the adherence to improved physical health as well as behavioral health.

This project's focus on behavioral health services and emphasis on peer support ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.6, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.10, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on the recruitment, training, and support of consumers of mental health services to provide peer support services along with these other Category 2 projects in our RHP: 136367307.2.1 Recruit, Train and Support Consumers of Mental Health Services to Provide Peer Support Services

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration. Another valuation factor used for this project is the monetary value for a behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.2.7	2.18	2.18.2	PEER-TO-PEER SUPPORT SERVICES	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.12**	**OD-6 IT-6.1**	***Patient Satisfaction, Percent improvement over baseline of patient satisfaction scores***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Hire and train staff, equip office, and purchase new vehicle Metric 1 P-X.1. Goal: Hire and train staff, equip office, and purchase new vehicle Data Source: Project documentation Milestone 1 Estimated Incentive Payment *:* $280,182	**Milestone 2** I-X: Number of clients receiving eCPR peer services who develop a whole health plan Metric 1 [I-X.1]: Number of clients receiving eCPR peer services who develop a whole health plan Baseline/Goal: 150 clients receiving peer services who develop a whole health plan Data Source: Electronic health record system Milestone 2 Estimated Incentive Payment: $307,673		**Milestone 3** I-X: Number of clients receiving eCPR peer services who develop a whole health plan Metric 1 [I-X.1]: Number of clients receiving eCPR peer services who develop a whole health plan Baseline/Goal: 200 clients receiving peer services who develop a whole health plan Data Source: Electronic health record system Milestone 3 Estimated Incentive Payment: $329,128	**Milestone 4** I-X: Number of clients receiving eCPR peer services who develop a whole health plan Metric 1 [I-X.1]: Number of clients receiving eCPR peer services who develop a whole health plan Baseline/Goal: 250 clients receiving peer services who develop a whole health plan Data Source: Electronic health record system Milestone 4 Estimated Incentive Payment: $318,013
Year 2 Estimated Milestone Bundle Amount: $280,182	Year 3 Estimated Milestone Bundle Amount: $307,673		Year 4 Estimated Milestone Bundle Amount: $329,128	Year 5 Estimated Milestone Bundle Amount: $318,012
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,234,995				

PROJECT OPTION: 2.13.2-"Other" Project Option

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.8-Pass 2
PERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

Project Title: Outpatient Substance Abuse Services

DSRIP Category/Project Area: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting
Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Spindletop Center will provide outpatient substance abuse treatment services to indigent clients using the MATRIX Curriculum, an evidence-based SAMSHA-approved program. For clients with co-occurring diagnoses of substance dependency and a mental health disorder, Spindletop's case management services will assist clients in navigating multi-systems to aid their recovery incorporating transition assistance, nutritional counseling, employment support, prescription medications, psychosocial rehabilitation, HIV/STD education, and transportation.
Need for project: Spindletop Center and its community partners have identified the need in our area for expanded substance abuse treatment and case management services, particularly for those diagnosed with co-occurring disorders. With high unemployment, lower educational attainment, and lower income levels, many citizens of our region are unable to afford substance abuse treatment and the support services needed to achieve recovery. Instead they utilize the ED departments of hospitals more frequently or are incarcerated. Although Spindletop currently has an outpatient substance abuse treatment program, every year dozens of citizens in need of treatment in the area we serve are turned away due to lack of sufficient funding to hire staff. The State's limited funding does not provide the range of services needed to deal with all of these people, particularly those with co-occurring psychiatric and substance addiction disorders.
Target: This project program is targeted primarily to the 1070 substance abuse clients that Spindletop serves. 15% of these clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.
Expected benefits: The expected outcome of this program is to strengthen the recovery of our clients through substance abuse treatment programs and case management services; to improve the quality of life for these clients; and to reduce general and psychiatric hospital recidivism, emergency department usage, and criminal justice system interaction.

- For demonstration year 2, the process milestone is to hire additional staff; train staff on identifying referral sources and community services, curriculum, and Motivational

Interviewing techniques; equip offices for additional staff; and purchase a vehicle for case manager use. In demonstration years 3-5, the improvement milestones will be the increase in the number of adults served in the outpatient substance abuse program, beginning with 80 in year 3 and increasing to 90 in years 4-5. Since the ratio of counselor to client is determined by the state, the growth will be limited.

- Spindletop has selected improvement outcome domain OD-10, Quality of Life/Functional Status. For DY2, the process milestone is P-1, project planning—identifying current capacity and needed resources, determining timelines, and documenting implementation plans. For DY3-5, the improvement target is 10.1 , Quality of Life as measured by the Texas Department of State Health Services outcome tool. The target will be 70% of the participating clients discharged successfully from the program each year.

Project Description:

Goal: The goal of this project is to facilitate recovery to a historically underfunded population to avert such potentially avoidable inpatient admission and readmissions for detox or substance abuse treatment; to avert disruptive and deleterious events such as criminal justice involvement; to promote wellness and adherence to behavioral health treatments; and to promote recovery in the family and community.

Description: To achieve this goal, Spindletop Center will provide outpatient substance abuse treatment services to indigent clients using the MATRIX Curriculum, an evidence-based SAMSHA-approved program. For clients with co-occurring diagnoses of substance dependency and a mental health disorder, Spindletop's case management services will assist clients in navigating multi-systems to aid their recovery, incorporating transition assistance, nutritional counseling, employment support, prescription medications, psychosocial rehabilitation, HIV/STD education, and transportation. Culturally competent case managers will provide enhanced social support and navigation services to targeted clients who are at high risk of disconnecting from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others).

Case managers will also help integrate services for patients who have participated in the detox program that is another of Spindletop's DSRIP projects.

Substance abuse services will be provided in Jefferson, Orange, and Hardin counties to adult female and males. Case management services will be delivered in Jefferson and Orange counties. Depending on individual needs, each client's treatment program will be from 3 to 6 months in duration.

Challenges: Although Spindletop currently has an outpatient substance abuse treatment program, every year dozens of citizens in need of treatment in the area we serve are turned away due to lack of sufficient funding to hire staff. The State's limited funding does not provide the range of services needed to deal with all of these people, particularly those with co-occurring psychiatric and substance addiction disorders. These complex populations become frequent users of local public health systems. With 1115 Waiver funds, Spindletop will be able

to provide outpatient substance abuse treatment and case management to all of those clients who are referred to us.

Outcomes: The expected outcome of this program is to strengthen the recovery of our clients through substance abuse treatment programs and case management services; to improve the quality of life for these clients; and to reduce general and psychiatric hospital recidivism, emergency department usage, and criminal justice system interaction. By the end of DY5, the goal is to serve 90 more clients per year.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop already has an outpatient substance abuse treatment program with an existing administrative staff, curriculum and programs, facilities, and electronic health record system. We serve about 400 adult clients currently but need more staff to provide services for all people who are referred to us.

Rationale:

Spindletop Center and its community partners have identified the need in our area for expanded substance abuse treatment and case management services, particularly for those diagnosed with co-occurring disorders. With high unemployment, lower educational attainment, and lower income levels, many citizens of our region are unable to afford substance abuse treatment and the support services needed to achieve recovery. Instead they utilize the ED departments of hospitals more frequently or are incarcerated. Funds provided by the 1115 Waiver will make these treatment and case management services available to a greater number of indigent citizens.

The outpatient substance abuse services proposed in this plan relate to community needs CN.1, CN.6, CN.10, CN.16, and CN.17.

Spindletop currently receives some pass-through Block Grants for Prevention and Treatment of Substance Abuse from the U.S. Department of Health and Human Services, administered by South East Texas Regional Planning Commission, to fund its existing program for youth and adults. The 1115 Waiver funds requested would allow expansion of the adult program.

Components of the project include the following:

- Hire 3 additional licensed chemical dependency counselors and 1 case manager.
- Equip existing Spindletop Center offices to house new staff.
- Train new staff in the existing curriculum.
- Train case manager/health care navigator in cultural competency.
- Identify and assess adults who might benefit from these services through the Spindletop Center Intake Department.
- Identify patients in the Detox program and use case manager/navigator as part of a preventable ED reduction program.
- Purchase a vehicle and provide co-occurring clients with transportation to referral sources.
- Provide clients with individual and group counseling.

- Measure results, such as adherence to treatment protocols, at monthly intervals to track the effectiveness of the program in increasing client recovery from substance abuse addictions . Make adjustments to curriculum/treatment programs as needed to improve results.

For demonstration year 2, the process milestone is to hire additional staff; train staff on identifying referral sources and community services, curriculum, and Motivational Interviewing techniques; equip offices for additional staff; and purchase a vehicle for case manager use.

In demonstration years 3-5, the improvement milestones will be the increase in the number of adults served in the outpatient substance abuse program, beginning with 80 in year 3 and increasing to 85 in year 4 and 90 in year-5. Since the ratio of counselor to client is determined by the state, the growth will be limited.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome domain OD-10, Quality of Life/Functional Status. For DY2, the process milestone is P-1, project planning— identifying current capacity and needed resources, determining timelines, and documenting implementation plans. For DY3-5, the improvement target is IT 10.1, Quality of Life as measured by the Texas Department of State Health Services outcome tool. The target will be 70% of the participating clients discharged successfully from the program each year.

Relationship to Other Projects and Measures:

The case management/navigator services will work closely with Spindletop's DSRIP project for an inpatient detox program (#096166602.1.7). The project to integrate primary care with behavioral health (#096166602.2.1) could also benefit adults who are in the outpatient substance abuse treatment program.

This project's focus on behavioral health and emphasis on detox and substance abuse services ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.10, 096166602.2.11, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on interventions for a targeted behavioral health population to prevent unnecessary use of services in a specified setting along with these other Category 2 projects in our RHP:096166602.1.3-Youth respite/residential treatment; 096166602.2.2 - Community behavioral crisis services; 096166602.2.3 - Behavioral health training; 096166602.2.11 - Inpatient detox services; 096166602.2.4 - Affordable housing for people with mental illness; 135222109.2.2- Provide an intervention for targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specified Setting- "OTHER"; 096166602.2.5- "Other" Project Option; 096166602.2.6-"Other" Project Option; 096166602.2.8- "Other" Project Option.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and substance abuse disorders, emergency room visits, and criminal justice incarceration.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.*2.8*	2.13	2.13.2	Outpatient Substance Abuse Services	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	096166602.3.13	***OD-10*** ***IT-10.1***	Quality of Life/Functional Status, Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Hire and train 4 staff, equip offices, and purchase new vehicle Metric 1 P-X.1. Goal: Hire and train 4 staff, equip offices, and purchase new vehicle Data Source: Project documentation Milestone 1 Estimated Incentive Payment *:* **$**278,180	**Milestone 2** I-X: Increase in number of adults served in outpatient substance abuse program Metric 1 [I-X.1]: Increase in number of adults served in outpatient substance abuse program Baseline/Goal: 80 additional adults served during year Data Source: Admission records Milestone 2 Estimated Incentive Payment: $305,475		**Milestone 3** I-X: Increase in number of adults served in outpatient substance abuse program Metric 1 [I-X.1]: Increase in number of adults served in outpatient substance abuse program Baseline/Goal: 85 additional adults served during year Data Source: Admission records Milestone 3 Estimated Incentive Payment: $326,777	**Milestone 4** I-X: Increase in number of adults served in outpatient substance abuse program Metric 1 [I-X.1]: Increase in number of adults served in outpatient substance abuse program Baseline/Goal: 90 additional adults served during year Data Source: Admission records Milestone 4 Estimated Incentive Payment: $315,741
Year 2 Estimated Milestone Bundle Amount: **$**278,180	Year 3 Estimated Milestone Bundle Amount: $305,475		Year 4 Estimated Milestone Bundle Amount: $326,777	Year 5 Estimated Milestone Bundle Amount: $315,741
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: *$*1,226,173				

PROJECT OPTION: 2.6.4 Implement evidence-based health promotion programs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 096166602.2.9-Pass 2
PERFORMING PROVIDER NAME/TPI: Spindletop Center/096166602

Project Area**:** 2.6 Implement Evidence-based Health Promotion Program
Project Title**:** Early Childhood Intervention Community Outreach
Provider: Spindletop Center is a public entity community center established under the Texas Mental Health and Mental Retardation Act of 1965 and organized under Chapter 534, Title 7 of the Texas Health and Safety Code. It provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.
Intervention: Spindletop will develop an effective and comprehensive public outreach plan to provide information about evidence-based ECI services to community medical and other healthcare providers. We will also assist families in accessing community healthcare resources and health information by providing case managers with laptops and aircards for internet access to be used when providing home and community-based case management services to families.
Need for project: ECI responds to the critical needs of children who have developmental delays and their families by promoting development and learning, providing support to families, coordinating services, and decreasing the need for costly special programs. Public outreach is critical in improving access to services by ensuring that medical and other healthcare providers have accurate information about ECI services and resources so that they can refer patients to ECI as soon as developmental concerns are suspected. The existing ECI program does not have sufficient funding to hire qualified staff dedicated to public outreach and community education.
Target: This project is targeted to infants and toddlers from birth to three years old with developmental delays who are in the four-county region Spindletop serves. The ECI program currently serves approximately 700 families each year; with the proposed community outreach and public awareness, the number of families served is expected to increase about 15% by the end of DY5. Since 70% of Spindletop's current ECI clients are on Medicaid, it is likely that new referrals will also be primarily Medicaid eligible.
Expected benefits: The expected outcomes of this program are to ensure community medical and other healthcare providers have accurate information about ECI services and the benefits of early intervention in promoting overall growth and development of children, to increase quality referrals to the ECI program from medical/healthcare providers, and to provide each case manager with updated computer equipment in order to assist consumers in accessing needed medical, social, developmental and educational resources.

- For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including hiring and training the ECI Public Awareness Coordinator, identifying referral sources, and developing reports to track the number of referrals by

referral source. Equipment for use by case managers will be identified and purchased. In demonstration years 3, the improvement milestone will be that the Public Awareness Coordinator will implement strategies identified in the community outreach and public awareness plan to increase the number of families served by In year 4, the target will be to increase the number of families served an additional 35 (70 cumulative over DY2) and in year 5, the target will be to increase the number of families served an additional 35 (105 cumulative over DY2).

- Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, consumers getting timely ECI and health information. Since mobile devices will be used to expand access for consumers to internet healthcare resources, customer satisfaction surveys will be done to measure the effectivenss of mobile devices in providing consumer access to information. The survey will be designed to produce comparable data on the consumers' perspective on care that will allow objective and meaningful assessment of the program in meeting their needs. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Project Description:

Goal: The goal of this project is to promote the benefits of early childhood intervention (ECI) in improving developmental and health outcomes for infants and toddlers from birth to three years old increasing the number of families served, and to improve consumers' access to healthcare resources and information using technology in community-based settings.

Description: Spindletop will achieve this goal by developing an effective and comprehensive public outreach plan to provide information about evidence-based ECI services to community medical and other healthcare providers. Spindletop will also assist families in accessing community healthcare resources and health information by providing case managers with laptops and aircards for internet access to be used when providing home and community-based case management services to families with children in the ECI program.

Challenges: The existing ECI program does not have sufficient funding to hire qualified staff dedicated to public outreach and community education. All staff currently have caseloads and provide required direct care services (specialized skills training, occupational therapy, physical therapy, speech therapy, case management services, etc.) which prevents effective public outreach and community education efforts. Funding limitations also prevent purchase of computers to replace those that have reached end of use; case managers could use these computers with aircards to provide families with access to internet-based resources in home and community-based settings. DSRIP funding would allow us to hire needed staff and purchase appropriate equipment.

Outcomes: The expected outcomes of this program are to ensure community medical and other healthcare providers have accurate information about ECI services and the benefits of early intervention in promoting overall growth and development of children, to increase quality referrals to the ECI program from medical/healthcare providers, and to provide each case

manager with updated computer equipment in order to assist consumers in accessing needed medical, social, developmental and educational resources.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

Spindletop Center's ECI program currently provides home and community-based services to approximately 700 families with infants and toddlers birth to three years who have significant developmental delays or have medical diagnoses that potentially affect growth and development. The program seeks to coordinate care with primary care physicians and specialists by providing referral disposition information to medical providers via fax. Case managers have temporarily been issued internet aircards for laptop computers, but funding will not be available to continue these devices beyond this year. This will restrict their ability to assist families in effectively accessing health information and resources.

Rationale:

Research shows that growth and development are most rapid in the early years of life. ECI responds to the critical needs of children and families by promoting development and learning, providing support to families, coordinating services, and decreasing the need for costly special programs. Public outreach is critical in improving access to services by ensuring that medical and other healthcare providers have accurate information about ECI services and resources so that they can refer patients to ECI as soon as developmental concerns are suspected. Having staff dedicated to public outreach and community education is necessary to promoting the benefits of early intervention and improving access to services for eligible children.

In addition to providing allied healthcare services such as occupational therapy, physical therapy, speech therapy, and nutritional counseling, ECI case managers assist families in accessing needed social, educational, medical and developmental services in the community. Healthcare providers have begun to provide similar systems to allow for electronic distribution of client information via email or websites. However, one key factor that may limit the success of these programs is that all clients may not have ready access to a web-enabled device or computer. Clients of intensive Medicaid services are often those who have little or no access to the devices (laptops, tablets, or smartphones) that are able to help them find and use healthcare information being provided via the internet. Equipping case managers with laptop computers will allow them to share health information with client families in their homes or other community settings.

The program proposed in this plan relates to community needs CN.1 and CN.2

This project is a supplement to Spindletop's existing ECI program. Although Spindletop receives Federal funding for its ECI program, this money is used primarily to provide direct care services and is not sufficient to fund the costs of an ECI Public Awareness Coordinator or laptops for case managers to use in providing health information for client families. Components of the project include the following:

- Hire one staff to provide community outreach and public awareness for ECI and train to develop knowledge of early intervention services

- Identify medical and other healthcare providers who might recommend patients for ECI services
- Develop and implement a comprehensive ECI outreach and public awareness plan, including designing promotional materials
- Purchase and deploy laptops and aircards for 15 existing staff to use in providing health information to client families in their homes or other community settings.
- For ongoing quality improvement, monitor the results of the program as measured by an increase in referrals to the ECI program and by client satisfaction surveys.

For demonstration year 2, the process milestone is to design the project plan and begin the initial phases, including hiring and training the ECI Public Awareness Coordinator, identifying referral sources, and developing reports to track the number of referrals by referral source. Equipment for use by case managers will be identified and purchased.

In demonstration years 3, the improvement milestone will be that the Public Awareness Coordinator will implement strategies identified in the community outreach and public awareness plan to increase the number of families served by 35 . In year 4, the target will be to increase the number of families served an additional 35 (70 cumulative over DY2) , and in year 5, the target will be to increase the number of families served an additional 35 (105 cumulative over DY2).

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome measure IT-6.1 for DY3-5, percentage improvement over baseline of patient satisfaction scores, consumers getting timely ECI and health information. The annual ECI Family Outcome Survey currently proscribed by the ECI program will establish the baseline in DY2. . Since mobile devices will be used to expand access for consumers to internet healthcare resources, ECI Family Outcome survey will expanded to measure the effectiveness of mobile devices in providing consumer access to information. The survey will be designed to produce comparable data on the consumers' perspective on care that will allow objective and meaningful assessment of the program in meeting their needs. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Relationship to Other Projects and Measures:

This project relates to Spindletop's project to provide a client health information access portal since information on the portal would be available tp ECI consumers via the internet.

This project's focus on patient education using technology and emphasis on early childhood intervention ties to these Category 1 and 2 projects in our RHP: 112706003.2.5, 094092602.2.9, 096166602.2.8. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on promoting the benefits of early childhood intervention (ECI) in improving developmental and health outcomes for infants and toddlers from birth to three years old through information technology in community based settings. There are no other related Category 2 similar projects in our RHP.

Project Valuation:

In valuing this project, Spindletop considered the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention

096166602.2.9	2.6	2.6.4	Early Childhood Intervention Community Outreach	
Spindletop Center				096166602
Related Category 3 Outcome Measure(s):	**096166602.3.14**	**OD-6** **IT-6.1**	**Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X: Design plan, hire and train staff, identify referral sources and develop tracking report; purchase laptops and aircards Metric 1 P-X.1: Goal: Design plan, hire and train staff, identify referral sources and develop tracking report, purchase laptops and aircards Data Source: Project documentation, payroll records, purchase records Milestone 1 Estimated Incentive Payment *:* $180,912	**Milestone 2** I-X: Increase in number of families served Metric 1 [I-X.1]: Increase in number of families served Baseline/Goal: 35 additional families served Data Source: ECI service records Milestone 2 Estimated Incentive Payment: $203,536		**Milestone 3** I-X: Increase in number of families served. Metric 1 [I-X.1]: Increase in number of families served Baseline/Goal: 35 additional families served (cumulative 70 families from DY2) Data Source: ECI service records Milestone 3 Estimated Incentive Payment: $208,526	**Milestone 3** I-X: Increase in number of families served. Metric 1 [I-X.1]: Increase in number of families served. Baseline/Goal: 35 additional families served (cumulative 105 families from DY2) (cumulative 15% from DY2) Data Source: ECI service records Milestone 4 Estimated Incentive Payment: $215,450
Year 2 Estimated Milestone Bundle Amount: $180,912	Year 3 Estimated Milestone Bundle Amount: $203,536		Year 4 Estimated Milestone Bundle Amount: $208,526	Year 5 Estimated Milestone Bundle Amount: $215,450
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $808,424				

PROJECT OPTION: 2.18.1 Recruit, train, and support consumers of mental health services to provide peer support services

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136367307.2.1
PERFORMING PROVIDER NAME/TPI: The Burke Center/136367307

Provider: Under Texas statutes, the Burke Center is designated as a Community Mental Health and Mental Retardation Center. Burke Center provides community-based behavioral health, early intervention and intellectual disability services to persons living in a twelve county catchment area. Ten of these counties (Angelina, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler) are contained in RHP 2. The remaining two (Houston and Trinity) are contained in RHP 1. This service area stretches over 10,000 square miles and contains 370,000 persons. It has been designated a mental health professional shortage area.
Project: This project will train and employ Peer Specialists to provide "whole health" support to mental health consumers in order to prevent or manage comorbid chronic health conditions.
Need for the Project: Persons with severe mental illness are at increased risk of mortality and poor health outcomes as evidenced by their disparate life expectancy (dying 29 years younger than the general population).
Target Population: The target population for this project is persons with severe mental illness who have or are at risk of developing other chronic health disorders. The vast majority of these persons are medically indigent or Medicaid eligible.
Category 2 Patient Benefits: In DY 5, 50% of persons receiving peer support services will show improvement in at least one identified health risk area.
Category 3 outcomes: IT-10.1 This project will demonstrate improvement in quality of life scores as measured by evidence based and validated assessment tool for the target population.
PROJECT DESCRIPTION:
This project will develop a program to use 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 peer support services. Peer Providers have a unique opportunity to build relationships with others moving toward recovery by providing supportive services that are not necessarily clinical in nature. Peers will be certified as peer specialist with additional specific training geared toward whole health support and interventions of current consumers.
With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases and other related problematic health concerns, and improve quality of life. Funding is very limited in this area with resource limitation cited as a reason for few agencies building a peer network. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illnesses. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase.

Project Goals:

The goal of this project is to use 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 peer support services. These services are supportive and not necessarily clinical in nature. Building on a project originally established under the State's Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training is provided to certified peers specialists in "whole health". With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes and COPD. While such training currently exists, very limited numbers of peers are trained due to resource limitations. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase

1.) Expand use of peer providers
2.) Assess and improve health and quality of life of mental health consumers via peer specialist

Anticipated Challenges:

Some of the challenges faced by the center will be recruiting qualified peer providers and developing a referral program to ensure individuals receive this needed service. The center will utilize traditional recruiting practices to identify peer providers.

The 5-Year expected outcomes:

At the end of the five year project the center will have implemented a viable and thriving peer program which improves the health of individuals with severe and persistent mental illnesses identified with a myriad of health risks. Measured improvements in the quality of life of the individual being served will be documented outcomes.

Regional goals:

Regional goals focus on expanding and improving health care for the constituents in the region. An internal referral process will be developed within the intake department for mental health services to help with referrals for this service. Peer providers offer an expanded unique and specialized service for individuals who exhibit health risk factors. Collecting and synthesizing peer provider date will help in improving the quality of patient care.

STARTING POINT/BASELINE:

Burke Center currently runs a small peer provider service in one hub clinic. This project will allow the center to expand this service to all hub clinics as well satellite clinics throughout the service area. The center currently employees three part time peer providers who have

provided services to 75 individuals during the FY 2012. This project will allow for a total of eight fulltime peer providers working with a much greater number of individuals, and specifically those who are identified as having a health risk factor.

Burke Center services are limited by contractual agreement with the Department of State Health Services (DSHS) to persons in crisis or those meeting "priority population" or the more stringent "target population" diagnoses, per DSHS. Target Population diagnoses include individuals with schizophrenic disorders (32% of population served), bi-polar disorders (42%), and major depressive disorder (26%) with a global assessment of functioning below 50 in our adult population. There is a waiting list for adult outpatient services and large a number of individuals are referred to already strained and limited community resources. Resources are inadequate to provide care for persons with significant mental illnesses outside the "priority population" definitions. Most of the individuals referred or placed on the waiting list have limited funds to pay for services in the community. Adding peer services will help serve those individuals who may otherwise not receive needed services due to resource limitations.
Burke Center currently provides services to approximately 1950 adults. One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness and can be considered as population affected. The needs assessment morbidity data indicates there is a 76.8% gap in our area based on shortage of mental health providers. We anticipate this to equate to approximately 500 individuals per year being serviced in some capacity for mental health concerns. The peer specialist program will not only provide services to current individuals being served but also to those whom we anticipate providing services to under our related projects.

RATIONALE:

Relationship Between project choice and community needs:

The selected option is 2.18.1 which includes the development of a peer specialist program. In recent years the mental health field has seen an increase in the number of services provider by peer specialists. Peer specialist have unique opportunity to reach individuals in a number of areas that are generally not seen as clinical but more supportive.

a) Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.
    a. This is completed.
b) Conduct readiness assessments of organization that will integrate peer specialists into their network.
    a. This is completed.
c) Identify peer specialists interested in this type of work.
    a. We currently have four peer providers and will be utilizing our centers established recruiting tools to hire more peer specialists.

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.
    a. Currently our peer specialists are certified as Peer Specialists. All new peer specialists will be required to be certified. Additional training will be completed by each peer specialist around the areas of whole health as well as in delivering and interpreting a standardized health risk assessment tool.
e) Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.
    a. Health risk assessments will be conducting upon entrance into the behavioral health program. Individuals identified as having a health risk factor will be referred for peer services.
f) Identify patients with serious mental illness who have health risk factors that can be modified.
    a. A standardized health risk assessment tool that best fits the "Whole Health" model will be used to identify individuals with a health risk assessment.
g) Implement whole health peer support.
    a. As all the above factors line up a whole health support system will be implemented.

Some of the core components of the project are to train clinical staff in the use of peer specialists as part of the multidisciplinary provider team. Assessing readiness of other staff for the implementation of the program as well as identifying peer who have a passion to help others through their recovery journey. Peer specialist certification is already available but this project will expand into more areas of the whole health of individuals served. Training modalities on evidence based practices will be completed by peer specialist to better equip them to help identified individuals. The project will identify a health assessment tool looking at various quality of life issues. This tool will be used as a foundation for referral to peer services as well as the baseline for determining outcomes. Individuals with behavioral health issues, including severe mental illness and the safety net population will be directly impacted by the implementation of a whole health peer support program. In addition identified individuals will be linked with primary care and preventive service supports, as needed. The use of an evidenced based health risk assessment/quality of life tool will be used to mark progress. Periodic evaluations of the program to look at "lessons learned" as well as other barriers will be conducted to continue identify solutions to challenges and look identify success.

Several DY 2 and DY 3 Process Metrics and Milestones will be chosen to show the breadth and depth of the program. Process Milestone P-4 is the selection of a valid health risk

assessment/quality of life tool with Process Milestone P-4.1 being the increase in the number of assessments completed. Process Metric P-5 is the identification of the target population who are determined to have a health risk. Process Milestone P-5.1 will be the number of individuals who are identified with a health risk. Process metric P-6 is the implementation of peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors. Process Metric P-6.1 deals with actually providing services to the target population who were identified as having a health risk factor. Eighty percent of these individuals will receive a peer services in the area identified on the health risk assessment. For quality improvement we will utilize P-10. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.

All this items will lead to the Improvement Milestone I-18 which looks at a certain percent of identified target population with an identified health risk showing improvement in an area of deficiency. The target, to be determined later, will be based on a percentage of individuals demonstrating improvement in at least one identified health risk area over the course of supportive peer specialist intervention.

Unique Community Need Identification numbers:

CN.1
CN.5
CN.6

Expansion or Enhancement:

Burke Center is currently using peer providers in a limited manner but the individuals served in our area would benefit from expanded service. Services are enhanced by adding a whole health competent.

RELATED CATEGORY 3 OUTCOME MEASURES:

For this measure OD- 10 Quality of Life/ Functional Status will be utilized to determine Outcome Domain. The use of peer providers will significantly improve the quality of life of the individuals served. Further individuals moving towards recovery show improvement in identified health risk areas. Needs based services in this area helps eliminate concern over these identified areas leaving the individual the strength to focus on life domains to improve. The entire project relates back to the validated health assessment/quality of life tool utilized to identify individuals with a health risk need area. To accomplish this we will use Process

Milestone P-2 to establish a baseline rate using a standardized and validated health risk assessment tool. Using Process Milestone P-4 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection, determine barriers/challenges, develop interventions, and make changes to established interventions that lead to successful improvement outcome targets. Quality of Life improvements IT-10.1 will be seen as measured by pre/post validated health assessment tool. Special emphasis will be given to indigent and safety-net populations in the catchment. Currently approximately 50% individuals seeking services meet the safety-net definition and significantly more would fall into the indigent category.

RELATIONSHIP TO OTHER PROJECTS:

This project is related to Category 1.1.1 Expand Primary Care Capacity and to Category 1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth. Both of these projects will be focusing on the expansion of service in the medically underserved catchment area; one in the form of individuals to provide the services and the other to provide better modality of reaching clients in satellite locations. The addition of the peer specialist program will work help in providing services to the influx of individuals who will now be able to be served in the system. Peer specialist will provide a vital service as part of the multi-disciplinary team. Having enough peer specialists to cover individuals seeking these services will be extremely crucial to these projects.

This project's focus on behavioral health services and emphasis on peer support and whole health ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the recruitment, training, and support of consumers of mental health services to provide peer support services along with these other Category 2 projects in our RHP: 096166602.2.7 Recruit, Train and Support Consumers of Mental Health Services to Provide Peer Support Services

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase.

The target population for all of services is largely uninsured individuals or those with Medicaid/Medicare for whom no providers are available in the service region.

One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness. We are anticipating increasing our total number served through our Expansion of Behavioral Healthcare project at a rate to be later determined. Individuals identified as having health risk factors will receive targeted support services from peer specialists as well as linking to primary and preventative care. In the end individuals in our target population will have better health risk outcomes which impact the number of primary care visits they would throughout the year.

.

136367307.2.1	2.18	2.18.1 (a-g)	Recruit, train, and support consumers of mental health services to provide peer support services	
The Burke Center				136367307
Related Category 3 Outcome Measure(s):	136367307.3.3	IT-10.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone: 1 **P-4**- Select and implement a health risk assessment (HRA) tool. Process Metric: P-4.1 - Number of HRAs completed by consumers. Baseline: We have had zero HRA's completed in FY 2012. Goal: At least 10% of all newly opened individuals identified as safety-net population will complete an HRA. Data Source: An internal service code will be developed to track all HRAs completed by all new individuals receiving services. Individuals meeting safety-net population status (indigent) will be tracked. Milestone 1 Estimated Incentive Payment (maximum amount): $140,700.50 **Process Milestone:2** **P-5**- Identify health risks of consumers with serious mental illness.	**Process Milestone: 3** **P-6**- Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors. Baseline: We currently do not have peer services focused on whole health Goal: At least 10% of individuals identified as having a health risk factor will receive a related peer specialist service. Process Metric**:** **P-6.1**- Number of participants receiving peer services. Baseline: No individuals were identified as having health risk factors for FY 2012. Goal: At least 10% of individuals identified as having a health risk factor will receive a related peer service and 83 new peers served. Data source: Internal peer service code will be documented each time a peer service is provided to an individual.		**Improvement Milestone 1** I-18 - Health Outcomes Improvement Metric: I-18.1 - Improvements in standardized health measures for consumers who participate in whole health peer support Goal: A least 50% individuals receiving peer support services will show improvement in at least one identified health risk area and 167 new individuals will be served. Data Source: The initial Health Risk Assessment with identifiable health factors will be kept in the agencies EMR. A final Health Risk Assessment will be conducted and scores will be compared to baseline for each individual who received services. Milestone I-18 Estimated Incentive Payment (maximum amount): $256,374	**Improvement Milestone 2** I-18- Health Outcomes Improvement Metric: I-18.1 - Improvements in standardized health measures for consumers who participate in whole health peer support Goal: A least 50% of individuals receiving peer support services will show improvement in at least one identified health risk area and 250 new individuals will be served. Data Source: The initial Health Risk Assessment with identifiable health factors will be kept in the agencies EMR. A final Health Risk Assessment will be conducted and scores will be compared to baseline for each individual who received services. Milestone I-18 Estimated Incentive Payment (maximum amount): $227,888

136367307.2.1	2.18	2.18.1 (a-g)	Recruit, train, and support consumers of mental health services to provide peer support services	
The Burke Center				136367307
Related Category 3 Outcome Measure(s):	136367307.3.3	IT-10.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Metric: **P-5.1**- Number of consumers identified with modifiable health risks. Baseline: We have had zero consumers with serious mental illnesses identified with health risks in FY 2012. Goal: Utilizing an HRA we will identify 100% of the individuals completing an HRA who have a health risk. Data source: The HRA will be placed into the agencies EMR which will have identifiable codes associated with certain health risks. Milestone 2 Estimated Incentive Payment (maximum amount): $140,700.50	Milestone P-6 Estimated Incentive Payment (maximum amount): $256,374 **Process milestone 4** P-10. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest			

136367307.2.1	2.18	2.18.1 (a-g)	Recruit, train, and support consumers of mental health services to provide peer support services	
The Burke Center				136367307
Related Category 3 Outcome Measure(s):	136367307.3.3	IT-10.1	Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 4 Estimated Incentive Payment (maximum amount):			
Year 2 Estimated Milestone Bundle Amount: $281,401	Year 3 Estimated Milestone Bundle Amount: $256,374		Year 4 Estimated Milestone Bundle Amount: $256,374	Year 5 Estimated Milestone Bundle Amount: $227,888
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,022,037				

PROJECT OPTION: 2.15.1-Design, Implement and Evaluate Projects that Provide Integrated and Behavioral Health Care Services

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136367307.2.2- Pass 3b
PERFORMING PROVIDER NAME/TPI: The Burke Center/136367307

DSRIP Project: 2.15 Integrate Primary and Behavioral Health Care Services
Provider: Under Texas statutes, the Burke Center is designated as a Community Mental Health and Mental Retardation Center. Burke Center provides community-based behavioral health, early intervention and intellectual disability services to persons living in a twelve county catchment area. Ten of these counties (Angelina, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler) are contained in RHP 2. The remaining two (Houston and Trinity) are contained in RHP 1. This service area stretches over 10,000 square miles and contains 370,000 persons. It has been designated a mental health professional shortage area.
Project: This project will integrate primary care with behavioral health care services the Center provides in order to improve access to needed health services and improve overall health and wellbeing. Burke Center will partner with Angelina County/Cities Health District to create an integrated health home for Burke Center clients with one or more comorbid chronic conditions and expand access to behavioral health services for clients of the Health District Clinic.
Need for the Project: Persons with severe mental illness are at increased risk of mortality and poor health outcomes as evidenced by their disparate life expectancy (dying 29 years younger than the general population).
Target Population: The target population for this project is persons with serious mental illness who have or are at risk of developing other comorbid chronic health conditions. The vast majority of these persons are medically indigent or Medicaid eligible.
Category 2 patient benefits: By DY 5, 90% of the persons served who need primary care will be receiving integrated care, i.e. both physical and behavioral health care at the established locations. Estimated number served in DY5 is 990.
Category 3 outcomes: IT-6.1.1 improved access to care will be reflected in improved patient satisfaction in receiving timely care, appointments, and information. The Center will participate in a statewide learning collaborative to identify and implement other relevant measures and strategies for data collection through HIEs or other sources.
Project Description:
Goal: The goal of this project is to integrate primary care with the behavioral health care services the Center provides in order to improve access to needed health services for the clients we serve and improve their overall health and well-being.
Description: The Burke Center will partner with the Angelina County/Cities Health District to integrate primary and behavioral health using an approach based on the NCCBH Four Quadrant Model. Burke Center will make available behavioral health workers to the health clinic to provide mental health services and supports to clients best served in that setting. The Health District will co-locate a medical nurse practitioner/primary care physician in the Angelina

Mental Health Center to provide routine primary care to persons with severe and persistent mental illness or intellectual disabilities who are best served in the behavioral health setting. Together, we will create a health home for Burke Center clients with one or more comorbid chronic conditions and expand access to behavioral health services for clients of the Health District Clinic.

Challenges: Although The Burke Center currently provides some basic care related to psychiatric services, we have not expanded other physical health care services due to funding limitations. Clients who are uninsured or have Medical have problems finding a primary care physician who will see them. The Angelina County/Cities Health District is the major provider of primary care for the Medicaid and indigent population but lacks the capacity to serve all who need help. Partnering with the Angelina County/Cities Health District to expand primary care resources will help address these challenges.

Outcomes: By integrating primary care with The Burke Center's behavioral services in Angelina County, 1100 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of demonstration year 5. Addressing the physical health needs of clients will result in improved quality of life for these clients as well as reducing emergency room visits and hospitalizations for more severe illnesses and diseases that occur when physical health is neglected. This project will serve 90% of persons identified as needing primary care, an estimated 990 persons by DY5.

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Starting Point/Baseline:

The Burke Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression. We currently have plans to construct a new facility that will include space to co-locate primary care providers. This new facility will be very close to the Health District Clinic site and this proximity will help with coordination of services. DSRIP funds are not requested for construction costs.

Rationale:

Behavioral health clients have a high incidence of high blood pressure, cholesterol, obesity, diabetes, and other severe illnesses that shorten their life spans by 25 years compared to the general public. They are frequently high utilizers of hospital emergency departments because they do not have access to regular physical health care.

The Region 2 Community Needs Assessment has identified the need for expanded physical health care in our area. The Burke Center has determined further that many of our behavioral health clients do not have access to physical health care because they are uninsured or lack funds to pay for these services. Health clinics that serve indigent populations frequently do not have capacity to accept more patients and charge a fee higher than many clients are able or

willing to pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits. Co-locating primary care providers in our behavioral health facilities and coordinating healthcare appointments will increase the likelihood that our clients will receive the physical health care they need.

The primary care/behavioral health integration proposed in this plan relates to community needs CN.1, CN.2, CN.3, CN.10 and CN.12-15.

This project represents a new initiative for The Burke Center. No U.S. Department of Health and Human Services funding is received for this program.

Required core components:

a. Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Burke Center has identified its largest outpatient site, the Angelina Mental Health Center as the location for the integration project. The nearby Angelina County/Cities Health District clinic will be a partner in this project. What is undetermined is the exact number of persons served by Burke Center who would benefit from expanded access to primary care. Using the Four Quadrant Model, we will need to determine the number of individuals who would need primary care at each location. Analysis will be part of a plan developed by Burke Center in conjunction with the Health District for this project.
b. Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. These arrangements will be made between Burke Center and the Health District Clinic in DY 2 as part of the plan.
c. Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers. These arrangements will be made between Burke Center and the Health District Clinic in DY 2 as part of the plan.
d. Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations. The number of specialty providers will be determined as part of the plan. The appropriate number of providers will be recruited and hired beginning in DY 2
e. Train physical and behavioral health providers in protocols, effective communication and team approach. These trainings will be developed as part of the plan. They will be initiated collaboratively between Burke Center and the Health district Clinic in DY 2. Training will be ongoing and will focus on person-centered and recovery oriented treatment planning and service delivery. It will include licensed staff as well as peer consultants and community health workers.
f. Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting. These arrangements will be made between Burke Center and the Health District Clinic in DY 2 as part of the plan.

g. Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice. These arrangements will be made between Burke Center and the Health District Clinic in DY 2 as part of the plan.
h. Arrange for utilities and building services for these settings. This has been addressed.
i. Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings. The development of these mechanisms will be included as part of the plan.
j. Conduct quality improvement for project using methods such as rapid cycle improvement. The implementation plan will include the design of an ongoing approach to quality management and improvement. This will include key performance indicators and metrics designed to be used as part of a rapid cycle improvement process.

Category 3 Outcome Measure:

The Burke Center has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health.

In addition, Burke 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.

Relationship to Other Projects and Measures:

This project relates to The Burke Center's project 1.12 to enhance service availability of appropriate levels of behavioral health. Patients served through the expansion project in Angelina County would have access to primary care as well. This project also relates to 2.18 that expands peer support. Peers will be part of the integration team and will work to address health and wellness treatment goals.

This project's focus on integrating primary and behavioral health and emphasis on creating a patient medical home ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5,

096166602.2.6, 135222109.2.2, 096166602.2.8, 136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on the integration of primary and behavioral health care services along with these other Category 2 projects in our RHP: 135222109.2.1- Integrate primary and behavioral health care services in Brazoria/Galveston county; 109372601.2.2 - Expanding integrated primary care and behavioral/mental health care access using APC; 136367307.2.2- Design, Implement and Evaluate Projects that Provide Integrated and Behavioral Health Care Services.

Project Valuation:

The Burke Center 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.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

136367307.2.2	2.15	2.15.1	Integrate Primary and Behavioral Health Care Services	
The Burke Center				
Related Category 3 Outcome Measure(s):	136367307.3.4	OD-6 IT-6.1	Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X.1 Establish a baseline Metric 2.15.1 P-X.1 Determine the number of Burke Center clients in need of primary care according to the 4 Quadrant Model. Baseline/Goal: Establish baseline Data Source: Medical Records Payment: $721,595 **Milestone 2** P-X.2: Complete a planning process to implement the integration of primary and behavioral health care Metric 2.15.1 P-X Develop protocols, agreements, needs assessment and staffing plan Baseline/Goal: Completion of plan Data Source: Plan document Milestone 1 Estimated Incentive Payment : $721,595	**Milestone 3** P-5 Develop integrated sites Metric 2.15.1 [P-5.2]:Number of primary care providers newly located in behavioral health settings Baseline/Goal: One primary care provider Data Source: Scheduling records Milestone 3 Estimated Incentive Payment: $674,882 **Milestone 4** I-8.1 Integrated services Metric [I-8.1] % of Burke Center clients identified as needing primary care are receiving both physical and behavioral health care at the established locations. (# with integrated care/# Burke Angelina clients identified as needing primary care) Goal: 30% (estimated number 280) Data Source: Medical records Milestone 4 estimated incentive payment: $674,882		**Milestone 5** I-8 Integrated services Metric 2.13.1 [I-8.1] 20% of persons receiving both physical and behavioral health care at the established locations. Goal: 20% Metric [I-8.1] % of Burke Center clients identified as needing primary care are receiving both physical and behavioral health care at the established locations. (# with integrated care/# Burke Angelina clients identified as needing primary care) Goal: 60% (estimated number 600) Data Source: Medical Records Milestone 5 Estimated Incentive Payment: $1,032,062	**Milestone 6** P-7 Evaluate and continuously improve integration of primary and behavioral health services Metric P-7.1 Project planning and implementation documentation demonstrates plan, do, study act CQI cycles Goal: CQI implemented Data Source: Project documentation Milestone 6 Estimated Incentive Payment: $580,216 **Milestone 7** I-8 Integrated services Metric 2.13.1 [I-8.1] %of Burke Center clients identified as needing primary care are receiving both physical and behavioral health care at the established locations. (# with integrated care/# Burke Angelina clients identified as needing primary care) Goal: 90% (estimated 990 persons) Data Source: Medical Records Milestone 5 Estimated Incentive Payment: $580,216

136367307.2.2	2.15	2.15.1	Integrate Primary and Behavioral Health Care Services	
The Burke Center				
Related Category 3 Outcome Measure(s):	136367307.3.4	OD-6 IT-6.1	Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: $1,443,190	Year 2 Estimated Milestone Bundle Amount: $1,349,764		Year 4 Estimated Milestone Bundle Amount: $1,302,062	Year 5 Estimated Milestone Bundle Amount: $1,160,432
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $5,255,448				

PROJECT OPTION: 2.13.1-Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136367307.2.3- Pass 3b
PERFORMING PROVIDER NAME/TPI: Burke Center/136367307

DSRIP Project: 2.13.1 Intensive Specialized Services
Provider: Under Texas statutes, the Burke Center is designated as a Community Mental Health and Mental Retardation Center. Burke Center provides community-based behavioral health, early intervention and intellectual disability services to persons living in a twelve county catchment area. Ten of these counties (Angelina, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler) are contained in RHP 2. The remaining two (Houston and Trinity) are contained in RHP 1. This service area stretches over 10,000 square miles and contains 370,000 persons. It has been designated a mental health professional shortage area.
Project: The goal of this project is to promote mental health recovery and prevent individuals from experiencing repeated hospitalizations or incarcerations. This project would create a specialized interdisciplinary team (including psychiatrists, peers, substance use counselors, therapists, community health workers, and mental health deputies) to provide mobile treatment and supports for high risk/high need individuals through a variety of supportive interventions.
Need for the Project: Individuals with severe mental illness or with a combination of behavioral health and physical health needs are at high risk for functional deterioration. They often cycle through the mental health and criminal justice system. Intensive, specialized home/community based interventions are needed to help individuals receive specialized therapies, establish a stable living environment, access health care and substance use treatment and improve their daily functioning.
Target Population: The target population for this project is persons with serious mental illness who experience repeated hospitalizations or incarcerations. The vast majority of these persons are medically indigent or Medicaid eligible.
Category 2 Patient Benefits: By DY3 service volume will increase over baseline by 50% from 428 to 642 individuals served per year. By DY5, 75% (482 individuals) of all 642 individuals receiving specialized interventions will demonstrate improved functional status on standardized instruments like the ANSA.
Category 3 Outcomes: IT-6.1.1 improved access to care will be reflected in improved patient satisfaction in receiving timely care, appointments, and information. The Center will participate in a statewide learning collaborative to identify and implement other relevant measures and strategies for data through HIEs or other sources.
Project Description:
The goal of this project is to promote wellness and recovery in the community and prevent individuals from cycling through the mental health system, often requiring admission to intensive inpatient services for stabilization of recurring acute symptoms. Challenges currently faced include a limited number of specialized providers to serve a growing population of medically indigent individuals and a limited array of treatment modalities and resources to

meet the needs of individuals with multiple concomitant issues. There is currently no short-term, community-based residential, crisis respite care available within the Burke Center's region. Without this resource, individuals who are experiencing environmental stresses such as housing challenges or stressors in the family and/or increased psychiatric symptoms are at increased risk for going into crisis and requiring treatment in a more restrictive environment. Current restrictions impose time constraints on how long services can be provided to individuals. This often results in services being terminated prematurely, regardless of an individual's need for ongoing treatment. There are currently no mental health deputies available to respond to emergency calls and help divert individuals from the criminal justice system. This project addresses these challenges by creating a specialized interdisciplinary team comprised of: psychiatrists, therapists, peer providers/community health workers, a substance abuse specialist (via partnering with the Alcohol and Drug Abuse Council of Deep East Texas), and a mental health deputy (via partnering with local law enforcement agency/agencies) to provide a broad range of community-based specialized therapies and a variety of supportive services. Such a team could more adequately address significant co-occurring issues such as serious mental illness, substance use, homelessness, unemployment, lack of daily living skills, and lack of natural supports. The inclusion of crisis respite services in this project would create a "safety net" to prevent unnecessary hospitalization and assist individuals in maintaining residence in the community by providing close supervision and assistance, including group and individual services in a non-stressful environment. This project would also enable the length of treatment to be catered to the needs of each individual, allowing many to receive intensive home and community-based specialized services for as long as needed. The Burke Center would like to partner with members of the local law enforcement community to create a mental health deputy position. A mental health deputy could increase safety at the scene of an emergency and increase the likelihood of individuals being diverted from the criminal justice system.

The expected 5-year outcome is a 50% expansion of the number of clients served, an improvement of the quality of provider interventions, and an improvement of the functional status of individuals served. This project relates to RHP 2's goal to increase care that's centered on individual needs and that improves each individual's experience. It also relates to RHP 2's goals to improve the health of the population and use resources more efficiently, effectively, and equitably. Project 2.13 is focused on providing a variety of supportive interventions in homes and/or community locations which are convenient to individuals who would otherwise lack the ability to travel to a mental health/substance abuse provider. This project also proposes to create short-term crisis respite services and implement a number of specialized services (i.e., CAT, CBT, DBT, peer support, etc.) that have been proven effective.

Starting Point/Baseline:

The Mobile Crisis Outreach Team (MCOT) currently serves an average of 428 individuals per year. However, only 25% of MCOT providers are trained in any form of specialized services, yet this team provides over 2,600 direct service encounters within any given 12-month period. At this time, MCOT does not have any specialized counseling services, substance abuse specialists, peer providers, or mental health deputies. Also, there is no short-term crisis respite care available within the Burke Center's region. With additional resources, MCOT could continue

serving these individuals and serve 50% more (214 more individuals) per year, serving a total of 642 individuals per year more intensely.

Rationale:

The selected project option is 2.13.1, which includes designing, implementing, and evaluating research-supported and evidence-based interventions tailored towards individuals in a target population. Individuals with severe mental illness and/or who have a combination of behavioral health and physical health needs are at high risk for functional deterioration and frequently cycle through the mental health system. Intensive, specialized home/community-based interventions are needed to help individuals access specialized therapies, establish a stable living environment, access services for medical and/or substance use treatment, and ultimately improve their daily functioning.

Core project components include (a.) assessing the size, characteristics, and needs of the target population. Burke Center will be assessing the size, characteristics, and needs of the target population. Project components also include (b.) reviewing literature/experience with populations similar to the target population to determine community-based interventions that are effective in diverting negative outcomes such as decreased mental and physical functional status and in promoting correspondingly positive health and social outcomes/quality of life. Burke Center will review literature/experience to determine effective community-based interventions that avert negative outcomes and promote positive health and social outcomes. Further, (c.) a project evaluation plan will be developed using qualitative and quantitative metrics to determine outcomes. Burke Center will develop a project evaluation plan, using qualitative and quantitative metrics, to determine outcomes. (d.) Models will be designed which include an appropriate range of community-based services and residential supports. Burke Center will design models that address what's appropriate regarding community-based/residential supports. Last but not least, (e.) core project components include assessing the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Burke Center will assess the impact of interventions via relevant quantitative and qualitative analyses.

The DY2 process milestone (P-2) is to design community-based specialized interventions for the target population. The DY2 process metric (P-2.1) includes creating/documenting project plans based on evidence/experience and which address the project goals. The DY3 process milestone (P-3) includes enrolling and serving individuals with targeted complex needs that significantly impact their functioning, such as a diagnosis of severe mental illness with concomitant circumstances, including chronic physical health conditions, chronic or intermittent homelessness, substance use/abuse, and/or cognitive issues resulting from severe mental illness. The DY3 process metric (P-3.1) includes documenting the number of targeted individuals enrolled/served in the project. The DY4 and DY5 process milestones (P-4) include evaluating and continuously improving interventions. The process metric to be used in both DY4 and DY5 includes project planning and implementation documentation. These project reports will include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. The improvement milestone for DY2, DY3, DY4, and DY5 includes measuring the functional status of individuals receiving specialized interventions. The improvement metric for DY2, DY3, DY4, and DY5 includes finding and reporting the percentage of individuals receiving specialized interventions who demonstrate improved

functional status on standardized instruments. It also includes reporting the numerator and denominator associated with the percentage, revealing the data source, and providing rationale/evidence for the project.

This project represents a new initiative for the Burke Center that enhances the Mobile Crisis Outreach Team's services. There are no such DSRIP projects or activities at the Burke Center that receive funding from the U.S. Department of Health and Human Services. The primary care/behavioral health integration proposed in this plan relates to community needs CN.5, CN.6 and CN.10.

This rural area has a higher rate of individuals living in poverty and uninsured, as compared to the U.S. population. While 15% of the U.S. population lived below the federal poverty level and 8% were unemployed in 2011, 19-26% of this rural population lived below the poverty level and 10.5% were unemployed (U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011). Between 25% and 29% of individuals in this rural population were uninsured in 2009, compared to 16% of the U.S. population (U.S. Census Bureau and the Centers for Disease Control and Prevention, Small Area Health Insurance Estimates [SAHIE] for State and County by Demographic and Income Characteristics). The combination of poverty and being uninsured contributes to individuals having limited resources such as transportation, presenting barriers for persons needing treatment for mental illness and/or substance use disorders. These factors have a significant impact on the mental health of individuals within this area. Job or financial loss, mental disorders, and substance use disorders are among the high risk factors that increase the likelihood of suicide (American Association of Suicidology and the Suicide Prevention Resource Center) and two of the largest counties served within this rural area have a higher suicide rate (Angelina County=11.7%, Nacogdoches County=14.9%) than the state's rate (10.8%), and one of these counties has a higher rate than the U.S. rate (11.8%) [US Averages: Centers for Disease Control and Prevention's National Center for Health Statistics, 2005-2009: http://www.cdc.gov/nchs/data/dvs/deaths_2009_release.pdf]. This makes access to mental health care a priority. Unfortunately, there are further barriers to individuals accessing assistance in this rural area. There are too few places to get mental health services and limited resources for substance-related services. A locally-based interdisciplinary team that provides home/community-based services that includes mental health/substance abuse services creates a cost-effective way to engage and serve individuals in this impoverished rural area.

Related Category 3 Outcome Measure:

Burke Center has selected improvement outcome domain OD-6, Percent improvement over baseline of patient satisfaction scores and measure IT-6.1 for this project. The measure will be timely care, appointments, and information for individuals in the target population.

This Burke Center Project (2.13) is designed to increase patient satisfaction with timely care, appointments, and information, as home/community-based services provide for greater access to mental health providers. These outcomes are a priority for the Burke Center because all 12 counties served by the Burke Center are currently designated by DSHS as whole Mental Health Professional Shortage Areas (as verified by the Texas Primary Care Office - Texas Department of State Health Services). According to recent findings by the Health Resources and Services Administration's (HRSA), the number of mental health providers per 100,000 Texas residents is 27.7 (per the Area Resource File). The same findings indicate there are only 4.3 mental health

providers per 100,000 Polk County residents and 13.3 mental health providers per 100,000 Angelina County residents. These are two of the largest counties served within the Burke Center's catchment area, yet there are too few mental health providers and current funding limits the amount of assistance the Burke Center can provide. Intensive home/community-based services could provide more timely care, as services would be provided locally versus making individuals travel long distances to find a mental health provider. Individuals would more likely be pleased with appointments and the information provided, as the appointments would be conveniently located and information would target local resources.
Further, a disproportionate number of individuals within the Burke Center's service area, compared to the populations of Texas and the U.S., report being dissatisfied with their current level of social/emotional support. The percentage of individuals who reported, by county, not being satisfied with their current level of social/emotional support is as follows: Angelina County=25.7%, Nacogdoches County=17.7% and Polk County=23.4%. The national percentage is 19%. This data is anchored by the University of Texas Medical Branch, by The George McMillan Fleming Center for Healthcare Management at the University of Texas School of Public Health, Houston, the Center for the Elimination of Health Disparities and the Texas Area Health Education Center (AHEC-East), programs of the University of Texas Medical Branch, Galveston. The Burke Center's Project (2.13) is designed to provide peer support in addition to specialized interventions aimed at providing social/emotional support.

Individuals within this low-income rural area can enjoy greater mental health by having more timely care and information about resources and their mental health. They will also benefit from having appointments with specialized mental health/substance abuse providers and that are provided in their own home or community.

Relationship to Other Projects and Measures:

This project relates to Burke Center's Project 1.11, as Project 1.11 provides technology that enhances Project 2.15's capacity for service delivery in home/community-based settings. This project also relates to Burke Center's Project 2.15, which establishes a medical home for individuals served and supports the goal of Project 2.13 to promote wellness and recovery in the community. Major physical illness is one of the high risk factors increasing the likelihood of suicide (per the American Association of Suicidology) and individuals with mental illness have life spans that are 8-20 years shorter than average (according to BP Dembling, et al, Psychiatric Services, 1999; 50 [8]:1036-1042). In fact, individuals with mental illness are twice as likely to have multiple medical disorders, 40%-56% have a physical health problem, 42% have a health problem severe enough to limit daily functioning, and 35% have at least one undiagnosed medical disorder (Bazelon Center for Mental Health Law, 2004). Establishing a medical home via Project 2.15 is one step toward fostering improved physical health while concurrently supporting the goal of Project 2.13.
This project's focus on behavioral health and mobile services ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3, 096166602.1.5, 096166602.2.6, 135222109.2.2, 096166602.2.8,

136367307.2.2, 096166602.2.7. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects and Measures:

This project focuses on creating a specialized interdisciplinary team to provide mobile treatment and supports for high risk/high need individuals through a variety of supportive interventions. There are no other related Category 2 similar projects in our RHP.

Project Valuation:

Burke Center considered several factors in valuing this project, including reductions in costs associated with individuals cycling through the mental health system due to impairment in functioning. Specialized treatments and other interventions are needed in order to improve the functional status of individuals within the target population. This requires the creation of a specialized interdisciplinary team who is free from time constraints and can provide intensive home and community-based services tailored to individual needs. This project would more effectively meet the needs of a growing indigent population but it is not possible to implement without additional funding to sustain the project.

136367307.2.3	2.13	2.13.1 (A-E)	Intensive Home and Community-based Specialized Services	
The Burke Center				136367307
Related Category 3 Outcome Measure:OD-6	136367307.3.5	IT-6.1.1	Are getting timely care, appointments, and information.	

Year 2 (10/1/2012 – 9/30/2013)	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 I-5.1: Functional Status **I-1.5 Metric:** Establish baseline percentage of functional status for current population (428 individuals) who will be receiving specialized interventions. **Baseline/Goal:** obtain current functional status **Data Source:** standardized instruments (i.e., ANSA). Estimated Incentive Payment: $670,659 **Milestone P-2**: Design community-based specialized interventions for target populations. **P-2.1 Metric:** Project plans which are based on evidence/experience and which address the project goals **Baseline/Data Source:** Project documentation Estimated Incentive Payment: $670,659 **Goal:** Add 3 Masters-level clinicians, 2 additional QMHPs, 2 Peer Providers (or CHWs), and 1 Mental Health Deputy. Establish contract with ADAC. Train providers in specialized interventions.	**Milestone I-5.1**: Functional Status **I-1.5 Metric:** 65% percent (417 individuals) of the 642 individuals receiving specialized interventions will demonstrate improved functional status on standardized instruments (i.e., ANSA). **Baseline/Goal:** 65% of population served will demonstrate improved functional status. **Data Source:** standardized instruments (i.e., ANSA). Estimated Incentive Payment: $604,890 **Milestone P-3:** Enroll and serve individuals with targeted complex needs. **P-3.1 Metric:** Number of targeted individuals enrolled/served in the project. **Baseline/Data Source:** Project documentation Estimated Incentive Payment: $604,890 **Goal:** Begin providing community-based specialized services to individuals within the targeted population.	**Milestone I-5.1**: Functional Status **I-5.1 Metric:** 70% percent (450 individuals) of the 642 individuals receiving specialized interventions will demonstrate improved functional status on standardized instruments (i.e., ANSA). **Goal:** Increase the functional status over DY3 the baseline reporting period by 5% (33 individuals). **Data Source:** standardized instruments (i.e., ANSA). Estimated Incentive Payment: $607,858 **Milestone P-4:** Evaluate and continuously improve interventions. **P-4.1 Metric:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. **Baseline/Data Source:** Project reports Estimated Incentive Payment: $607,858 **Goal:** Improve quality of interventions	**Milestone I-5.1**: Functional Status **I-5.1 Metric:** 75% percent (482 individuals) of the 642 individuals receiving specialized interventions will demonstrate improved functional status on standardized instruments (i.e., ANSA). **Goal:** Increase the functional status over DY4 the baseline reporting period by 5% (32 individuals). **Data Source:** standardized instruments (i.e., ANSA). Estimated Incentive Payment: $542,983.50 **Milestone P-4:** Evaluate and continuously improve interventions. **P-4.1 Metric:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. **Baseline/Data Source:** Project reports Estimated Incentive Payment: $542,983.50 **Goal:** Improve quality of interventions

136367307.2.3	2.13	2.13.1 (A-E)	Intensive Home and Community-based Specialized Services	
The Burke Center				136367307
Related Category 3 Outcome Measure:OD-6	136367307.3.5	IT-6.1.1	Are getting timely care, appointments, and information.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
ear 2 Estimated Milestone Bundle Amount*:* $1,341,318	Year 3 Estimated Milestone Bundle Amount: $1,209,780		Year 4 Estimated Milestone Bundle Amount: $1,215,716	Year 5 Estimated Milestone Bundle Amount: $1,085,967
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $4,852,781				

PROJECT OPTION: 2.4.1-Implement Processes to Measure and Improve Patient Experience

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 136381405.2.1-Pass 2
PERFORMING PROVIDER NAME/TPI: Tyler County Hospital District/136381405

Project area: 2.4 Redesign to Improve Patient Experience

Provider: Tyler County Hospital District consist of a 49 acute care bed hospital, 5 practitioner rural health clinic, school of vocational nursing and a 501(c)(3) Foundation located in a rural Southeast Texas Community. Woodville has a population of 2,100 and a county population of 21,766 serving 935.7 square miles. There are no specialists living in the community. There are five school districts in Tyler County. Twenty percent live at or below the poverty level with an additional 9% unemployed.
Intervention(s): This project will improve the patient experience by strengthening the communication skills of all our employees. The goal of our organization is to create a training program to improve patient experience of care, improve health of population and reduce the cost of health care. Redesigning the patient experience at Tyler County Hospital will impact the health of our community by keeping patients engaged in the district. Tyler County Hospital is the only acute care provider in the county. All employees will be trained on patient experience during DY4.
Need for project: We do not currently have the staff to appoint an executive to be accountable to improve the patient experience. We will hire a RN, which will be given executive authority. He or she will then work with Press Ganey to develop a training program to improve the patient experience and write and disseminate a patient/family experience strategic plan. All New Hires and current Full-time staff will be trained to improve the patient experience.
Target Population: The largest population is our patients that have been receiving serves in urgent and emergency care settings. We have 26% of the community that is uninsured along with Medicaid clients. Our county has a high ED utilization rate and a high incidence of chronic disease. The rate for Tyler County was among the worst in Texas, which is in the bottom 25%. Our 30 day readmission rate for medial discharge, a measure of quality care, was higher than both the Texas and US rates. We also have the worse rates of diabetes and disability and more poor physical and mental health days than the State and National average.
Category 2 patient benefits: The project seeks to improve the patient experience by training our staff to better communicate with patients. Tyler County has a very high rate of uninsured which is almost double the US rate. The rate of ED visits for Tyler County was among the worst in Texas. Some of our other disease rates marked as being the worst of 10% or worst of 25% in all Texas Counties. All these factors support the need for this project which will more effectively meet the need of the county uninsured, indigent patients and Medicaid patients. It will also aid in reducing high readmission and ED visits. This project will affect a large portion of our community, be cost effective, have the potential to improve mortality rate (Diabetes 27.5 per 100,000) as well as educate patients of better managing their care. Integrating patient experience into all organizational learning is seen as a best practice in the field, as it prompts staff/employees to consider patient experience in all parts of their day-to-day job duties.

Category 3 outcome: IT-6.1. Our goal is to hire a RN to be an executive over improving the patient experience. He or she will work with Press Ganey to develop a training program. All Full-time staff and all new hires will be trained on improving the patient experience. Year 4 and 5 goal TBD based on baseline rates established in DY3. The goal is to increase the overall patient satisfaction scores by 5% in DY 4, and 10% in DY5 compared to DY3 baseline.

Project Description:
Tyler County Hospital is a 49 bed acute care hospital located in a Rural Southeast Texas. Woodville has a population of 2,100, and a county population of 21,766 serving 937.5 square miles. There are five school districts in Tyler County. Twenty percent live at or below the poverty level with an additional 9% unemployed.

Improving the patient experience and quality of care patients' receive is vital and necessary for Tyler County Hospital. Many healthcare organizations use HCAHPS Patient Satisfaction Report to see where their organization stands compared to other healthcare providers. If a healthcare provider does not know what its strengths and weaknesses are, it cannot improve patient health outcome and quality effectively. Patient Satisfaction surveys are used to improve the quality of care received by the patients. They can shed light to specific problem areas and be a reference point when making executive decisions. They can also serve as a means of holding physicians, nurses, and other employees accountable for their actions.

Several factors can influence how patients' rate a healthcare facility during their visit and the perception of the care received. These factors may include the facilities parking lot, the admissions process, encounters with physicians, nurses, lab personnel, and other service providers. The cleanliness of the facility and patient rooms, the billing/payment process, the amount of time they had to wait before being seen, and the quality and clarity of communication received are factors that can influence a patient's perception. Tyler County Hospital has scored below the State and Texas Rural hospital average on six HCAHPS Patient Satisfaction Report scores for 2011.

	Tyler County Hospital	State	Texas Rural Hospitals
"Staff always explained about medicines before giving them to patients"	65%	73%	73%
"Patients' rooms and bathrooms were always kept clean"	79%	83%	82%
"Area around patients' rooms was always kept quiet at night"	70%	81%	73%
"Patients were definitely given information about what to do during their recovery at home"	72%	89%	88%
"Patients who gave their hospital a rating of 9 or higher on a scale of 0 to 10"	67%	83%	77%

	Tyler County Hospital	State	Texas Rural Hospitals
"Patients would definitely recommend the hospital to friends and family"	63%	86%	78%

The goal of our organization is to create a training program to improve patient experience of care, improve health of population and reduce the cost of health care. Redesigning the patient experience at Tyler County Hospital will impact the health of our community by keeping patients engaged in the district. Tyler County Hospital is the only acute care provider in the county. All employees will be trained on patient experience during DY4.

Project goal:

Tyler County Hospital District's (TCHD) overall aim is to create an environment in which patients feel safe, listened to and empowered. Our DSRIP project goal is to improve inpatient experience by strengthening the communication skills of all our employees, including all departments. Nurses will be instructed regarding communicating about medication, discharge information and their patients. Nurses are the glue which holds the entire care team together, so engaging nurses' commitment and creativity in the overall patient experience project is a critical early step. TCHD will appoint an executive to implement the program. The five year goals are to

- Ensure that reports on patient experience are available monthly and widely disseminated throughout the organization.
- To develop a training program and integrate the program into new employee orientation
- To train and evaluate 100% of Full-time inpatient nurses, as well as all Full-time employees in all departments in communication skills. We currently have 111 Full-time employees.

Improve "Staff always explained about medicines before giving them to patients," "Patients' rooms and bathrooms were always kept clean," "Area around patients' rooms was always kept quiet at night," "Patients were definitely given information about what to do during their recovery at home," "Patients who gave their hospital a rating of 9 or higher on a scale of 0 to 10," and "Patients would definitely recommend the hospital to friends and family." The current average for 2011 is 65%, 79%, 70%, 72%, 67%, and 63%, respectively on HCAHPS patient experience survey by 10% over DY3 baseline by the end of DY5.

In 2012 there were 194 patients discharged aged 65 and older and there were 11 deaths. In 2011 there were 201 patients discharged aged 65 and older, and there were 9 deaths. We plan to have Press Ganey survey all discharged patients, which should be at least 190 patients. Five percent of the 2012 discharges were Medicaid clients and thirty-five percent were indigent, charity, or uninsured.

Project Options – Core Project Components:

a. Organizational integration and prioritization of patient experience

Proposed: Six HCAHPS scores have been identified as below State and Rural Hospital level. We will develop an organization strategic plan to train staff.

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;
   Proposed: Press Ganey will be the vendor of choice to survey patient experience. Findings will be analyzed every six months.

c. Implementing processes to improve patient's experience in getting through to the clinical practice;
   Proposed: A training program will be developed and implemented for new hires and full-time staff.

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.
   Proposed: The hospital will use Press Ganey as their independent vendor. Press Ganey leads the nation in the patient experience industry. They will bring together our key metrics in a single integrated view of performance to enable alignment and accountability across our organization. They have been providing services to healthcare providers for nearly 30 years.

Continuous Quality Improvement:

We will use the Plan-Do-Check-Act (PDCA) Cycle as a model for Continuous Quality Improvement. Using the PDCA cycle, we will evaluate our processes semiannually. We will analyze our data according to National and State standards, as well as our hospital goals. We will then address if changes need to be made to our training program. If scores are improving, then no changes will be needed at this time.

Anticipated challenges:

We anticipate a number of challenges with this program.

1. Staff being receptive to training program.
2. Hiring a nurse to complete the development of a strategic plan and to be appointed as executive.
3. We do not have a coordinated care team for patients upon discharge.
4. We do not have a program developed to follow-up with patients.
5. Because we have not previously developed a patient experience strategic plan, we will need support in responding to issues such as training of providers, management as well as requirement related to resources and personnel.

6. Having a significant impact on HCAHPS areas that are beyond our contract scores i.e. old facility, size of rooms, services offered that are prohibited due to cost – mammogram, 24 hr. dietary services, etc.
7. Being an acute care provider that transfers patients for a higher level of care.
8. Patient answering would not refer because they needed a surgeon, cardiologist, or nephrologist.

The 5-year expected outcome(s):

We expect at the end of the Waiver period to be comparable to other Texas Rural Hospitals. The HCAHPS scores are Medications 73%, Patient Rooms 82%, Quietness 73%, Recovery information 88%, Rating 77%, and Recommendation of Hospital 78%.

Regional goals:

This project supports at least 2 of Region 2 goals, including:

1. Improve the quality of patient care thru data collection, analysis reporting and continuous process improvement.
2. Grow the health system resources in our region by expanding and enhancing training of the health care workforce.

Starting Point/Baseline:

We chose our milestones and metric based on our Community Needs Assessment. In our current system more often than not, patients receive services on urgent and emergency care setting for conditions that could be managed by primary care. Improving communication on medication and recovery should aid in the need to receive emergency care. HCAHPS scores range Medications 65%, Patient Rooms 79%, Quietness 70%, Recovery Information 67%, Rating 77%, and Recommendation of Hospital 63%.

Rationale

Relation between Project Choices and Community Needs:

Our county has a high ED utilization rate and a high incidence of chronic disease. The rate for Tyler County was among the worst in Texas, which is in the bottom 25%. A coordinated system of patient centered care will improve the patient experience (increased access to appropriate levels of care), improve the health of the population and will use resources more efficiently, effectively, and equitably.

Our 30 day readmission rate for medical discharge, a measure of quality care, was higher than both the Texas and US rates. We also have the worse rates of diabetes and disability and more poor physical and mental health days than the State and National average. There is 20% of the county living at or below the poverty line. TCH spent $2 million in 2012 on uninsured and indigent patients. The project choice is a direct reflection of Tyler County's community needs. The project focuses on training staff and improving patient experience.

Unique Community Need Identification Numbers:

CN.1 Access Barriers: Lack of Personal Resources
CN.2 Access Barriers: Lack of
CN.10 High ED Utilization Rates
CN.11 30 Day Readmission Rates

Expansion or enhancement

This project is a new initiative, which will both expand and enhance current services. Expansion will be accomplished by training staff on improving patient experience. Enhancement will include development and implementation of a strategic plan.

Related Category 3 Outcome Measures

Category 3 Outcome Measures IT-6.1. Redesigning the patient experience at Tyler County Hospital will impact the health of our community by keeping patients engaged in the district. Tyler County Hospital is the only acute care provider in the county.Our goal is to hire a RN to be an executive over improving the patient experience. He or she will work with Press Ganey to develop a training program. All staff and all new hires will be trained on improving the patient experience. Year 4 and 5 goal TBD based on baseline rates established in DY3. The goal is to increase the overall patient satisfaction scores by 5% in DY 4, and 10% in DY5 compared to DY3 baseline.

Relationship to other Projects

- Pass 1 Category 1
    - 1.1 Expand Primary Care – Adding a PCP and Nurse will give access to a PCP for initial and follow-up visits in lieu of ED use and readmission to hospital.
    - IT 1.10 Diabetes Care 4bA1c Poor Control (>9.0%)

This project's focus on improving communication and emphasis on the patient and family's experience ties to these Category 1 and 2 projects in our RHP: 131030203.2.2, 1363814.5.2.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on improving the patient experience along with these other Category 2 projects in our RHP: 1363814.5.2.1- Implement Processes to Measure and Improve Patient Experience; 131030203.2.2- Redesign to Improve Patient Experience

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.
Table A Redesign to Improve Patient Experience
Table B Percent Improvement over baseline scores

Tyler County Hospital considered factors of what affected population, severity, cost effectiveness, and community benefit. The Community Needs Assessment identified many needs for Tyler County. There is 19.9% of county living at or below poverty line and 9% unemployment in Tyler County. The population of on average is older than the State of Texas. The median household income is more than $10,000 less than Texas average. Tyler County has worse rates of diabetes and disability. Tyler County has a very high rate of uninsured which is almost double the US rate. The rate of ED visits for Tyler County was among the worst in Texas. Some of our other disease rates marked as being the worst of 10% or worst of 25% in all Texas Counties. All these factors support the need for this project which will more effectively meet the need of the county uninsured patients, charity patients, indigent patients, and Medicaid patients. It will also aid in reducing high readmission and ED visits. This project will affect a large portion of our community, be cost effective, have the potential to improve mortality rate (Diabetes 27.5 per 100,000) as well as educate patients of better managing their care.

136381405.2.1	2.4	2.4.1 (A-C)	TO IMPROVE PATIENT EXPERIENCE	
Tyler County Hospital				136371405
Related Category 3 Outcome Measure(s):	136381405.3.2	IT 6.1	Percent Improvement over baseline of Patient Satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1. Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance. P-1.1 Metric: Documentation of an executive assigned responsibility experience performance. Baseline/Goal: We do not have anyone appointed or anyone that has time. Goal is to hire RN and appoint him/her as an executive accountable for improving patient satisfaction. Rationale/Evidence: The organizational culture that creates positive patient experience must be driven from the very top of the organization. Depending upon the organization, one executive could be accountable for both patient and employee experience, or two separate executives could be appointed. Data Source: Organizational Chart or	**Milestone 3** P-15. Develop a training program on patient experience for staff. P-15.1 Metric: Submission of training program materials. Baseline/Goal: No training Program for patient/family experience. Will work with Press Ganey to develop program. Data Source: Training Program Materials Rationale/Evidence: Training Program needed to improve patient experience in six areas that are below the state level and Texas rural level on 2011 HCAHPS Patient Satisfaction Report. Milestone 3 Estimated Incentive Payment $42,500 **Milestone 4** P-4. Integrate patient experience into employee training. P-4.1. Percent of new employees who		**Milestone 5** 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 I-18.1. Metric: 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 a. Data Source: Display and internal communication b. Rationale/Evidence: Keeping the workforce informed on the progress of improvement efforts is key to developing an organization-wide ownership of the efforts.	**Milestone 6** 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 I-18.1. Metric: 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 a. Data Source: Display and internal communication Rationale/Evidence: Keeping the workforce informed on the progress of improvement efforts is key to developing an organization-wide ownership of the efforts. Milestone 6 Estimated Incentive Payment $ 71,208

136381405.2.1	2.4	2.4.1 (A-C)	TO IMPROVE PATIENT EXPERIENCE	
Tyler County Hospital				136371405
Related Category 3 Outcome Measure(s):	136381405.3.2	IT 6.1	Percent Improvement over baseline of Patient Satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Job Description (if percentage of time) Milestone 1 Estimated Incentive Payment $39,463 **Milestone 2** P-2. Write and disseminate a patient/family experience strategic plan . P-2.1 Metric: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization Baseline: We do not have a strategic plan that addresses patient experience. Goal: Appointed executive to create a strategic plan. Data Source: Internal organizational communications, experience, strategic plan. Rationale/Evidence: A strategic plan is seen by experts in the field as an essential foundation for any	received patient experience training as part of their new employee orientation. a. Numerator: Number of employees receiving patient experience training. b. Denominator: Total number of new employees. Baseline: TBD based on number of New Hires. Goal: 100% Training including New Hires. Data Source: Human Resource Records. Rationale/Evidence: Integrating patient experience into all organizational learning is seen as a best practice in the field, as it prompts staff/employees to consider patient experience in all parts of their day-to-day job duties. It is recommended that employee experience also be included in organizational training.		Milestone 5 Estimated Incentive Payment $ 80,000	

136381405.2.1	2.4	2.4.1 (A-C)	TO IMPROVE PATIENT EXPERIENCE	
Tyler County Hospital				136371405
Related Category 3 Outcome Measure(s):	136381405.3.2	IT 6.1	Percent Improvement over baseline of Patient Satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
organizational work toward improving patient experience. Employee experience could be integrated into the patient experience strategic plan, or a separate plan could be created. Milestone 2Estimated Incentive Payment $39,463	Milestone 4 Estimated Incentive Payment $42,500			
Year 2 Estimated Milestone Bundle Amount $ 78,926	Year 3 Estimated Milestone Bundle Amount $ 85,000		Year 4 Estimated Milestone Bundle Amount $ 80,000	Year 5 Estimated Milestone Bundle Amount $ 71,208
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 315,134				

PROJECT OPTION: 2.1.1: Enhance/Expand Medical Homes

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.1
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/ 094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will expand and enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model throughout twelve UTMB primary care clinics by restructuring the clinic staffing model into multidisciplinary care teams that manage a panel of patients, reducing system costs associated with readmissions and ED visits, and improving the patient experience through improved access to a care provider. Restructure would require a project manager, a data manager, and one additional medical assistant for each clinic location. Through this project we will reach approximately 50,000 patients providing primary care and chronic disease management through 200,000 annual clinic visits.
NEED FOR THE PROJECT: Expanding and implementing the PCMH model throughout the primary care clinics will enable UTMB to meet the challenges listed below by reorienting the care delivery team.

- Offering new services in a cost effective manner
- Creating high functioning teams
- Engaging patients in their care
- Achieving NCQA recognition for all primary care clinics

TARGET POPULATION: Our target population is the medically underserved areas with in Galveston and Brazoria counties. Within Galveston County, there are 8 census tracts that are federally designated as Medically Underserved Areas and in Brazoria County there are 6 large areas designated as Medically Underserved Areas. There are approximately 367,000 medically underserved individuals in the region.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project aims to improve the health of our region by expanding and coordinating access to patient centered primary care and behavioral health care services that include health promotion and disease prevention as well as improve the quality of patient care through data collection, analysis, and reporting and continuous process improvement.
CATEGORY 3 OUTCOME: I.T-6.1 Our goal is to show improvement over baseline patient satisfaction scores.
PROJECT DESCRIPTION:
This project will expand and enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model throughout twelve UTMB primary care clinics by restructuring the clinic staffing model into multidisciplinary care teams that manage a panel of patients, reducing system costs associated with readmissions and ED visits, and improving the

patient experience through improved access to a care provider. Restructure would require a project manager, a data manager, and one additional medical assistant for each clinic location.

Implementing PCMH throughout the twelve UTMB Primary Care clinics will prepare the institution for transition to an Accountable Care Organization by milestone year 5. In addition to the primary care, preventative services and chronic disease management already identified, there will be an initiative to provide patient and family involvement and education to participate in health maintenance.

Project Goals:

The goal of projects under this heading is to expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care.

Specific goals include:

i. Providing patients with easily accessible primary care services in their community.

ii. Maximize the match between level of training and clinic roles ("top of license" practice) with patient needs.

iii. Improved patient self-management of chronic conditions such as diabetes, ischemic vascular disease, and COPD.

iv. Decreased misuse of ED for primary care services.

Anticipated Challenges:

- Improving access during a period of increasing demand for primary care services
- Offering new services in a cost effective manner
- Creating high functioning teams
- Engaging patients in their care
- Achieving NCQA recognition for all primary care clinics

Expanding and implementing the PCMH model throughout the primary care clinics will enable UTMB to meet the challenges listed above by reorienting the care delivery team. The team will be expanded to include physician extender roles, such as nurse practitioners and physician assistants and medical assistants. The licensed providers will enable enlarging patient panels, and improve patient access, and the medical assistants will be the health coaches for the patient and the team, and enable all licensed professionals to practice at the top of their license. Health coaches will use their motivational interview skills to assess patient readiness and then guide participating in self-care and healthy life styles. Recognition of all primary care clinics as NCQA recognized PCMH model clinics will enable participation in innovative managed care models, and move the practice toward a high functioning Accountable Care Organization (ACO).

5-year expected outcomes:

- NCQA recognition for all primary care clinics, adult and pediatric

- Patient engagement in care
- Preventive health management
- Improved patient satisfaction: 6.1.1: This targeted outcome will be measured by the increase in patient satisfaction as defined all related questions in the Press Ganey survey and the CG- CAHPS survey focusing on the patients getting timely care, appointments and information. We have chosen this measure as the Press Ganey surveys have identified access to care as a measure in which there is a wide variation in performance between clinics and a measure that is important to patient. Access to care scores has a significant impact on the overall satisfaction score for each clinic and the practice.

Regional Goals:

- Improve the health of our region by expanding and coordinating access to patient centered primary care and behavioral health care services that include health promotion and disease prevention
- Improve the quality of patient care through data collection, analysis, and reporting and continuous process improvement.

STARTING POINT/BASELINE:

UTMB Health has 12 adult and/or pediatric primary care clinic locations; in October 2012 the NCQA application for the 3 family medicine clinics was submitted. Over the next 18 months we plan to use this model to submit applications for the remaining 9 clinics, and to achieve recognition for all 12 locations. We expect the process to accelerate as we benefit from the early adopters, and gain experience and economies of scale.

This project addresses a number of identified community needs within the region. Regionally, there is an increased ED utilization rate (CN.10) and 30 re-admission rate (CN.11). Restructuring clinics towards a patient-centered medical home model creates a system to begin reducing these potentially preventable burdens on the existing healthcare system. Further, the region experiences a higher than expected prevalence of diabetes (CN.12), heart and vascular related diseases (CN.14), obesity (CN.13), and pulmonary diseases (CN.15). Shifting care delivery towards a patient-centered medical home model would begin to reduce the relatively higher prevalence of chronic illness in this part of the region. Finally, such a shift in how primary care is delivered would provide a vehicle for providing early cancer screening (particularly for prostate, breast and cervical cancers). Morbidity rates for these cancers are elevated in this project's targeted counties (Galveston and Brazoria).

RATIONALE:

Relationship between Project Choices and Community Needs:

Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health,

better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers.

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care.

The success of the project will be measured by the improvement in patient satisfaction scores for all the primary care clinics, using the Overall Patient Satisfaction score for each clinic in September 2012 as baseline. These measures will include same day access targets.

The option selected for this program and the required components is: Category 2.1.1 Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
Each component is listed below with a summary of our status on that component.
Required core project components:

a) Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness. The gap analysis has been completed for three Family Medicine clinics, and an action plan is in place to address the "gaps". Since UTMB is an integrated practice the gap analysis is applicable to all adult primary care clinic sites.
b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status. Application for the three family medicine primary care clinics has been submitted to NCQA to initiate the recognition process. Application will be expanded to include the Community Based Clinics (CBC) adult primary care clinics by the end of the fiscal year (August 31, 2013).
c) Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision. Initial presentations have been made to primary care clinic leadership, and an institutional steering committee is appointed and guiding the overall direction for PCMH implementation. Specific educational programs are available for the Health Coach role.
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. In addition to

the Press Ganey patient satisfaction data, which is driving performance improvement projects in problem areas, a pre-implementation patient survey was conducted to establish a baseline of patient readiness for the PCMH model of care. A post implementation survey will be conducted in May 2013. The PDSA model is used for PI projects, with the focus on patient access and moving through the visit, as areas identified in the Press Ganey surveys.

Unique Community Needs Identification Numbers:

CN.1
CN.3
CN.10
CN.12

Service Enhancement:

Specialized training for the medical assistants and nursing staff and increasing their numbers to incorporate new roles will expand primary care clinic knowledge and staffing. Clinic staffing, including physicians and mid-level providers, will be organized in teams to support defined panels of patients

UTMB's EMR already provides batch data to the Texas Immunization Registry and has done so for years. UTMB is in the process of testing ImmTrac and beginning to utilize this new interface. The clinic will utilize registries to facilitate disease and population health management.

The patient-centered medical home will facilitate and promote preventive services for patients in Galveston and Brazoria County. Our EMR, PCMH processes, and commitment to care of these patients will create a high degree of compliance with recommended medical screening guidelines. Currently no state or federal monies are being spent on this project.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on enhancing the patient-centered medical home model and emphasis on reducing ED visits and readmissions through multidisciplinary care teams ties to these Category 1 and 2 projects in our RHP: 139172412.1.2, 109372601.1.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the enhancement of patient-centered medical home model and expands throughout our primary care clinics. There are no other related Category 2 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared

learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.1	2.1	2.1.1 (a-d)	Patient Centered Medical Home
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.9	IT-6.1	Percent Improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1. Milestone: Implement the medical home model in primary care clinics P-1.1. Metric: Increase number of primary care clinics using medical home model by 2 a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of primary care clinics c. Rationale/Evidence: NAPH found that nearly 40% of programs could offer either anecdotal or quantitative evidence of reduced ED usage—attributed to the redirection of primary care-seeking patients from the ED to a medical home.62 In addition to reductions in ED utilization, the medical home model has helped Milestone 1 Estimated Incentive Payment *(maximum amount):* $340,654 **Milestone 2** P-14. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning	**Milestone 3** P-2. Milestone: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. P-2.1. Metric: Performing Provider policies on medical home a. Data Source: Performing Provider's "Policies and Procedures" documents b. Rationale: Will help to establish the norm Milestone 3 Estimated Incentive Payment: $227,103 **Milestone 4** P-4. Milestone: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members. P-4.1. Metric: Expanded primary care team member roles; a. Data Source: Revised job descriptions	**Milestone 6** I.18 Obtain medical home recognition from NCQA as PCMH for all primary care clinics 1.18.1 Metric: medical home recognition/accreditation Baseline: Applications submitted Goal: Complete all documentation required for recognition Data Source: NCQA database Milestone 6 Estimated Incentive Payment: $340,654 **Milestone 7** 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 I-17.1. Metric: Reminders for patient preventive services are in place a. Numerator: For select specific preventive service (e.g., pneumococcal vaccine for diabetics), 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	**Milestone 8** I-16. Milestone: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home I-16.1. Metric: Percent of primary care visits at medical home a. Numerator: Number of enrolled patients' primary care visits with medical home primary care provider/team b. Denominator: Total number of enrolled patients' primary care visits within the Performing Provider c. Data Source: EPIC d. Rationale/Evidence: Patients know the professionals on their care team and establish trusting, ongoing relationships to reinforce continuity of care. Medical home model should enhance continuity. Milestone 8 Estimated Incentive Payment *(maximum amount):* $681,308

094092602.2.1	2.1	2.1.1 (a-d)	Patient Centered Medical Home	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.9	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)
around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements P-14.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 2 Estimated Incentive Payment *(maximum amount):* $340,654	b. Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. P-4.2. Metric: Schedule of training and educational opportunities for providers and staff on expanded roles is complete Milestone 4 Estimated Incentive Payment *(maximum amount):* $227,103 **Milestone 5** P-5. Milestone: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and	patients in the registry needing the preventive service c. Data Source: Registry, or other documentation as designated by Performing Provider d. Rationale/Evidence: Panel manager (or staff on care team) identifies patients who have process or outcome care gaps and contacts them to come in for services. Milestone 7 Estimated Incentive Payment *(maximum amount):* $340,654	

094092602.2.1	2.1	2.1.1 (a-d)	Patient Centered Medical Home	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.9	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)
	demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. . P-5.1. Metric: Determine Panel size a. Data Source: Panel size determination tool, patient registry, EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for proactive panel management b. Rationale/Evidence: Panel size analysis could support panel management decisions as clinics approach population management. Milestone 5 Estimated Incentive Payment: $227,102		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $681,308	Year 3 Estimated Milestone Bundle Amount: $681,308	Year 4 Estimated Milestone Bundle Amount: $681,308	Year 5 Estimated Milestone Bundle Amount: $681.308
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,725,233			

PROJECT OPTION: 2.8.8 Improved Access to Care

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.2
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/ 094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This LEAN project aims to use systems engineering to improve efficiency of care, reduce costs and enhance capacity. Ultimately, because of better and standardized workflows, we will also improve staff satisfaction and patient experience.
NEED FOR THE PROJECT: This project is needed to systematically evaluate patient work flows, driving out wasteful activities and enabling efficiencies. It will help:

- Decrease the number of patient no-shows
- Decrease the number of days a new patient must wait to be seen (third-next-available appointment)
- Maintain or increase continuity of patients seeing a member of their care team
- Accurately capture the level of service required
- Maintain or improve patient satisfaction with getting an appointment

TARGET POPULATION: The target population is the patient population in Galveston County seeking primary care services at UTMB, in multiple settings along with the neurology clinic which will serve as a model for specialty services access redesign. During fiscal year 2012 (ending Sept 2012) there were more than 10,000 primary care visits with a Medicaid payer source or that were Medicaid eligible or who were uninsured. There were 9,566 visits to our Neurology Clinic in that same period.
CATEGORY 1 EXPECTED PATIENT BENEFITS: Through standardization we expect to reduce the variation in services and provide a better overall patient experience. It will also aid in the continuity of patients seeing a member of their care team and assist with scheduling.
CATEGORY 3 OUTCOME: I.T-1.1 and I.T-6.1 Our goal is to show improvement over baseline patient satisfaction scores and aim to improve Third Next Available Appointment in primary and specialty clinics.
PROJECT DESCRIPTION:
P-9 Complete a value stream map, which is a detailed, real-time sequence of steps in a given process to identify value-added and non-value-added steps for the patient and staff.
To improve standardization of workflows, we will model patient visit "value streams" – mapping/timing them from beginning to end to determine how time in the clinic is spent, identify any bottlenecks in the visit process, and understand the required resources for each step. A skill-task matrix will be developed to understand the most appropriate staffing for each clinic. Standardized workflows will make staff substitution easier, lowering our need of expensive clinical staffing. This will help optimize the capacity of UTMB's clinics by leveling

staffing to more appropriately fit the requirements of each clinic population, reduce clinic costs, and provide job enrichment.

P-8 Train project team in advanced process improvement.

P-X Engage consultant in Patient Centered Scheduling (PCS) to instruct/coach local analyst.

Primary Care Clinic Patient Centered Scheduling (PCS): PCS is designed to improve the ability of patients to see their doctor when they want to—even the same day. Random patient calls will be recorded and examined with staff to understand patients' experiences trying to make an appointment. No-show rates and wasted time will be reduced in part by doing as much appointment pre-work as possible, also including clinical information such as finding out what prescriptions need to be refilled. Pre-work also gives staff the time to prepare and plan for any unforeseen changes. Demonstrated reductions in no-show rates and days to third-next-available appointments will contribute to truly offering patients a patient-centered medical home.

P-10 Develop a quality dashboard that will quantify and determine the effectiveness & efficiency of scheduling.

P-6 Implement a Patient centered scheduling program to improve efficiencies and/or reduce program variation, including an open access scheduling template implemented in all Primary Care clinics.

P-8 Train providers/staff in process improvement and revised workflows and operations.

Simulation- Enhanced Specialty Clinic Scheduling: Existing specialty scheduling solutions still result in sub-optimal performance. A more robust approach simulation & optimization will be implemented, accounting for scheduling ambulatory care activities as a series of closely related activities rather than a group of unique and independent events. Activities will be sequenced in a logical manner, and linked with relevant to other clinical, operational, and administrative activity information. Utilizing statistical analysis techniques, operations research and design of experiments, scheduling enhancements and resources optimization will be improved. Two elements influence overall scheduling performance: first, how well the Time slot type specification matches the actual patient arrival, and second, the scheduling method used (the selection of a timeslot per patient given the time slot type specification).

Project goal(s):

Capitalizing on learnings from the application of Lean production systems in health care, we aim to use systems engineering to improve efficiency of care, reduce costs, enhance capacity and, ultimately, because of better and standardized workflows, we will also improve staff satisfaction and patient experience. By systematically evaluating patient work flows, driving out wasteful activities and enabling efficiencies, we aim to

- Decrease the number of patient no-shows
- Decrease the number of days a new patient must wait to be seen (third-next-available appointment)
- Maintain or increase continuity of patients seeing a member of their care team
- Accurately capture the level of service required
- Maintain or improve patient satisfaction with getting an appointment

Challenges:

Standardizing work flows will be challenging if diverse operational conditions of individual outpatient clinics even within same care type. We will need an effective change management plan to counter commitment to "the way we have always done things" and provider-centric schedules. We are prepared to provide just in time training and support to counter variable clinic staff knowledge of process/performance improvement techniques and running operations based on the concept of standard work flows and instructions. Developing uniform templates and systems will be challenging with the anticipated variability in patient preferences and behavior characteristics on appointments.

The 5-year expected outcome(s):

We expect to meet or exceed 50% of benchmark University Health System Consortium (UHC) peers in third next available appointment across all primary and specialty care clinics and also be in top quartile of UHC peers in Patient Satisfaction supplemental module-"Are patients getting timely care, appointments and information". Through standardization we expect to reduce the variation in services and also improve employee satisfaction.

Regional goals:

This project directly supports a number of RHP 2 regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

Existing ambulatory operations reports are currently limited to high level summary performance indicators (KPI's) – primarily cost indicators with limited benchmarks. KPI's will be supplemented with finer level process measures that support more precise decision making. Exploiting UTMB's adoption of electronic medical records, we will deploy a set of tools and services that support outcome, safety, service, and performance improvement initiatives with quick turns of reliable information (including hierarchical scorecards with detailed dashboards). This ability to manipulate and visually analyze the KPI/measure will inform strategic and tactical decisions and well as provide evidence as to the success or failure of initiatives and interventions.

We have significant variability in access as measured by 3rd available appointment

- Primary Care: From 14 to 22 days,
- Specialty Care: The Neurology Clinic has an average patient wait time of 40 days for initial visit (next available appointment) and other specialties range from 1 to 65 days.

We will try to eliminate non-value-added activities and minimize business-value-added activities to create efficient workflows. We will focus standardization of patient flows and patient-centered scheduling efforts initially in the Family Medicine clinics.

Starting with the Neurology Clinic, we will model and learn/extend simulations to other specialty clinics.

RATIONALE

Enhancing the patient care experience begins with advancing patient access with responsive support systems. Improving access to primary and specialized patient care is a UTMB institutional goal for 2012-2015, including appropriate patient scheduling and coordination of care across multiple medical specialties and care settings. Active population management to promote health maintenance and the self-management of chronic illness is not limited to encounters, but when access to needed services is impeded, patient care has no chance to be effective. The appropriate use of information technology is key for optimal results in patient scheduling (e.g. tracking utilization and next available).

RELATION BETWEEN PROJECT CHOICES AND COMMUNITY NEEDS:

National statistics indicate that seventy-five percent of patients want appointments on the same day they call. However, today's systems yield lengthy waits, limited access to appointments, dissatisfied patients, and stressed staff. Prior solutions have accomplished workarounds without solving the root causes of limited access. UTMB's traditional "provider centric" scheduling systems are designed to alleviate management challenges for the day (e.g. appointment types and allotted times vs. being engineered to satisfy patients). Problems with access to primary care are related at least in part to inefficiencies in scheduling systems and in part because work hasn't been designed to promote team members working to the maximum of their capability/license. These problems delay treatment and compound misuse of the health care system when patients can't gain immediate access to primary care with episodic acute problems. If the number of Medicaid enrollees increases under PPACA, access to primary care will be even further reduced/challenged.

Unique Community Need Identification numbers:

Many factors affect access. This project focuses on controllable UTMB system factors since many of the challenges in our served population are arguably not in provider control.

CN.1	**Access Barriers: Lack of Personal Resources**
CN.2	**Access Barriers: Lack of Insurance**
CN.3	**Primary Care Physician Shortage**
CN.4	**Specialty Care Physician Shortage**

Expansion or enhancement

We will first apply data modeling to patient centered scheduling in primary care clinics and, using a hybrid adaptive approach, and then spread the approach to the specialty clinics to which they refer. Starting with the Neurology specialty clinic, we will model and learn/extend simulations to other specialty clinics.

Second, by applying lean and systems engineering approaches, we will isolate inhibitors and streamline clinic work flows and more efficiently manage resources. We will examine each segment of patient flow, from the time of patient scheduling through patient discharge from clinic. By breaking down each flow segment, we will be able to properly evaluate and continually adjust work flows and increase efficiency and enhance access. We will initially focus standardization of patient flows and patient-centered scheduling efforts in the Family Medicine West clinic and then spread changes/learning to all other Family Medicine sites – East and

Mainland, and ultimately throughout UTMB primary care settings. Once successful we are more than willing to share learnings and approaches with other primary care and specialty settings in RHP2 who struggle with issues of access.

RELATED CATEGORY 3 OUTCOME MEASURES:

OD-1 – Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment [217,218] (Non-standalone measure)

OD-6 – Patient Satisfaction

IT – 6.1 Percent Improvement over baseline of patient satisfactions scores (all questions within a survey need to be answered to be a standalone measure)

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

REASON/RATIONALE FOR SELECTING OUTCOME MEASURE:

Access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their health care providers will have higher satisfaction, will likely return to work sooner, and may well have better health outcomes. County the third next available appointment indicates how long a patient waits to be seen and drives patient satisfaction.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on improving patient access and emphasis on patient centered scheduling in primary care clinics ties to these Category 1 and 2 projects in our RHP: 121805903.1.1, 121805903.1.2,112671602.1.1, 019053001.1.1, 139172412.1.1, 139172412.1.2, 131030203.1.1, 131030203.1.2, 136381405.1.1, 094092602.1.1, 094092602.1.2, 094092602.1.3, 109372601.1.2, 135222109.2.1, 109372601.2.2, 094092602.2.2, 284333601.1.1, 261955689.1.1. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS:

This project focuses on process improvement methodology to improve quality/efficiency. There are no other related Category 2 similar projects in our RHP.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning

collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.2	2.8	2.8.8	Empowering the care team with lean/systems engineering
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.11	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-9]: Complete a value stream map, which is a detailed, real-time sequence of steps in a given process to identify value-added and non-value-added steps for the patient and staff. Metric 1[P-9.1]: Value stream mapping. a. Submission of completed value stream map b. Data Source: Value stream map c. Rationale/Evidence: Value stream mapping is a helpful method that can be used in Lean environments to identify opportunities for improvement in lead time. Value stream mapping can be used in any process that needs an improvement. <u>Goal:</u> Complete value stream mapping by 9/30/13. Milestone 1 Estimated Incentive Payment (maximum amount): $304,310	**Milestone 4** [P-10]: Develop a quality dashboard that will quantify and determine the effectiveness & efficiency of scheduling. Metric 1 [P-10.1]: Submission of quality dashboard development, utilization and results. a. Data source: Dashboard software, policies and procedures for use and sample dashboard report 9 Epic EMR build and IT service request records). b. Rationale/Evidence: Hard-wiring new processes into the existing EMR/decision support tools enable usage of data feedback in real time. Annual performance targets and benchmarks also aid in monitoring impact of scheduling and access activities. <u>Goal</u>: Publish dashboard for Family Medicine by 6/15/14. Milestone 4 Estimated Incentive Payment (maximum amount):	**Milestone 6** [P-X]: Complete open access scheduling and workflow enhancement implementation of all Primary Care clinics. Metric 1[P-X]: Open access scheduling template implemented in all Primary Care clinics. Baseline: N/A <u>Goal</u>: Open access scheduling template implemented in all primary care clinics by 9/30/15. Data Source: Patient arrival distribution/pattern; Epic EMR build and IT service request records Milestone 6 Estimated Incentive Payment (maximum amount): $1,594,526	**Milestone 7** [P-8]:Train providers/staff in process improvement and revised workflows and operations. Metric 1 P-8.1: Number of providers/staff trained in Family Medicine and Neurology Clinic. Numerator: Number of providers/ staff trained in Family Medicine and Neurology Clinic. Denominator: Total number of providers/staff in Family Medicine and Neurology Clinic. Baseline: N/A <u>Goal:</u> 90% of Family Medicine and Neurology clinic staff are raining. Data Source: Training attendance records. Milestone 7 Estimated Incentive Payment (maximum amount): $585,941 **Milestone 8** [I-14]: Measure efficiency and/or cost

094092602.2.2	2.8	2.8.8	Empowering the care team with lean/systems engineering
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.11	IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 [P-8]: Train project team in advanced process improvement - Metric 1 [P-9.1]: Number of staff attending Virginia Mason Baseline: N/A Goal: At least 4 staff members attend Virginia Mason Lean Workshop by February 29, 2013. Data Source: Virginia Mason participation records; After visit report of findings. Milestone 2 Estimated Incentive Payment (maximum amount): $304,310 **Milestone 3** [P-X]: Engage consultant in Patient Centered Scheduling (PCS) to instruct/coach local analyst. Metric 1: Structured consultation deliverables for scheduling analysis/simulation achieved. Baseline: N/A Goal: Documentation of	$611.481 **Milestone 5** [P-6]: Implement a Patient centered scheduling program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events. a. Number of performance improvement events b. Data Source: Patient arrival/scheduling training curriculum, schedule, attendance logs; template exhibits for same day patient access for focus clinic. c. Rationale/Evidence: Improving efficiencies and reducing variation will not only help to reduce waste and redundancies, but also will help providers/staff focus on value-added work and improve quality and experience of care for patients. Increasing		Metric 1 [I-14.1]: Avg. 3rd Available Appt. Numerator: On same day, sum of calendar days between a request for an appointment for each provider in the Family Medicine and Neurology services and the 3rd next available appt. for a new patient physical, routine exam, or return visit exam (Incl. w/e and days off; Excl. saved urgent appts). Denominator: Number of providers in the same service. Data Source: Clinic schedule Rationale/Evidence: More sensitive reflection of true appt. availability. Improvement Target: All three Family Medicine and PCP IM clinics and Neurology and four additional specialty clinics exceed or meet UHC 2013 50%ile Data Source: UHC benchmark data reports Milestone 8 Estimated Incentive

094092602.2.2	2.8	2.8.8	Empowering the care team with lean/systems engineering	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.11	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)**
executable methodology for the analysis of existing data, to identify missing data, and demonstrate/assist with goal-oriented simulation. Data Source: Project management documents. Milestone 3 Estimated Incentive Payment (maximum amount): $304,311	efficiencies and reducing variation can help create more patient access and provider/staff capacity and enhance patient outcomes (right time, right place, and right care). Baseline: N/A Goal: Hold two performance events by 9/30/14 with one focused on primary care and the other focused on specialty care. Milestone 5 Estimated Incentive Payment (maximum amount): $611,480			Payment (maximum amount): $585,942
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $912,931	Year 3 Estimated Milestone Bundle Amount: $1,222,961		Year 4 Estimated Milestone Bundle Amount: $1,594,526	Year 5 Estimated Milestone Bundle Amount: $1,171,883
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,902,302				

PROJECT OPTION: 2.9.1 Establish/Expand a Patient Navigator Program

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.3
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/ 094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: The Community Health Program, Chronic Disease Education program will provide care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible (Medicare/Medicaid) and uninsured patients who have chronic disease (i.e. diabetes, hypertension, heart disease, COPD).
NEED FOR THE PROJECT: Vulnerable and/or high-risk patients need assistance navigating the healthcare system. Community Health Workers and Case Managers acting as patient navigators provide enhanced social support and culturally competent care to this patient population. Patient navigators will help and support these patients to navigate through the continuum of health care services and ensure that patients receive coordinated, timely, and site-appropriate health care services. The navigators in this program will assist in connecting patients to primary care physicians and/or medical home sites as well as expand care management services and educational classes to patients with chronic disease.
TARGET POPULATION: Our target population are adult Medicaid, dual eligible (Medicare/Medicaid) and uninsured patients who have chronic disease (i.e. diabetes, hypertension, heart disease, COPD).
CATEGORY 1 EXPECTED PATIENT BENEFITS: Improve the health patient population by expanding and coordinating access to:

- Patient-Centered Primary Care
- Behavioral Healthcare Services
- Specialty Care Services
- Chronic Disease Management

CATEGORY 3 OUTCOME: I.T-1.7 Our goal is to show improvement with high blood pressure in our target population.
PROJECT DESCRIPTION:
The Community Health Program, Chronic Disease Education program will provide care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible (Medicare/Medicaid) and uninsured patients who have chronic disease (i.e. diabetes, hypertension, heart disease, COPD). The program will have an emphasis on patient education and self-management support. Chronic disease education classes will be conducted by RN Care Managers and Community Health Workers. Patients will be enrolled in a care management program and will receive self-management support and education to better manage their chronic conditions and decrease utilization of acute health care.

The project plans to serve 600 people with an anticipated total volume of 8,900 encounters provided. The encounters may be provided in face-to-face meetings, telephonically and/or via email.

Project goal(s):

The goal of this project is to utilize community health workers and case managers as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. The navigators in this program will assist in connecting patients to primary care physicians and/or medical home sites as well as expand care management services and educational classes to patients with chronic disease. The care managers and community health workers, supported by a social worker and nutritionist, will engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through integrated health care delivery systems. Heart health/hypertension and diabetes will be the focus of the educational classes. These efforts will be bolstered by education and support for developing self-management goals.

Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care."(From RHP planning protocol)

Challenges:

The main challenge anticipated is that the geographic area to be covered by this project is large and therefore will require increased communication and coordination among all members of the care team. Also, patients in the target population frequently have transportation issues which may make attending classes difficult. Understanding this, we will work to schedule classes at convenient locations and times, near public transportation.

The 5-year expected outcome(s):

Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) The over-arching expected outcome of the 5 year project will be to effect blood pressure control in an underserved population. The exact goal has yet to be determined, pending establishment of a baseline. On a broader scale, the project hopes to achieve the "Triple Aim": improving the individual experience of care; improving the health of the target population; and reducing the per capita costs of care for the target population. Improving the individual experience of care and improving the health of the target population will be measured with health status/quality of life surveys and by reports demonstrating the improvement target of controlling high blood pressure. Cost of care should be impacted by the programs self management education as evidenced in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

Regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Starting Point/Baseline:

Although the Community Health Program has been in operation for 5 years, the expansion initiatives proposed here are all new. The initiatives are proposed based on the following facts: In Galveston County, the mortality rate of diseases of the heart is 201.5 – 295.2 per 100,000 and for hypertension specifically, the mortality rate is 8.5 per 100,000, which is in the bottom 25% of Texas counties. In Brazoria County, the mortality rate of diseases of the heart is 223.5 per 100,000 and for hypertension specifically, the mortality rate is 6.9 per 100,000, also in the bottom 25% of all Texas counties. Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The populations that will be served by this proposed program consists of a significant number of uninsured; 25% uninsured in Galveston County and 26% uninsured in Brazoria County. These counties also have a number of areas that are federally designated as Medically Underserved Areas, 6 in Brazoria County (deemed significantly underserved) and 3 in Galveston County. The current Community Health Program services an average of 485 uninsured patients (200 unique patients) with over 9,000 encounters per year in an intensive care management, disease management and patient navigation program for adult patients in Galveston County with a chronic disease diagnosis.

RATIONALE

Relation between Project Choices and Community Needs:

The project option chosen is: 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

Required core project components:

a. Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency This will be accomplished by working closely with the UTMB ED care manager and other ED staff and reviewing reports on ED use. The program will employ Texas certified Community Health Workers who are trained in cultural competency. Additional training for the CHWs and other staff on the program will be provided within 3 months of hire date.

b. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. The Community Health Program will employ RN care managers, Community Health Workers, a social worker and a nutritionist to assist in meeting the goals of the program.

c. Connect patients to primary and preventive care. The navigators in this program will assist in connecting patients to primary care physicians and/or medical home sites as well as expand care management services and educational classes to patients with chronic disease (diabetes, heart disease, hypertension, COPD).

d. Increase access to care management and/or chronic care management, including education in chronic disease self-management. The proposed project will expand care management services and educational classes to patients with chronic disease (as outlined in the project description). The care managers and community health workers, supported by a social worker and nutritionist, will engage with patients in a culturally and linguistically appropriate manner to provide chronic disease education and support for developing self-management goals. Behavior modification and motivational interviewing techniques will be utilized to develop self-management goals and create action plans.

e. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. Quality improvement will take place in face-to-face learning collaboratives (as described in the project milestones table). The project will also identify project impacts in Years 4 & 5 by measuring improvement in health status and/or quality of life (as described in the project milestones table).

The proposed program will follow all of the required core project components as described above. The process and improvement milestones chosen support the project as follows: [P-3] Provide care management/navigation services to targeted patients.; [P-4] Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources.; **[**P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements; [I-10] Improvements in access to care of patients receiving patient navigation services using innovative project option.

Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by patient navigators vary by program and the needs of the patient. This proposed program may include the following services, based on the individual needs of each patient:

- Facilitating communication among patients, family members, survivors and healthcare providers.
- Coordinating care among providers.
- Assisting in arranging financial support and assisting with paperwork.
- Assisting in ensuring that appropriate medical records are available at medical appointments.
- Facilitating follow-up appointments.
- Community outreach and building partnership with local agencies and groups.
- Assisting in health education as lay health advisors/advocates

The Community Health Program, Chronic Disease Education program plans to use Registered Nurse Care Managers in a team based approach with Community Health Workers. Community health workers have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also posses the linguistic and cultural skills needed to connect with patients from underserved communities. Community health workers are also known as community health advisors, lay health advocates and promotoras de salud. The Community Health Program, Chronic Disease Education program will use Community Health Workers as lay health advisors/advocates in providing culturally appropriate chronic disease and self-management education. This program will also include trained social workers, and a nutritionist to support the navigation teams. In Galveston County, the mortality rate of diseases of the heart is 201.5 – 295.2 per 100,000 and for hypertension specifically, the mortality rate is 8.5 per 100,000, which is in the bottom 25% of Texas counties. In Brazoria County, the mortality rate of diseases of the heart is 223.5 per 100,000 and for hypertension specifically, the mortality rate is 6.9 per 100,000, also in the bottom 25% of all Texas counties. Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The populations that will be served by this proposed program consists of a significant number of uninsured; 25% uninsured in Galveston County and 26% uninsured in Brazoria County. These counties also have a number of areas that are federally designated as Medically Underserved Areas, 6 in Brazoria County (deemed significantly underserved) and 3 in Galveston County. The proposed project will be a relatively small scale project that can have a large impact by providing education on heart health and hypertension self-management to underserved areas with a demonstrated need.

Unique Community Need Identification numbers:

CN.1, CN.2, CN.3, CN.12, CN.13, CN.14

Expansion or enhancement

The Community Health Program, Chronic Disease Management program expands a current, successful initiative in several different ways. First, it expands the current care

management/chronic disease management program to a new population (Medicaid & Medicare/Medicaid [dual eligible]). Second, it expands the entire program geographically to include Brazoria County. And third, it expands the offering of chronic disease education classes to include classes on heart health/hypertension in both counties. The management of chronic disease is an existing delivery system reform initiative. There is no DHHS funding for the current program/initiative.

RELATED CATEGORY 3 OUTCOME MEASURES:

OD 1 Primary care and chronic disease management

IT- 1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure) Numerator/Denominator or other metric: The numerator is the number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year and the denominator is patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The data source for this information will be the care management data system/patient registry. This outcome measure was chosen because of the project's focus on chronic disease management and heart health/hypertension education and classes, including self-management education and support. The improvement target is to be determined as a baseline has yet to be established, however, we would expect to see year over year improvement in hypertension control for the patients in this proposed program. The rationale for choosing the outcome improvement target of "Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)", the following was considered: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). In Galveston County, the mortality rate of diseases of the heart is 201.5 – 295.2 per 100,000 and for hypertension specifically, the mortality rate is 8.5 per 100,000, which is in the bottom 25% of Texas counties. In Brazoria County, the mortality rate of diseases of the heart is 223.5 per 100,000 and for hypertension specifically, the mortality rate is 6.9 per 100,000, also in the bottom 25% of all Texas counties. Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee. Also, evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care."

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on expanding community health and chronic disease education programs and emphasis on adult Medicaid, dual eligible and uninsured patients in Galveston and Brazoria

Counties ties to these Category 1 and 2 projects in our RHP: 121805903.2.1, 112706003.2.3, 094092602.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on establishing/expanding patient care navigation programs along with these other Category 2 projects in our RHP: 121805903.2.1-Establish/expand a patient care navigation program; 094148602.2.2-Expand care transition program; 094092602.2.3-Establish/expand a patient navigation program - community health program, chronic disease education; 112706003.2.4- Establish/Expand a Patient Care Navigation Program.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.

- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.3	2.9	2.9.1 (A-E)	Establish/Expand a Patient Care Navigation Program – Community Health Program, Chronic Disease Education
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.12	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Metric: Increase in the number or percent of targeted patients enrolled in the program. Baseline: The baseline is zero, there are no targeted patients enrolled in the program. Goal: Enroll 20 patients (Medicaid, dual eligible or uninsured) with chronic disease in Brazoria County and in Galveston County in the navigator program for a total of 40 enrollees. Data Source: Enrollment reports (Pecsys and/or Chocalat reports). Milestone 1 Estimated Incentive Payment: $332,598 **Milestone 2** [P-4]: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or	**Milestone 3** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Metric: Increase in the number or percent of targeted patients enrolled in the program. Baseline: The baseline is zero, there are no targeted patients enrolled in the program. Goal: Enroll an additional 152 patients (Medicaid, dual eligible or uninsured) with chronic disease from either Brazoria or Galveston County in the navigator program by 9/30/14. Total enrollment by end of DY5 projected to be 600. . Data Source: Enrollment reports (Pecsys and/or Chocalat reports). Milestone 3 Estimated Incentive Payment: $210,003 **Milestone 4** [P-4]: Increase patient engagement, such as through patient education, self-management support, improved patient-provider	**Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 []: [I – 10.4]: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate or end result. The Community Health Program has chosen to focus on: Improved health status and/or quality of life of target population as measured by score improvement on validated assessment tool administered pre and post navigator program. Goal: 60% of patients enrolled in the navigator program will demonstrate an improvement in health status and/or quality of life from beginning of program to dis-enrollment or at class completion. Improvement will be measured by administering a validated assessment tool at the initial navigator interaction and comparing those results to the same tool administered at dis-	**Milestone 7** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1]: [I – 10.4]: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate or end result. The Community Health Program has chosen to focus on: Improved health status and/or quality of life of target population as measured by score improvement on validated assessment tool administered pre and post navigator program. Goal: 70% patients enrolled in the navigator program will demonstrate an improvement in health status and/or quality of life from beginning of program to dis-enrollment or at class completion. Improvement will be measured by administering a validated assessment tool at the initial navigator interaction and comparing those results to the same tool administered at dis-enrollment from the navigator

094092602.2.3	2.9	2.9.1 (A-E)	Establish/Expand a Patient Care Navigation Program – Community Health Program, Chronic Disease Education
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.12	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
coordination with community resources. Metric 1 [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program. Baseline: Baseline is zero, there are currently no classes in Brazoria County and only diabetes classes in Galveston County, not heart health classes. Goal: Hold 2 diabetes education classes in Brazoria County and one (1) heart health education class in Galveston County. Data Source: class participant lists/sign-in sheets. Milestone 2 Estimated Incentive Payment (maximum amount): $332,558	communication techniques, and/or coordination with community resources. Metric 1 [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program. Baseline: Baseline is zero, there are currently no classes in Brazoria County and only diabetes classes in Galveston County, not heart health classes. Goal: Conduct 2 diabetes education classes and one heart health class in Brazoria County. Conduct 2 heart health education classes in Galveston County Data Source: class participant lists/sign-in sheets. Milestone 4 Estimated Incentive Payment: $210,003 **Milestone 5 [**P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with	enrollment from the navigator program or at time of class completion. The program has set the goal of 60% of patients demonstrating an improvement in health status and/or quality of life while taking into consideration that not all patients will "complete" the program. Data Source: Baseline information will be collected by validated assessment tool (to be selected) at time of enrollment – data source will be patient record and assessment tool scores. Milestone 6 Estimated Incentive Payment: $594,328	program or at time of class completion. The program has set the goal of 70% of patients demonstrating an improvement in health status and/or quality of life in DY5, taking into consideration "lessons learned" from DY4 to make changes leading to higher improvement rates. Data Source: Baseline information will be collected by validated assessment tool (to be selected) at time of enrollment – data source will be patient record and assessment tool scores. Milestone 7 Estimated Incentive Payment: $454,497

094092602.2.3	2.9	2.9.1 (A-E)	Establish/Expand a Patient Care Navigation Program – Community Health Program, Chronic Disease Education	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.12	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate two times a year in meetings/seminars organized by the RHP and/or with other performing providers implementing the same kind of project. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Rationale/Evidence: The highest			

094092602.2.3	2.9	2.9.1 (A-E)	Establish/Expand a Patient Care Navigation Program – Community Health Program, Chronic Disease Education	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.12	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 5 Estimated Incentive Payment: $210,003			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $665,197	Year 3 Estimated Milestone Bundle Amount: $630,009		Year 4 Estimated Milestone Bundle Amount: $594,328	Year 5 Estimated Milestone Bundle Amount: $454,497
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,344,031				

PROJECT OPTION: 2.12.1 Implement/expand care transition programs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.4
PERFORMING PROVIDER NAME/TPI: University of Texas Medical Branch at Galveston/ 094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will enable improvements in care transitions and coordination of care for patients 65+ transitioning from a hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination.
NEED FOR THE PROJECT: The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks. Many times this leads to otherwise preventable hospital readmissions. This project will aim to address these issues by ensuring that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely for this target population.
TARGET POPULATION: UTMB'S target population is the medically underserved areas with in Galveston and Brazoria counties. Within Galveston County, there are 8 census tracts that are federally designated as Medically Underserved Areas and in Brazoria County there are 6 large areas designated as Medically Underserved Areas. This project specifically targets those individuals 65+ transitioning from a hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination. Baseline target population is 500 patients. Baseline is determined by the 3, 253 patients greater than 65+ discharged from UTMB hospital with 15.2% directly discharged to a nursing home/rehabilitation facility.
CATEGORY 1 EXPECTED PATIENT BENEFITS: The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to nursing home, and from nursing home to home health in order to prevent increased health care costs and avoidable 30-day re-hospitalizations.
CATEGORY 3 OUTCOME: I.T-3.1 All cause 30 day readmission rate-NQF 1789 (standalone measure)
PROJECT DESCRIPTION:
The Transitional Care Program will design and implement an effective care transition program that promotes patient centered care for patients 65+ transitioning from the UTMB hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination with the goal of eliminating avoidable 30-day readmissions. The role of the Care Transition Coordinator will be to work with families to provide support and education and to work in partnership with other care providers community resources (e.g. nursing home staff, community home care providers, hospital discharge planners, hospital ER staff, MDs,) to ensure quality continuity of care for older persons navigating across different healthcare sectors.

Required core project components:

a. Review best practices from a range of models. UTMB is currently engaged in Project RED. We will incorporate best practices from this model

b. Conduct an analysis of the key drivers of 30-day hospital readmissions using the IHI State Action on Avoidable Re-hospitalizations.

c. We will employ the use of the institution's EMR or, if needed, develop a database to facilitate and enable continuity of care

d. A patient registry will be developed to assist in the identification of patients at risk of needing acute care services within 30-60 days

e. Implement a discharge planning program and a post discharge support program

f. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, nursing home, and home care providers

g. Employ LEAN and Process re-engineering to evaluate and assess the program's efficacy and efficiency.

In order to implement this program so that it meets the requirements, the following Process Milestones and improvement milestones have been selected.

Year 2 10/01/2012-09/30/2013
Because this is a new program, we will start by establishing the infrastructure needed to follow fragile patients to nursing homes or other care facilities. To guarantee this is a comprehensive program that connects our facility with other providers effectively, we will host some face to face meetings to discuss problems and solutions.

P-2 Milestone: Implement standardized care transition processes. P-2.1 Metric Care Transitions policies and procedures. a. Submission of protocols b. Data Source: Policies and procedures of care transitions program materials. **c.** Rationale/evidence

It is critical to develop policies and procedures and identify responsible parties, activities, timelines and anticipated outcomes. Goal: 100% of discharged patients will have written discharge plans upon discharge. 70% of discharged patients will have advanced directive documented by the discharge summary packet.

Year 3 10/1/2013-09/30/2014
P-9 Milestone: Implement a case management related registry. P-9.1Metric: Documentation of registry implementation. a. Data source: Registry reports demonstrating case management

functionality. b. Rationale/evidence: implementation of proactive and seamless case management services will improve outcomes and insure better transitions.
Home Health Care case manager will have 50% contacts with destination nursing home.

P-4 Milestone: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge

P-4.1 Metric: Care transitions assessment. a. Submission of care transitions assessment and resource planning documents. b. Data Source: Care transitions assessment and resource planning documents. c. Rationale/evidence It is important to try to coordinate with facilities outside the provider's own delivery system. Randomly selected discharged patients will be chosen and record will be reviewed for compliance.

P-12. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. P-12.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the Rapa) Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.

Year 4
Once we have systems developed, we will study the major conditions that care plans will address. We will then focus on meeting patients with improved discharged plans based on improved protocols and gradually increase the numbers of clients reached with enhanced care transitions.

Improvement Milestones: I-10. Milestone: Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions I-10.1. Metric: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. List by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest re-admission rates. Data Source: Registry or EHR report/analysis. Rationale/Evidence: Assessing the most prevalent conditions and factors that lead to re-admissions will allow the provider to address the needs of the patient population more effectively.

I-11. Milestone: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies
I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by

approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. Data Source: Registry or EHR report/analysis
Year 5
As the program matures we will expand the care transition to include all at risk clients prior to discharge.

I-13. Milestone: Increase the number or percent of patients in the case management related registry. I-13.1.Metric: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas

a. Numerator: Number of unique patients in the registry. b. Denominator: Number of targeted patients. c. Data Source: EHR, claims, registry or other program documents

Project Goal

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to nursing home, and from nursing home to home health in order to prevent increased health care costs and avoidable 30-day re-hospitalizations. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care have been shown to be prone to errors. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases. The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Anticipated Challenges:

Post discharge care coordination is not a reimbursable service by Medicare or Medicaid; however, the Patient and Affordable Care Act of 2010 does allow CMS to implement changes to its reimbursement model that include penalties based on readmission rates beginning in October 2012. It will be a challenge to support additional expenses that currently do not directly or indirectly generate revenue.

The implementation of a centralized discharge planning program that can efficiently monitor and communicate discharges of patients 65+ years of age to the Care Transition Coordinator in a timely manner presents a challenge. We plan to develop a centralized registry. This registry will be based within the electronic medical record. Investment in a database may be required.

5-year expected outcome:

Our proposal will result in the establishment of a sustainable, dynamic, effective, care transition program that demonstrates a reduction in avoidable 30-day rehospitilization for patients 65+ transitioning from the hospital setting to the nursing home and from the nursing home to home health. We recognize that hospitals are only one component of the care continuum that impact

30-day readmissions. At the end of 5-years, we expect to have strong partnerships with community stakeholders and external providers that share our responsibility to provide high quality, coordinated care to our patients as they transition across the care spectrum. We will engage in meaningful discussion, promote continuous education and quality improvement to collectively improve the care transition process.

Regional Goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce

STARTING POINT/BASELINE:

UTMB discharged 3,253 patients greater than 65 years from all units between (9/1/10-8/31/11). Of these 500 were discharged to nursing homes or rehabilitation facilities. Of these 500, 121 patients (24%) were readmitted to the hospital within 30 days.

RATIONALE

This project directly addresses the need for our region to lower our 30 Day Readmission Rate (CN.11).

The provision of coordinated transitional care of our patients, 65 and older, from the hospital to the nursing home, and from the nursing home to home health does not currently exist within our institution. No state or federal funds are currently dedicated to this project.

RELATED CATEGORY 3 OUTCOME MEASURES:

IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure)

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the transition from the hospital to the nursing home. The implementation of a Care Transition Coordinator to work with families to provide support & education and work in partnership with other care providers & community resources (e.g. community home care providers, hospital discharge planners, hospital ER staff, MDs,) to ensure quality & continuity of care for older persons navigating across different healthcare sectors is vital in preventing avoidable hospital readmissions. (McAiney, Carrie A., et al. "A Unique Practice Model for Nurse Practitioners in Long-term Care Homes." Journal of Advanced Nursing 62.5 (2008): 562-71.) Transitions between healthcare settings are associated with errors in communication of information and treatment plans for frail older patients, but strategies to improve transitional care are lacking. (LaMantia, Michael A., et al. "Interventions to Improve Transitional Care Between Nursing Homes and Hospitals: A Systematic Review." Journal of the American Geriatrics Society 58.4 (2010): 777-82.)

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on care transitions between hospital and nursing home and home health settings and emphasis on patient centered care that reduces preventable readmissions ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2,

094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation/expansion of care transitions programs along with these other Category 2 projects in our RHP: 139172412.2.1-Develop, implement and evaluate standardized clinical protocols and evidence - based care delivery model to improve care transitions; 094092602.2.4-Develop and implement a transitional care program between hospital, nursing home, and home health care home via a care transition coordinator; 094092602.2.7-Implement/expand care transitions programs (Obstetrics/STORK); 094092602.2.5 - Implement a care transitions program care management registry.

PLAN FOR LEARNING COLLABORATIVE:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.

- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.4	2.12	2.12.1	Develop and Implement a Transitional Care program Between Hospital, Nursing Home, and Home Health Care Home via a care transition coordinator
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.13	IT -3.1	All cause 30 day readmission rate –NFQ 1789 (standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-2 Milestone: Implement standardized care transition processes P-2.1 Metric Care Transitions policies and procedures a. Submission of protocols b. Data Source: Policies and procedures of care transitions program materials **c.** Rationale/evidence It is critical to develop policies and procedures and identify responsible parties, activities, timelines and anticipated outcomes 100% of discharged patients will have written discharge plans upon discharge 70% of discharged patients will have advanced directive documented by the discharge summary packet Milestone 1 Estimated Incentive Payment: $429,060	**Milestone 2** P-9 Milestone: Implement a case management related registry P-9.1Metric: Documentation of registry implementation a. Data source: Registry reports demonstrating case management functionality. b. Rationale/evidence: implementation of proactive and seamless case management services will improve outcomes and insure better transitions. Home Health Care case manager will have 50% contacts with destination nursing home. Milestone 2 Estimated Incentive Payment: $134.607 **Milestone 3** P-4 Milestone: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge P-4.1 Metric: Care transitions assessment a. Submission of care transitions	**Milestone 5** I-10. Milestone: Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions I-10.1. Metric: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. a. List by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest re-admission rates. b. Data Source: Registry or EHR report/analysis c. Rationale/Evidence: Assessing the most prevalent conditions and factors that lead to re-admissions	**Milestone 7** I-13. Milestone: Increase the number or percent of patients in the case management related registry I-13.1.Metric: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas a. Numerator: Number of unique patients in the registry. b. Denominator: Number of targeted patients c. Data Source: EHR, claims, registry or other program documents Milestone 7 Estimated Incentive Payment: $287,722

094092602.4	2.12	2.12.1	Develop and Implement a Transitional Care program Between Hospital, Nursing Home, and Home Health Care Home via a care transition coordinator	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.13	IT -3.1	All cause 30 day readmission rate –NFQ 1789 (standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	assessment and resource planning documents b.Data Source: Care transitions assessment and resource planning documents c. Rationale/evidence It is important to try to coordinate with facilities outside the provider's own delivery system Randomly selected discharged patients will be chosen and record will be reviewed for compliance. Milestone 3 Estimated Incentive Payment: $134,607 **Milestone 4** P-12. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. P-12.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a) Data Source: Documentation of		will allow the provider to address the needs of the patient population more effectively. Milestone 5 Estimated Incentive Payment: $189,291 **Milestone 6** I-11. Milestone: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines a. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for care	

094092602.4	2.12	2.12.1	Develop and Implement a Transitional Care program Between Hospital, Nursing Home, and Home Health Care Home via a care transition coordinator
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	094092602.3.13	IT -3.1	All cause 30 day readmission rate –NFQ 1789 (standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. a. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 4 Estimated Incentive Payment: $134,607	transition services c. Data Source: Registry or EHR report/analysis Milestone 6 Estimated Incentive Payment: $189,291	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $429,060	Year 3 Estimated Milestone Bundle Amount: $403,821	Year 4 Estimated Milestone Bundle Amount: $378,582	Year 5 Estimated Milestone Bundle Amount: $287,722
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,499,186			

PROJECT OPTION: 2.12.1 Implement/expand care transition programs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.5
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: This project will enable improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.
NEED FOR THE PROJECT: People with serious and complex illnesses need transitions in setting of care—for example from hospital to home or nursing home, or from facility to home- and community-based services. Education and planning for safe, effective, and efficient care transitions will reduce the risk of potentially preventable readmissions by ensuring that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.
TARGET POPULATION: Our target population is the medically underserved areas with in Galveston and Brazoria counties. Within Galveston County, there are 8 census tracts that are federally designated as Medically Underserved Areas and in Brazoria County there are 6 large areas designated as Medically Underserved Areas. Currently 32% of UTMB's payor mix is comprised of the uninsured and Medicaid. The project will implement a case management registry system on all adult inpatient units excluding OB and TDC, this is equivalent to approximately 5,000 inpatient admission each year.
CATEGORY 1 EXPECTED PATIENT BENEFITS: Effective care transitions will aid the patient with safe, effective, and efficient care once discharged from the hospital to prevent potentially preventable readmissions.
CATEGORY 3 OUTCOME: I.T-3.1 All cause 30 day readmission rate-NQF 1789 (standalone measure)
PROJECT DESCRIPTION:
The project is to implement a case management registry system for John Sealy Hospital, all adult inpatient units excluding OB (ante partum, post-partum) and TDC with a focus on decreasing potentially preventable 30 day readmissions by 1% each year at UTMB. The registry system will allow the user to track/trend data regarding identified risk factors for readmission. Currently UTMB does not have a system that has the ability monitor and trend data. This project is associated with 2.2.4 Develop and Implement a Transitional Care Program between hospital, nursing home, and home health care via a care transition coordinator.
Prior to the implementation of the case management registry, a documentation flow sheet will be created from current templates including the Social Functional Assessment (SFA) and the Discharge Disposition Note (DCDN). Report will be developed from the data and analyzed.

Project goal(s):

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care—for example from hospital to home or nursing home, or from facility to home- and community-based services—have been shown to be prone to errors.[1] Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases.[2]The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. [3]The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Anticipated challenges:

An anticipated challenge to this project will ensuring there is enough IT support to implement the project with other competing IT priorities. Additionally having IT support to write reports to obtain data. Consider hiring a CM departmental IT employee to focus efforts on this project.

The 5-year expected outcome(s):

The project is to implement a case management registry system with a focus on decreasing potentially preventable 30 day readmissions by 1% each year at UTMB, with an expected outcome to decrease PPR by 5%. For FY 12 the readmission rate for UTMB was 10%. A case management registry system that will report the social, functional, psychological and economic factors to identify risk factors for readmission will help to prioritize needs. The CM will review and identify other risk factors prior to discharge. In 5 years we will have a system that tracks inputted information that will allow us to analyze and develop interventions to ensure a smooth, safe and sustainable discharge/transition.

Regional goals:

Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

STARTING POINT/BASELINE:

For FY2012 the readmission rate for UTMB John Sealy Hospital was 10%. Currently UTMB does not have a case management registry system to examine different factors that may impact 30

1Coleman EA. "Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs." Journal of the American Geriatrics Society (2003) 51:549-555

2 Rittenhouse D, Shortell S, et al. "Improving Chronic Illness Care: Findings from a National Study of Care Management Processes in Large Physician Practices." Medical Care Research and Review Journal (2010) 67(3): 301-320

3 Coleman, E., Parry, C., ET. Al. "The Care Transitions Intervention: a patient centered approach to ensuring effective transfers between sites of geriatric care." Home Health Care Serv Q (2003) 22 (3): 1-17

day readmission rates. The registry will give the ability to analyze social, functional, psychological and economical factors that can impact potentially preventable readmissions. Hospitals are required by CMS and Joint Commission to assess and safely transition to the appropriate care environment. Currently patient data is entered into Epic however there is not a way to track/trend or identify high risk indicators. There are no information technology or case management systems nor are there personnel trained to implement this program.

RATIONALE

Relation between Project Choices and Community Needs:

2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidenced based care delivery model to improve care transitions. Listed below are the required core project components with our status on implementation.

Required core project components:

a. Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.). This is fulfilled.

b. Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews. This is fulfilled.

c. Integrate information systems so that continuity of care for patients is enabled. This component serves as the starting point for this Care transition program.

d. Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days. This plan will be addressing this component.

e. Implement discharge planning program and post discharge support program. This plan is addressing this component.

f. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers. Plan will be addressing this component.

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

Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home and community-based service. When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Patients cannot fully participate in their care during and after hospital stays unless sufficient information and an understanding of their diagnoses, medication, and self-care needs id provided. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. The first step is the development of the documentation flow sheets, ultimately the registry will meet the need of our under-served and uninsured population including chronic conditions will be collected and documented in this registry.
In order to meet the required options components, we have selected the following milestones. They are listed by year.
Year 2
Essential to get our information technology program running, we will focus on development of documentation flow sheets prior to the implementation of the registry. Milestone 1 P-9 Implement a case management related registry. Metric 1 P-9.1 Documentation of registry implementation Data source: registry reports documenting case management functionality Baseline/Goal: Increase the number or percentage of patients in the CM related registry Data Source: EHR, claims, registry or other documents
Year 3
Once the registry is running we will link with area providers. Milestone 2 P-4 Conduct an assessment and establish linkages with community based organizations to create a support network for targeted patients post discharge. Metric 1 P-4.1 Care transitions assessment. Baseline/Goal: submission of care transitions assessment and resource planning documents. Data Source: care transitions assessment and resource planning documents

To guarantee smooth care transitions, we will create protocols for managers and others to follow. Milestone 3 P-3 Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge Metric 1 [P-8.1]: P-3.1 Care transitions protocols Baseline/Goal: care transitions materials Data Source: care transitions program materials

Year 4
Because this is a new program, we will create a staffing plan and begin to enroll clients into the registry. Milestone 4 P-7 Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 P-7.1 Documentation of the staffing plan Baseline/Goal: no baseline: New program needs staffing plan. Develop realistic staffing plan, including role descriptions and implementation plan with timeline Data Source: staffing

and implementation plan Rationale: This describes the number and type of staff needed and role for each participant.

Year 5
As we enroll clients, we will document conditions to focus patient education plans. After this step, we will implement our care transition with dedicated staff. Milestone 5 I-13 Increase the number or percent of patients in the case management related registry Metric I-13.1 Increase in the number or percentage of patients in the case management registry; patients may be targeted from ED and inpatient areas Goal: Increase in the number or percentage of patients in the case management registry Data Source: EHR, claims, registry or other program documents
In 2012, approximately 80% of UTMB discharges are disposition to home, 10% discharge home with home health, 6% discharge to a skilled nursing facility.

Milestone 6
I-10 Identify the top chronic conditions (e.g. heart attack, heart failure and pneumonia) and other patient characteristics (e.g. medical home assignment and demographics such as age) or socioeconomic factors (e.g. homeless) that are common causes of avoidable readmissions—Metric I-10.1 Identification and report of those chronic conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admission. Goal: list by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates Data Source: registry of EHR report analysis

Milestone 7
I-14 Implement standard care transition processes in specified patient populations; Metric: I-14.1 Measure adherence to processes Goal: measure adherence to processes Data Source: hospital administrative data and the patient medical record.

Unique Community Need Identification numbers:

CN 1, 2, 6, 10, 11, 12, 13, 14, 15, 16, 17

Expansion or enhancement:

We currently have Epic; this is a new initiative for UTMB for case management registry system. Currently we do not have any DHHS funding from the state or government to pay/supporting this improvement.

Related Category 3 Outcome Measure:

IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline.
The process measures to accomplish this outcome for year two are:
[P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Engaging stake holder includes the following: Information Services, Care Management Staff, Patient Care Facilitators, Physicians, Billing Services, Compliance, staff on inpatient units; to ensure understanding and awareness of the software and the care transition initiatives. We would collaborate to identify anticipated challenges and “buy in” from all. This will be documented by meeting agendas, minutes, sign in sheets, handouts, etc. Metric: Conduct meetings 2times per year with stakeholders to make them aware of the care transitions program, identify anticipated challenges, obtain “buy-in”

and outline expectations. Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2 and continuing in DY3 as the project is implemented. Data Source: Meeting agendas, minutes, sign-in sheets, handouts, etc.

Rationale: All of the stakeholders in the metric play a role in the discharge process and therefore, will need to understand the project including any expectations for their involvement.

[P-3] Develop and test data systems. Identification of patients readmitted within 30 days of discharge and the causes of the readmissions is critical to this project and therefore, reports will be developed to improve identification of the patients in a timely manner. Also, reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives. Developing reports, evaluating the data and initiatives will be modified as needed on an ongoing basis. Metric: Make necessary modifications to care management system and develop reports from both hospital and care management data systems to identify target patients and report on required improvement milestones & metrics

Goal: Modification will be made as necessary to care management system and reports will be developed from hospital and care management data systems during DY2 and tested during DY3 with continued modifications made on an as needed basis. Data Source: Hospital and care management data systems. Rationale: Identification of the target population is critical to the project. Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives.

[P-2]: Establish baseline rates. Baseline readmission rates can be established from current UTMB data systems however a data base containing the multiple causes of readmission is not captured currently. The specific readmission cause data that will be collected with this system will be the first steps in identifying strategies for readmission reduction. This data will trend throughout the implementation of the project. Metric: Determine baseline readmission rates at UTMB for the identified target diagnosis AMI. Goal: Establish baseline rates to measure against improvement targets. Data Source: Hospital administrative data system reports.

Rationale: Need to establish a baseline number in order to demonstrate improvement.

For year three, we will implement two more milestones including: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. As data is collected through the care management software, pt demographics, data from the social functional assessment, discharge follow up, discharge plan and discharge disposition will be examined and trended. Analysis of the data will be performed and interventions started base on the findings, either by unit, financial class, readmission reasons, etc.
Metric: Conduct computer runs to determine the integrity of the data base Goal: Find and improve any errors in implementing a registry that supports our care transition program.
Data source: case management registry reports and EHR, claims. Rationale:

This is a new program and we will have to test the ability of our software expansion and the inclusion of resources and clients for a coordinated care transition to reduce 30 day readmissions. The software will collect, patient demographics, data from the social functional assessment, discharge follow up, discharge plan and discharge disposition to identify specific factors specifically related to readmission rates. This will include a set of questions that specifically drill down to causative reasons. P-5 Disseminate findings, including lessons learned and best practices, to partners.

Metric: reports on protocols, client lists, resource pathways and staffing roles will be shared with extended team. Goal: Obtain approval with transition staff and regional partners on the ability of the registry and care transition program to meet the needs that support a smooth discharge and follow-up care. Data source: case management registry reports and EHR, claims

Rationale: This is a new system and needs to be reviewed by concerned parties.

Year four and five will focus on accomplishing the improvement outcome target. The chosen outcome measure for this project is the Implementation of a care transitions program with a care management registry system. Currently, UTMB-Case Management does not utilize a system, all processes are manual. The outcome target is to decrease the number of potentially preventable 30 day readmissions. The goal is to decrease the percentage of potentially preventable 30 day readmits by 1% each year. By the end of the year 5, the percentage of potentially preventable 30 day readmissions would decrease by 5%. In FY2012 the 30 day readmit rate was 10%.

The metric will be calculated as follows: the numerator for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. The denominator claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or (2) admissions to acute care facilities for patients aged 18 years or older. In FY12 there were over 26,000 patients discharged, 23% who were Medicaid and uninsured. Of the Medicaid and uninsured, 35% are readmitted within 30 days.

After the implementation of the care management registry, we will begin to identify trends and patterns for patients that are readmitted within 30 days of discharge. The data sources, case management registry, EHR and claims will be compared to ensure validity.

RATIONALE:

The reason for selecting implementation of a case management registry and specifically decreasing potentially preventable readmissions is identify opportunities to improve quality care and transitions of care. The goal is to decrease potentially preventable readmissions by 1% each year.

RELATIONSHIP TO OTHER PROJECTS:

This project's focus on implementing a case management registry and emphasis on decreasing potentially preventable readmissions ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.8. All required reporting domains in Category 4 will be measured and reported on by the provider.

RELATIONSHIP TO OTHER PERFORMING PROVIDERS' PROJECTS IN THE RHP:

This project focuses on the implementation/expansion of care transitions programs along with these other Category 2 projects in our RHP: 139172412.2.1-Develop, implement and evaluate standardized clinical protocols and evidence - based care delivery model to improve care transitions; 094092602.2.4-Develop and implement a transitional care program between hospital, nursing home, and home health care home via a care transition coordinator; 094092602.2.7-Implement/expand care transitions programs (Obstetrics/STORK); 094092602.2.5 - Implement a care transitions program care management registry.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.

- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.5	2.12	2.12.1 (A-G)	Implement a Care Transitions Program Care Management Registry
The University of Texas Medical Branch Hospital			094092602
Related Category 3 Outcome Measure(s):	094092602.3.14	IT-3.1	OD-3 Potentially Preventable Re-admissions-30 day readmission rates (PPR)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-9 Implement a case management related registry Metric 1 [P-9.1 Documentation of registry implementation Data source: registry reports documenting case management functionality Baseline/Goal: Increase the number or percentage of patients in the CM related registry Data Source: EHR, claims, registry or other documents Milestone 1 Estimated Incentive Payment (maximum amount): $1,432,526	**Milestone 2** P-4 Conduct an assessment and establish linkages with community based organizations to create a support network for targeted patients post discharge. Metric 1 [P-5.1]: P-4.1 Care transitions assessment Baseline/Goal: submission of care transitions assessment and resource planning documents Data Source: care transitions assessment and resource planning documents Milestone 2 Estimated Incentive Payment: $449,255 **Milestone 3** P-3 Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge	**Milestone 4** P-7 Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 P-7.1 Documentation of the staffing plan Baseline/Goal: no baseline New program needs staffing plan. Develop realistic staffing plan, including role descriptions and implementation plan with timeline Data Source: staffing and implementation plan Rationale: This describes the number and type of staff needed and role for each participant. Milestone 4 Estimated Incentive Payment: $842,354	**Milestone 5** I-13 Increase the number or percent of patients in the case management related registry to 25% of the target population. Metric I-13.1 Increase in the number or percentage of patients in the case management registry; patients may be targeted from ED and inpatient areas Goal: Increase in the number or percentage of patients in the case management registry Data Source: EHR, claims, registry or other program documents Milestone 5 Estimated Incentive Payment: $213,396 **Milestone 6** I-10 Identify the top chronic conditions (e.g. heart attack, heart failure and pneumonia) and other patient characteristics (e.g. medical home assignment and demographics such as age) or socioeconomic factors (e.g. 0. homeless) that are common causes of avoidable readmissions—Metric I-10.1 Identification and report of those chronic conditions, socioeconomic factors, or other

094092602.2.5	2.12	2.12.1 (A-G)	Implement a Care Transitions Program Care Management Registry	
The University of Texas Medical Branch Hospital				094092602
Related Category 3 Outcome Measure(s):	094092602.3.14	IT-3.1	OD-3 Potentially Preventable Re-admissions-30 day readmission rates (PPR)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 1 [P-8.1]: P-3.1 Care transitions protocols Baseline/Goal: care transitions materials Data Source: care transitions program materials Milestone 3 Estimated Incentive Payment: $449,256			patient characteristics resulting in highest rates of re-admission. Goal: list by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates Data Source: registry of EHR report analysis Milestone 6 Estimated Incentive Payment: $213,396 **Milestone 7** I-14 Implement standard care transition processes in specified patient populations; Metric: I-14.1 Measure adherence to processes Goal: measure adherence to processes Data Source: hospital administrative data and the patient medical record Milestone 7 Estimated Incentive Payment: $213,396
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,432,526	Year 3 Estimated Milestone Bundle Amount: $898,511		Year 4 Estimated Milestone Bundle Amount: $842,354	Year 5 Estimated Milestone Bundle Amount: $640,189
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,813,581				

PROJECT OPTION: 2.12.2 Implement Care Transitions Program

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.6
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/TPI: 094092602

Title of Project: Implement Care Transitions Program
PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: The Transitions of Care project is specifically focused on improving the transitions of care for adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of Acute Myocardial Infarction (AMI), heart failure or pneumonia. A transition coordinator will be assigned to each patient who is willing to participate in this new program involving home visits and telephonic follow-up.
NEED FOR THE PROJECT: Without sufficient information and an understanding of their diagnoses, medications and self-care needs, patients cannot fully participate in their care during and after hospital stays. This project aims to address the lack of transition coordination through a team approach that focuses on creating smooth transitions of care from inpatient to home by assisting patients and their families to make necessary arrangements for transitioning care, coordinating follow-up care, identifying barriers to obtaining medication and necessary supplies, functional/ADL assessment and education on fall prevention, and teaching "red flags" that may arise and could signal a potential for readmission.
TARGET POPULATION: The target population is adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of Acute Myocardial Infarction (AMI), heart failure or pneumonia.
CATEGORY 1 EXPECTED PATIENT BENEFITS: Effective care transitions will aid the patient with safe, effective, and efficient care once discharged from the hospital to prevent potentially preventable readmissions. Also, this project specifically aims to show improvements with Acute Myocardial Infarction (AMI) 30 day readmission rate when compared to the baseline 30 day readmission rate for Acute Myocardial Infarction in adult patients of Galveston County.
CATEGORY 3 OUTCOME: I.T-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure)
Project Description:
The Transitions of Care project is specifically focused on improving the transitions of care for adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of Acute Myocardial Infarction (AMI), heart failure or pneumonia. A transition coordinator will be assigned to each patient who is willing to participate in this new program

involving care coordination, patient education and red flag identification through home visits and telephonic follow-up.
This project aims to serve a total of 800 patients with approximately 3200 encounters from DY2 – DY5.

Project Goal(s):

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. The proposed program is designed to create smooth transitions of care from inpatient to home by assisting patients and their families to make necessary arrangements for transitioning care, coordinating follow-up care, identifying barriers to obtaining medication and necessary supplies, functional/ADL assessment and education on fall prevention, and teaching "red flags" that may arise and could signal a potential for readmission. Medication reconciliation, identification of ongoing needs and patient/family education regarding diagnoses and self-management strategies will also be performed. The Transitions Coordination program will consist of Registered Nurse Care Managers as "transition coordinators" to transition patients to their home setting. The Transition Coordinator will follow up with the patient at their home within 48 hours of discharge and be available by phone and email. The Transition Coordinator will assure communication among and between all providers, patient, family and ancillary services (i.e. home care agencies and medical equipment suppliers). A consulting pharmacist will perform medication profile reviews to identify problems and opportunities for improvement in medication regimes (medication therapy management, MTM). Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community. The goal is to ensure that care transitions occur effectively and safely.**Anticipated Challenges:**

One of the anticipated challenges of this project is being able to effectively contact the patient post-discharge. A recent study of one adult medicine unit at UTMB revealed that, on average, 35% of patients cannot be reached by phone within 48 hours of discharge. Understanding this, we have designed the program so that the transition coordinators begin their interaction with the patients while they are still in the hospital. We anticipate that by making this initial contact, we can begin to develop a relationship with the patient/family and obtain accurate contact information.

Post discharge care coordination is not a reimbursable service by Medicare or Medicaid; however, the Patient and Affordable Care Act of 2010 does allow CMS to implement changes to its reimbursement model that include penalties based on readmission rates beginning in October 2012. It will be a challenge to support additional expenses that currently do not directly or indirectly generate revenue

5-year expected outcome:

IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure)

The improvement target that was selected for this project is to reduce the Acute Myocardial Infarction (AMI) 30 day readmission rate when compared to the baseline 30 day readmission rate for Acute Myocardial Infarction in adult patients of Galveston County. The exact goal has yet to be determined, pending establishment of a baseline. The over-arching goal of the project would be to achieve the "Triple Aim": improving the individual experience of care; improving the health of the target population; and reducing the per capita costs of care for the target population. The project should achieve this by improving the transitions of care and coordination of care and ultimately, reducing 30-day readmissions in this population. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. The project will promote continuous quality improvement, meaningful discussion among all stakeholders and ongoing education to collectively improve the care transition process.

Regional Goals:

-

The regional goals that this project will contribute to are as follows:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Starting Point/Baseline:

This project is an implementation of a new program so the baseline is zero. There are no clients currently receiving this type of transitions coordination service in an effort to reduce the 30 day readmission rate for the target population. Baseline 30 day readmission rates will be determined in DY2.

Rationale

Relation between Project Choices and Community Needs

2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.

In reference to the examples given in the RHP planning protocol, the Transitions of Care program will include interventions similar to:

- Patient and family education initiatives including patient self-management skills and "teach-back"
- Post-discharge medication planning
- Early follow-up such as homecare visits, primary care outreach, and/or patient call-backs.

The process milestones selected: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program; Implement standardized care transition processes; 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 and the improvement milestone selected, "Increase the number or percent of patients in the case management related registry" all support the implementation of this care transitions intervention.

The rationale for this project is multi-fold. When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. This is even more true when the patients lack the resources to acquire medications and other necessary services post-hospitalization. The target population for this project, adult patients of Galveston County with Medicaid, Medicare/Medicaid (dual eligible) or uninsured, historically lacks resources for healthcare; Galveston has 8 census tracts that are federally designated as Medically Underserved Areas (MUAs-see Appendix 2). The number of people that reported not being able to see a doctor due to cost concerns was lower than the Texas rate, but higher than the US rate. Finally, the rate of preventable hospital stays—an indicator of lack of access to primary care—for the county is higher than the Texas rate and the 30 Day Readmission Rate for All Medical Discharges is at or slightly higher than Texas and national averages. Additionally, 25% of the Galveston County population lacks insurance – another barrier to acquiring the healthcare required post-hospitalization. Also, the mortality rate for diseases of the heart is 201.5 – 295.2 per 100,000 which is higher than the US average for mortality in this disease.

Without sufficient information and an understanding of their diagnoses, medications, and self-care needs, patients cannot fully participate in their care during and after hospital stays. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. The project that is proposed intends to accomplish the above by developing and implementing care transitions policies and procedures and developing and implementing a care transitions program. The program intends to engage stakeholders through face-to-face meetings to discuss the project, provide data and implement rapid cycle improvement projects. The program will begin providing transitions of care services to patients, entering them in a care management data system and increasing the number of patients year over year of the project. Data systems will be modified and reports generated to disseminate project results and lessons learned. The over-arching goal of improving the 30-day readmission for the target population will be achieved by providing transitions of care services to patients to provide them with sufficient information and an understanding of their diagnoses, medications, and self-care needs using standardized procedures that can be easily replicated and expanded to broader populations as necessary.

The UTMB Community Health Program has experience in implementing this type of "transitions of care program." In 2011, courtesy of a Social Services Block Grant, UTMB developed and implemented a short-term pilot program aimed at reducing readmissions in an adult, uninsured population with a chronic disease diagnosis. The pilot program provided care transitions services to 97 patients in both Galveston and Brazoria counties over a 5 month period. Un-verified data at the end of the program showed an "all-cause" readmission rate of 5.3% for those participating in the transitions program vs. an average all-cause readmission rate for UTMB of 16-18% (2010-2011 data). The lessons learned from this pilot program have been

taken into consideration for this proposed program. The funding for this program ended in October of 2011 and the program was terminated. There is no current funding for a "transitions of care program" at UTMB.

Unique Community Need Identification numbers:

CN.1, CN.2, CN.3, CN.11, CN.14

Expansion or enhancement

The Transitions of Care program represents a new initiative for UTMB and there is currently no funding for this project by DHHS. This project does, however, correlate with existing delivery system reform initiatives for reducing preventable 30-day readmissions as CMS will begin assessing readmission penalties for hospital poor performers in 2014.

Related Category 3 Outcome Measures:

The process measures for the project are as follows:

In DY2, P-1 – We will conduct project planning to engage stakeholders by conducting meetings with stakeholders (inpatient care management, patient care facilitators, adult medicine unit nurses, faculty, residents, health unit coordinators) to make them aware of the transitions of care program, identify anticipated challenges, obtain "buy-in" and outline expectations. This will be documented by meeting agendas, minutes, sign-in sheets, handouts, etc. The goal is to conduct meetings with all stakeholders outlined above starting in DY2 and continuing into DY3 as the project is implemented. All of the stakeholders mentioned above play a role in the discharge process and therefore, will need to understand the project including any expectations for their involvement.

We will also need to establish baseline rates (P-2) for the project by determining the baseline 30 day readmission rates at UTMB for the identified target patients: adult patients in Galveston County with a discharge diagnosis of AMI, CHF or pneumonia. The data will come from hospital administrative data systems and will establish baseline rates to measure improvement targets.

Another process measure key to this project is P-3, Develop and test data systems. Identification of the target population is critical to the project and therefore, reports will need to be developed to improve identification of the patients in a timely manner. Also, Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives. We will make necessary modifications to the care management data system and develop reports from both the care management and hospital data systems to identify target patients and report on required improvement milestones & metrics. Modification will be made to the care management system and reports will be developed from both hospital and care management data systems during DY2 and tested during DY3 with continued modifications made on an as needed basis.

The process measures listed above are a necessary lead-in to the overall success of the project and therefore, to achieving the goals designated by the region. When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce

readmission rates, improve health outcomes, and ensure quality transitions. Creating policies, procedures and reporting mechanisms are all part of designing a comprehensive and reliable transitions of care program.

The Transitions of Care project is specifically focused on reducing readmission rates in adult patients with a diagnosis of AMI, heart failure or pneumonia by providing a "transition coordinator". Therefore, the improvement target that we chose to measure is IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate. The over-arching goal of the project is to improve the 30-day readmission rate for adult patients in Galveston County with a discharge diagnosis of AMI over baseline and then to sustain and improve on the readmission rates year over year of the project. By achieving improvement in the 30 day readmission rate in this target population, ultimately, the project would like to achieve the "Triple Aim": improving the individual experience of care; improving the health of the target population; and reducing the per capita costs of care for the target population. The project should achieve this by improving the transitions of care and coordination of care.

Relationship to other Projects:

This project's focus on improving care transitions and emphasis on adult Galveston County patients with a diagnosis of AMI, heart failure or pneumonia ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the implementation of one or more pilot intervention(s) in care transitions targeting a defined patient population along with these other Category 2 projects in our RHP: 139172412.2.2- Implement one or more pilot interventions in care transitions targeting one or more patient care units; 094092602.2.4 – Develop and Implement a Transitional Care program Between Hospital, Nursing Home, and Home Health Care Home via a care transition coordinator 109372601.2.1-Implement EpicCare link to improve clinical communication between UTMB and referring providers; 094092602.2.11- Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population .

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will

establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.6	2.12	2.12.2	IMPLEMENT CARE TRANSITIONS PROGRAM	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	**094092602.3.5**	**IT - 3.5**	**All cause 30 day readmission rate –NFQ 1789 (standalone measure)**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program. Metric 1 [P-7.1]: Documentation of the staffing plan. Baseline/Goal: No baseline. New program so need to create staffing plan. Develop a realistic staffing plan, including role descriptions and an implementation plan with timeline. Data Source: Staffing and implementation plan. Rationale: This describes the number and type of staff needed and the specific roles of each participant. Milestone 1 Estimated Incentive Payment *(maximum amount):* $939,211	**Milestone 2** [P-2]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transitions policies and procedures Baseline/Goal: No baseline. New program so need to create policies and procedures to submit. Care transition policies and procedures will be developed in DY2. Data Source: Policies and procedures of care transitions program. Rationale: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. Milestone 2 Estimated Incentive Payment: $2,944,641	**Milestone 3** [P-12]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in at least semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment: $891,406 **Milestone 4** [I-13]: Increase the number or percent of patients in the case management related registry. Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry; patients may be targeted	**Milestone 5** [I-13]: Increase the number or percent of patients in the case management related registry. Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas. Numerator: number of unique patients in registry. Denominator: number of targeted patients. Data Source: Care management system reports that will document patients registered in the care management registry. Goal: Increase of 600 from baseline in the number of patients in the case management related registry. Milestone 5 Estimated Incentive Payment: $1,191,423

094092602.2.6	2.12	2.12.2	IMPLEMENT CARE TRANSITIONS PROGRAM	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.5	IT - 3.5	All cause 30 day readmission rate –NFQ 1789 (standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			from ED and inpatient areas. Numerator: number of unique patients in registry. Denominator: number of targeted patients. Data Source: Care management data system reports that will document patients registered in the care management registry. Goal: Increase of 300 from baseline in the number of patients in the case management related registry. Milestone 4 Estimated Incentive Payment: $891,406	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $923,211	Year 3 Estimated Milestone Bundle Amount: $2,944,641		Year 4 Estimated Milestone Bundle Amount: $1,782,812	Year 5 Estimated Milestone Bundle Amount: $1,191,423
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*: $6,842,088*				

PROJECT OPTION: 2.12.2 Implement/Expand Care Transitions Programs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.7
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston/ 094092602

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: By implementing the use of an obstetric specialty registry, we will provide comprehensive, structured "hand off" communication plans with receiving providers to support care transitions from prenatal care to inpatient Labor triage/delivery/post-partum recovery and for the transition to community and post-natal mother/baby follow-up.
NEED FOR THE PROJECT: This project is needed to address the need of structured "hand off" communication plans with subsequent providers for obstetric care transitions for the target population served by this project.
TARGET POPULATION: This project targets Medicaid funded prenatal patients, especially those with high risk conditions or at high risk for other than an uneventful labor, delivery, and postpartum course. Virtually all UTMB prenatal patients are covered by Medicaid, Title V, CHIP-P, or an OB Package for those who financially screen just over the limits so I have included them all as Medicaid and uninsured.

	Prenatal patients	Prenatal visits	RMCHP deliveries at UTMB
Total RMCHP Prenatal patients	10,946	101,873	4,915

In calendar 2011, there were 38 infants with a mean length of stay (ALOS) of 2.24 days and a total of 59 potentially avoidable days in a single year

CATEGORY 1 EXPECTED PATIENT BENEFITS: This specialty obstetric database registry provides an integrated view of the obstetrical record with a focus on the continuum of care from the initial prenatal visit through delivery and the postpartum period with linkage to the newborn's record. We aim to prevent readmissions and their associated costs/waste and to assure the safety of mothers and infants in the perinatal period by assisting in the prevention, early detection, and intervention to reduce the effects of hyperbilirubinemia as one example of perinatal complications with enduring effects
CATEGORY 3 OUTCOME: I.T-8.9 Other Improvement Target – 14-day readmission rate for hyperbilirubinemia.
PROJECT DESCRIPTION:

Project Goal: The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care—for example from hospital to home or nursing home, or from facility to home- and community-based services—have been shown to be prone to errors.181 Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases.182The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. 183The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

Specifically, we will implement specialty obstetric episode database registry in order to 1) integrate obstetric care across UTMB obstetrical clinic and inpatient settings; and 2) streamline the daily tasks of obstetricians, nurses, midwives, clerks, and technologists in creating and maintaining up-to-date obstetric health information records. As a result of these efforts, we aim to prevent unnecessary readmissions and their associated costs/waste and to assure the safety of mothers and infants in the perinatal period by assisting in the prevention, early detection, and intervention to reduce the effects of hyperbilirubinemia as one example of perinatal complications with enduring effects.

Project Option/Project Component:

2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.

By implementing the use of a obstetric specialty registry, we will provide comprehensive, structured “hand off” communication plans with receiving providers to support care transitions from prenatal care to inpatient Labor triage/delivery/post-partum recovery and for the transition to community and post-natal mother/baby follow-up. This specialty database registry will:

- Integrate information systems so that continuity of care for patients is enabled
- Structure “hand off” communication plans with subsequent providers at obstetric care transitions
- Develop a system to identify patients at high-risk for other than routine labor and delivery and information to guide targeted post-natal follow-up

- Support the communication to the next provider regarding patients at high risk for developing complications, i.e. in this project 14-day hospital readmissions for hyperbilirubinemia.

- We will identify any issues with the transmission of vital information across transitions and identify crucial handoffs related to infants at risk for developing hyperbilirubinemia, conduct rapid cycle tests of change and, ultimately, identify and hard-wire "lessons learned."

Project Description:

This specialty obstetric database registry provides an integrated view of the obstetrical record with a focus on the continuum of care from the initial prenatal visit through delivery and the post partum period with linkage to the newborn's record. Specialized tools integrating the entire obstetrical experience, including ultrasound procedures, amniocentesis, genetic counseling, grease board management in labor and delivery and labor documentation with delivery reporting, make this specialty module adjunct to the EHR important in the care of Medicaid funded maternity patients, especially those with high risk conditions or at high risk for other than a uneventful labor, delivery, and postpartum course.

Anticipated challenges:

There should be no difficultly in gaining agreement among attending obstetric faculty and nurse midwives over the standard information important to managing across transitions of care. We have had, however, difficulty getting sufficient IT attention to such decision support solutions because of competing priorities. The budget associated with this project submission will guarantee allocation of knowledgeable IT and data analytics staff dedicated to the goals of the initiative.

5-year expected outcome(s):

By providing a reliable and comprehensive specialty obstetric database, interdisciplinary maternal/child teams will have vital patient information in one database, available at all locations, to take action to direct and safeguard care of pregnant and laboring women and infants in real-time. These data will be immediately available across the Regional Maternal Child Health network. While we anticipate the reduction of adverse safety events related to communication, these data are voluntarily reported. Therefore, we will focus attention on the reduction of avoidable readmission rates of infants for hyperbilirubinemia in DY 4 and DY 5 of the cycle when compared to baseline rates of hospital readmission in DY 2.

Regional goals:

The work of this collaborative directly supports Region 2-wide goals

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention– *by identifying and eliminating/reducing common barriers to effective patient self-management after discharge*

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management– *by decreasing unnecessary hospital days and overusage*

Starting Point/Baseline:

Before undertaking implementation of this obstetric specialty database registry, the base electronic Medical Record (EMR) will have been implemented for OB specialty users. While this information platform supports the basic transmission of patient demographics and medications, only with this specialty obstetric database registry will we be able to tie together the entire episode, the mother and baby records, and provide management reports.

RATIONALE:

Project Milestones:

- [P-X] Stakeholder participation in pre-implementation registry planning meetings will be required to incorporate structured industry-standard maternal and infant assessment and treatment information variables that drive care at transitions in the entire obstetric care episode. This will lay the foundation for configuring the database with common obstetric inpatient documentation tools (triage/admission, the laboring patient, delivery), and the display and supporting clinical decision support for episode test results, including serial ultrasounds.

- [P-9] Through implementation of an obstetric episode specialty registry we expect to assure that clinicians across the episode will have access to documented prenatal visits (initial, routine, high risk); provide required information to support birthing site with prenatal and obstetric history and birth plan; provide management reports to better support the Labor & Delivery setting (patient lists, pregnancy episodes, electronic grease board, mother-baby records); and communicate crucial information about mother and baby to the next provider of care after discharge.

- [P-8] Improve perinatal summary timeliness. Only through the use of this registry do we anticipate that pre- and post-partum information will assure the transmission not only of comprehensive snapshot of relevant mother/baby information but to assure its availability in a timely way.

- [P-X] Conduct a rapid cycle improvement project focused on causal risk for hyperbilirubinemia and enhancing transmission priority information at discharge.

When a patient's transition is less than optimal, the repercussions can be far-reaching — adverse medical events, complications, hospital readmission, and even mortality. Without sufficient information and an understanding of patient diagnoses, medications, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Comprehensive and reliable patient information (e.g. history, prenatal assessments, birth history and risk factors), along with post-discharge support, can reduce readmission rates,

improve health outcomes, and ensure quality transitions. Patient transitions in obstetric care is multidimensional and typically includes transfer from prenatal clinic to maternal assessment and triage, labor and delivery, post-partum care, from hospital to home, and return to community-based maternal/child services.

The vast majority of the patients within the maternity population delivering at UTMB are Medicaid patients who receive their prenatal care in UTMB Regional Maternal Child Health (RMCHP) clinics in surrounding counties including those within five of the sixteen RHP 2 counties: Brazoria, Nacogdoches, Orange, Jefferson, and Galveston. The EPIC Stork EHR enhancement will greatly benefit this population in RHP2. Stork provides a seamless transition from each contact within prenatal care, through labor and delivery, adding the electronic link between mother and baby(ies), and back to the clinics for post partum and newborn care. With this product, our pediatric providers in newborn nursery will have immediate linked access to all maternal information that may affect the newborn so that they may immediately react and appropriately care for the child. As the newborn is discharged and soon seen in the clinics, the clinic providers will have the same access to the care that was provided to the baby while in hospital so that their follow up can be timely and accurate.

RELATION BETWEEN PROJECT CHOICES AND COMMUNITY NEEDS:

Our region has a high incidence of chronic disease and some of the highest healthcare costs in the US. Hospital readmission has been shown to be related to chronic illness self-management efficacy (including mental health and substance use issues), patient resources, access to primary and specialty care. In addition, especially considering Galveston, Nacogdoches, Orange, and Jefferson counties have higher 30 day all cause readmission rates than Texas as a whole. As a key service line for the organization and southeastern Texas, this software is a crucial component to meet the episode management demands for pregnancy care through delivery.

Today, when an individual's care is provided in multiple settings, the comprehensive record for pregnant women is fragmented, making coordination across the continuum difficult.

Unique Community Need Identification numbers:

CN.11	30 Day Readmission Rates
CN.1	Access Barriers: Lack of Personal Resources
CN.2	Access Barriers: Lack of Insurance

While hyperbilirubinemia (neonatal jaundice) is often not considered among readmission statistics, because it focuses on children in the perinatal period, it carries substantial risk. Since parental education and access to care are factors[1] influencing its care and treatment, access barriers in our RHP are also listed.

Expansion or enhancement

This project enhances UTMB's existing EMR, but the addition of a specialty obstetric database registry is a new initiative at UTMB. After the infrastructure for this specialty obstetric database registry are achieved and being sustained, learnings about the beneficial transmission of vital mother/baby information across transitions and the benefits for reducing readmissions

[1] National Quality Forum (NQF). National Voluntary Consensus Standards for Perinatal Care 2008: A Consensus Report. Washington, DC: NQF; 2009

for hyperbilirubinemia can clearly be shared with other RHP 2 maternal/child programs as well as across Texas.
No DHHS funding.

Relationship to other Projects:

This project's focus on care transitions and emphasis on obstetrics ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the implementation/expansion of care transitions programs along with these other Category 2 projects in our RHP: 139172412.2.1-Develop, implement and evaluate standardized clinical protocols and evidence - based care delivery model to improve care transitions; 094092602.2.4-Develop and implement a transitional care program between hospital, nursing home, and home health care home via a care transition coordinator; 094092602.2.7-Implement/expand care transitions programs (Obstetrics/STORK); 094092602.2.5 - Implement a care transitions program care management registry.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.7	2.12	2.12.1	Implement/Expand Care Transitions Programs	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	**094092602.3.16**	**IT- 8.9**	**Other Outcome Improvement Target-14 day readmission rate for hyperbilirubinemia (Standalone measure)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X] Stakeholder participation in pre-implementation registry planning meetings Metric 1 [P-X.1] Participate in regularly scheduled meetings organized by information system staff. Baseline: None Available Goal: Dedicated RHP data analyst, contract IT analyst, along with designated OB administrative and clinical staff meet at least bi-weekly during pre-implementation registry planning. Data source: Documentation of attendance/agendas/minutes of key implementation planning meetings. Milestone 1 Estimated Incentive Payment (maximum amount): $1,405,309	**Milestone 2** [P-9]: Implement a case management related registry Metric [P-9.1]: Documentation of registry implementation Goal: Obstetric episode specialty registry implemented for all UTMB maternal/child settings. Data source: Registry reports demonstrating case management functionality. Rationale/Evidence: Implementation of proactive and seamless case management services will improve patient outcomes around patient discharge and ensure better coordinated care transitions. Milestone 2 Estimated Incentive Payment (maximum amount): $188,421 **Milestone 3** [I-13]: Increase the number or percent of patients in the obstetric episode specialty registry Metric [I-13.1.]: Increase in the number or percentage of patients in the obstetric episode specialty registry. Numerator: Number of unique patients in the registry. Denominator: Number of obstetric		**Milestone 4** [P-8]: Improve discharge summary timeliness. Metric [P-8.1]: Improve percent discharge summary completion within 48 hours of discharge. Numerator: Number of obstetric patients and newborns for which post-partum/perinatal summary is complete within 48 hours of mother/baby discharge. Denominator: Number of obstetric patients and newborns discharged. Baseline: None Available Goal: Improve percent post-partum/perinatal summary completion within 48 hours of mother/baby discharge Data Source: Automated report from Health Information Services or other Milestone 4 Estimated Incentive Payment: $353,290	**Milestone 5** [P-X] Conduct a rapid cycle improvement project focused on causal risk for hyperbilirubinemia and enhancing transmission priority information at discharge. Metric 1 [P-X.1] Number of meetings organized within this initiative, using registry data, to drive rapid cycle change. Baseline: None available Goal: 80% attendance at all meetings of the improvement team and PDSA milestones met, during 120 day project. Data source: Documentation of regular meeting agendas and/or meeting notes. Metric 2 [P-X.2] Share challenges and solutions successfully during regular team interactions. Baseline: None available Goal: Storyboard reflects targeted, time-oriented milestone achievements of PDSA improvement cycle. Data source: Catalogue of challenges, solutions, tests, and progress shared by the team during interactions. Summaries advanced to UTMB sponsor and leadership.

094092602.2.7	2.12	2.12.1	Implement/Expand Care Transitions Programs	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.16	IT- 8.9	Other Outcome Improvement Target-14 day readmission rate for hyperbilirubinemia (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)**
	patients with visits/encounters in DY 3. Goal: Enroll 100% of mother/baby patients who present for care upon registry implementation. Data Source: EHR, claims, registry or other program documents Milestone 3 Estimated Incentive Payment: $188,422			Milestone 5 Estimated Incentive Payment: $268,500
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,405,309	Year 3 Estimated Milestone Bundle Amount: $376,843		Year 4 Estimated Milestone Bundle Amount: $353,290	Year 5 Estimated Milestone Bundle Amount: $268,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,403,942				

PROJECT OPTION: 2.5.1 – Redesign for Cost Containment – Develop an integrated care model with outcome-based payments.

UNIQUE RHP PROJECT ID: 094092602.2.8-Pass 2
PERFORMING PROVIDER NAME/TPI – The University of Texas Medical Branch at Galveston /094092602

Provider: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of the Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
Intervention(s): This project will implement a bundled pricing pilot program in preparation for changes enacted in the Patient Protection and Affordable Care Act (PPACA).
Need for the project: In preparation of the Patient Protection and Affordable Care Act (PPACA), the effect of bundled payments is not currently known. Developing financial computer systems and clinical protocols to understand how the new legislation will impact both physician practices and hospital care is widely needed.
Target Population: In FY '12, UTMB had 26,545 admissions of which approximately 50.0% were Medicaid and 5.9% were unsponsored. Together these 2 groups make up approximately 55.9% of the inpatient volume at UTMB. This project will target 2 specific DRG's in which services are provided at UTMB. Due to the high proportion of Medicaid / Unsponsored volume at UTMB, it is anticipated that the 2 DRG's that will be selected will have a proportionate representation of these 2 groups. These services will be identified by a cross-functional committee made up of physician group administrators & health system leaders. The criteria for selection of these DRG's will include, but will not be limited to, adequate volume, variability of costs/utilization by physicians and diagnosis with low incidences of outliers and/or complications.
Category 1 or 2 expected patient benefits: The expected results from this project will be improved quality & clinical outcomes, reduction of cost/utilization, reduced length of stay and reduced number of readmissions.
Category 3 outcomes: The goals of this project are to decrease cost/utilization by 2.5% in DY3 and 5% in DY5 while improving quality and clinical outcomes for the selected DRG's.
Project Description:
With the impact of healthcare reform not known, costs of providing care increasing annually and with reimbursements declining, an understanding of the impact of bundling payments needs to be understood. To begin understanding this impact, a pilot program is going to be established that will measure the impact by reducing variation in clinical practices, cost / utilization savings while improving quality.
This project will address:

- Reduce variation in clinical practice
- Improve patient outcome and quality metrics
- Reduce cost to deliver care

Goals and Relationship to Regional Goals:

This project correlates with the regional goal of improve the quality of patient care through data collection, analysis, reporting and continuous process improvement. Post pilot, project results and outcomes will be shared within the region.

Project Goal(s):

1. Improve coordination of care between the hospital and physicians toward a common goal of efficient use of resources
2. Reduce variation in clinical practice
3. Improve patient outcome and quality metrics
4. Reduce cost to deliver care by 5% over current baseline for specific identified DRG's

This project meets the following regional goals:

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Challenges:

- Getting physicians and hospital to work together to achieve desired outcomes
- Resources in getting physician practice demographic data/cost information into a useable format
- Improving the timeliness of data used for the project
- Identifying common quality metric benchmark data to use
- Balancing improved quality while reducing costs / utilization
- Modifying physician behavior

The 5-year expected outcome(s) for Provider and Patients:

By standardizing evidenced based clinical protocols, we expect to see reduced variation in clinical practice, improved quality and patient outcomes, reduced cost to deliver patient care.

Starting Point/Baseline:

UTMB's current cost accounting and decision support systems only contain one side of the patient care experience. These systems allow users to understand the impact of changes in clinical practice on cost and vice versa. Missing today is physician financial and clinical data. By integrating physician financial and clinical data, a UTMB enterprise wide view of clinical practice and cost relationships can be developed.

Rationale:

In preparation of the Patient Protection and Affordable Care Act (PPACA), the effect of bundled payments is not currently known. Developing financial computer systems and clinical protocols to understand how the new legislation will impact both physician practices and hospital care is widely needed. We have selected Project Option 2.5.1 – Redesign for Cost Containment – Develop an integrated care model with outcome-based payments.

Project Components:

UTMB Health System's proposal to redesign the cost-accounting system will meet all the required core components:

a) ***Implement cost-accounting systems to measure intervention impacts*** **-** this software includes both clinical and financial data and will allows users to understand the impact of changes in clinical practice on cost and vice versa. This will be accomplished by milestone 2; P-3.

b) ***Establish a method to measure cost containment –*** the system classifies cost between direct patient care labor, supplies, and drugs and other cost categories based upon episodes of care. Once we join the hospital and physician costs we will be able to measure the overall financial impact to the institution and by type of cost from the implementation of evidence-based clinical protocols. This will be accomplished by milestone 1; P-1.

c) ***Establish a baseline for cost*** – baseline costs will be established by using historical costing data for selected DRG's. This will be accomplished by milestone 4; P-2.

d) ***Measure cost containment –*** initiate quarterly reviews of selected DRG's measuring the impact on quality, cost, and patient outcomes as compared to baseline data. This will be accomplished by milestone 5; P-4.

Unique Community Need Identification numbers:

This project will identify variations in physician practices and develop standard clinical protocols to improve quality and improve utilization for patient care which will improve specialty care capacity, physician availability, and 30 day readmission rates.

- CN.4 – Specialty Care Physician Shortage
- CN.11 – 30 Day Readmission Rates

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

Currently, hospital and physicians are incentivized to provide more care based upon current reimbursement methodologies. This project promotes improvements in quality and reductions in cost/utilization in preparation for bundled pricing. By enhancing our cost accounting system to include physician costs and clinical data together, we have a more comprehensive view of the impact of healthcare reform and bundled pricing. In order to support this initiative, we must have the appropriate information systems and analytical support to understand and correlate the impact of evidence based clinical protocols on outcomes and cost.

Related Category 3 Outcome Measure(s):

OD-5 Cost of Care

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure)

Type of analysis – Cost Minimization Analysis

We will measure the cost effectiveness by comparing cost per episode before and after implementation of the specific evidence based clinical protocols for selected DRG's.

Data Source: Cost accounting system with the addition of physician costs and other clinical data enhancements.

Reasons/rationale for selecting the outcome measures:

The evidence based clinical protocols are being implemented for specific DRG's; therefore, we will measure the change in cost for those DRG's.

Relationship to other Projects:

This project's focus on using data systems to improve hospital efficiency and emphasis on cost of care ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1,

139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.8. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:
This project focuses on redesigning for cost containment by developing an integrated care model with outcome-based payments. There are no other related Category 2 similar projects in our RHP.

Plan for the Learning Collaborative:
Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:
Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.

- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.8	2.5	2.5.1 (a-d)	Redesign for Cost Containment – Develop an integrated care model with outcome-based payments	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]**:** Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions. Metric 1 [P-1.1]: Cost-accounting methodology/metric. Goal: Documentation of the methodology and metric average cost per case for identified DRG's by 9/30/13. Data Source: Cost-accounting system or other administrative, financial or clinical data sets. Rationale: An accurate cost-accounting methodology/metric is a necessary tool for a Performing Provider to gauge the impact of implementing standard clinical evidence based protocols on quality, efficiency, and cost. Milestone 1 Estimated Incentive Payment (maximum amount): $207,350	**Milestone 4** [P-2]: Establish baseline for cost. Metric 1 [P-2.1]: Establish a baseline for cost. Goal: . Establish baseline cost for selected DRG's by 9/30/14. Data Source: Cost-accounting system or other administrative, financial, or clinical data sets. An accurate baseline for cost per case by DRG must be established in order for a Performing Provider to effectively measure its progress towards lowering costs while improving quality and outcomes. Milestone 4 Estimated Incentive Payment: $421,715		**Milestone 5** [P-4]: Conduct cost analysis. Metric 1 [P-4.1]: Cost analysis plan or results. Goal: Submission of cost minimization plan or results on identified DRG's by 9/30/15. Baseline: TBD based upon each DRG selected. Data Source: Program plan and cost analysis report. Milestone 5 Estimated Incentive Payment: $483,636	**Milestone 6** [P-9]: 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. Metric 1 [P-9.1]: Participate in semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Goal: To have two meetings during each year. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentation, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $310,130

094092602.2.8	2.5	2.5.1 (a-d)	Redesign for Cost Containment – Develop an integrated care model with outcome-based payments	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 [[P-3]: Implement the cost-accounting methodology and related systems to measure intervention impacts. Metric 1 [P-3.1]: Cost accounting system Goal: Establish baseline cost for selected DRG's by 9/30/13. Baseline: Current cost accounting system with only hospiital cost data available. Data Source: Cost-accounting system Rationale: Clinical care interventions require the investment of numerous resources at many levels of the delivery system. A cost-accounting system provides the institution with the necessary tools to gauge the financial return on investment of interventions and increased quality of care. Milestone 2 Estimated Incentive Payment: $ 207,350 **Milestone 3** [I-7]: Measure cost				

094092602.2.8	2.5	2.5.1 (a-d)	Redesign for Cost Containment – Develop an integrated care model with outcome-based payments	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (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)
containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvement in cost. Metric 1 [I-7.1]: Validate data in cost accounting system vs. clinical systems & financial statements. Numerator: TBD by performing provider Denominator: TBD by performing provider. Data Source**:** Cost-accounting system, clinical systems & financial statements. Goal: To ensure that variance between the cost accounting system and the data sources is no more than 2%. Milestone 3 Estimated Incentive Payment: $483,636				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $622,050	Year 3 Estimated Milestone Bundle Amount: $421,715		Year 4 Estimated Milestone Bundle Amount: $483,636	Year 5 Estimated Milestone Bundle Amount: $310,130

094092602.2.8	2.5	2.5.1 (a-d)	Redesign for Cost Containment – Develop an integrated care model with outcome-based payments	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (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)	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD): $1,837,531				

PROJECT OPTION: 2.6.1-Engage in Population Based Campaigns or Programs to Promote Healthy Lifestyles Using Evidence Based Methodologies including Social Media and Text Messaging in an identified population.

UNIQUE RHP PROJECT IDENTIFICATION NUMBER*: 094092602.2.9-Pass 2*
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston /094092602

Category Project Area

2.6 Implement evidence-based health promotion programs

Title of project: Social Media

Title of project

Advancing Health Promotion through Social Media

Summary

Description of the provider. UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.

The intervention. This project seeks to create a coordinated social media initiative (understood to include text messaging and other electronic and communications media) at UTMB to create evidence-based health promotion campaigns and improve effective delivery of care. This project will result in the establishment of social media platforms tailored for specific health issues, health behaviors, and social determinants as well as for specific sub-populations; development of content to be fed through those social media platforms for a number of initiatives; improved patient satisfaction; and documentation and dissemination of lessons learned.

Need for the project. Currently, no organized social media initiative focused on actively promoting health exists at UTMB or other major local providers, although there appear to be a number of health issues that social media could be effectively employed to address, including general health promotion and lifestyle issues; disease prevention and chronic disease management; infectious disease protection; and many opportunities for more effectively linking providers and patients to improve communication. A particular application that has been identified is the use of social media to support breastfeeding, which provides multiple health benefits to women and their babies.

Although UTMB does have a Facebook page, it is utilized primarily for public relations and advertising purpose, nor are there any current plans to explore its utility for that purpose. According to the Region 2 Community Needs Assessment Galveston County Profile, lifestyle and behavioral factors contribute significantly to regional burden of disease. The community reported "access (insurance, resources, geographic location, and closed systems), education (about disease, medicine, and available resources)...[and] lifestyle (poor choices and attitudes)," among the major barriers to being healthy and suggested "community-based

educational/support services" as a way to improve health. Finally, "Galveston County is a federally-designated Health Professional Shortage Area (HPSA) in full for primary care, and partially for dental and mental health providers," indicating a need for the delivery of health information beyond the traditional, in-person doctor-patient encounter. Additionally, Region 2 and Texas in general suffer from high rates of overweight and obesity, including for pregnant women.

Target population.

The first target population will be UTMB patients, who will be targeted for health promotion messages related to their individual health issues and information/care coordination needs. The second target population will be the broader Galveston County population, as well will develop campaigns built around a community-wide population-based approach, e.g. through partnerships with other local providers as well as mass media messaging. The third target population includes prenatal patients in the Regional Maternal and Child Health Program (RMCHP).

Number of patients the project will serve.

The first target population—UTMB patients generally—includes approximately 26,000 patients (with more than 680,000 hospital and clinic outpatient admissions and almost 37,000 emergency room visits), and including over 8,300 Medicaid and Uninsured patients. The second population—the broader Galveston County community population (beyond those who are direct UTMB patients) includes over 291,000 people, of which over 78,000 are Medicaid or Uninsured. Third, in FY12 the Regional Maternal and Child Health Program had 10,946 new OB patients who had 101,873 OB visits, of which 4,915 delivered at UTMB. Virtually all RMCHP patients are covered by Medicaid or Uninsured. Additionally, we hope to set up the program to allow providers across Region 2 to take advantage of the social media platforms and content that will be created, greatly expanding the number of patients reached.

How Medicaid and/or indigent patients will benefit from the project. This project will specifically benefit Medicaid and Uninsured patients (as well as broader patient populations) seen at UTMB each year, who make up one-third of the payer mix, through patient-specific targeted interventions, such as messaging focused on patients' specific health issues (healthy heart messaging to heart patients), reminders of preventive care needs (e.g. reminders of children's immunization needs as renewal dates approach), bi-directional communication between patients and providers, etc. This will allow UTMB to much more pro-actively support healthy behaviors, care support, and appropriate care management of patients. Self-management and health promotion messages as well as social networking opportunities in particular support Medicaid and Uninsured patients, who typically have lower levels of health literacy and benefit from circles of support. While these populations sometimes have lower access to internet connectivity, this gap is beginning to close; some of the sub-populations we would want to target, such as African Americans, use particular social media platforms at *higher* rates that others; and mobile phones with texting and social media capabilities are become much more affordable and widespread than even a few years ago, all of which will support the project reach to Medicaid and Uninsured populations. Additionally, the broader county-wide efforts targeting the general population will focus on the health issues and information that is most relevant and useful to Medicaid, Indigent, and Uninsured populations, such as general and one-off opportunities to access services relevant to their access needs, resources to support

healthy lifestyles, messaging focused on priority health issues identified in the needs assessment, etc. The most effective and successful social media experiences will be targeted for expansion to other Region 2 areas during the later years of the project. Specifically, the social media programs will be intentionally designed to be useful to and inclusive of racial minorities and those at lower socioeconomic levels, such as an emphasis on text messaging for some individuals/groups, and platforms more often frequented/utilized by certain groups (e.g. youth use of twitter and YouTube). Information on patient social media capabilities and preferences will be integrated into administrative intake data and linked into medical records as much as possible.

Expected benefit of the project to patients based on Category 1 or 2 milestones. The benefits to the Medicaid and Uninsured populations outlined above will also benefit broader populations. Because this social media initiative will have an emphasis on promoting healthy lifestyles, it will help compensate for some of the specific challenges of our region related to the lack of access to primary care as well as health problems modifiable through lifestyle and primary prevention strategies.

Expected benefit of the project to patients based on Category 3 outcome measures. Social media can support breastfeeding among new mothers, which has multiple health benefits to women including a reduced risk of type 2 diabetes, overweight/obesity and related complications, breast cancer, ovarian cancer, and post-partum depression; as well as benefits to babies including lowered risk of ear infections, diarrhea, necrotizing enterocolitis, lower respiratory infections, asthma, obesity and types 1 and 2 diabetes, childhood leukemia, atopic dermatitis, and sudden infant death syndrome.[1][2][3][4] . By enrolling women as early during pregnancy as possible in the social media program, we will also be able to support healthier pregnancies and births through improved uptake of preventive care, improved patient self-management of chronic disease during pregnancy, information on nutritional needs during pregnancy, support for appropriate weight management, warning signs to alert patients to seek medical care during pregnancy, earlier detection of disease, decreased infectious disease, and prevention of life-threatening conditions. In relation to Patient Satisfaction, our second Category 3 outcome measure, social media tools also have the potential to benefit broad populations of patients especially in relation to timely and targeted delivery of health promotion messages, sharing among patients with similar health challenges, improved communication with providers, improved appointment monitoring and care coordination, and other pathways.

Category Project Area

---

[1] Ip S, Chung M, Raman G, Trikalinos T, and Lau J. "A Summary of the Agency for Healthcare Research and Quality's Evidence Report on Breastfeeding in Developed Countries." Breastfeeding Medicine. October 2009, 4(s1): S-17-S-30. doi:10.1089/bfm.2009.0050.

[2] Chen A and Rogan W. "Breastfeeding and the Risk of Post-neonatal Death in the United States." Pediatrics. May 2004, 113(5): e435-e439.

[3] Layde P et al. The independent associations parity, age at first full term pregnancy, and duration of breastfeeding with the risk of breast cancer *J Clin Epidemiol* 1989; 42: 963.

[4] Lucas A and Cole TJ. Breast milk and neonatal necrotizing enterocolitis. Lancet 1990; 336:1519-1523.

2.6 Implement evidence-based health promotion programs

Project Description

Describe project. This project seeks to expand UTMB's social media activities to create evidence-based initiatives for three populations. 1) Social media programs will be integrated into regular hospital and clinical systems to support UTMB to better address specific health issues tailored for individual UTMB patients2) Social media programs will target the general Galveston County population, focused on priority health issues identified in the Community Needs Assessment. 3) A social media program specifically targeted at pregnant women in our Regional Maternal and Child Health Program will be developed to support pregnant women to have healthy pregnancies and babies, with focus on support for breastfeeding through the sixth month post-partum. We hope to set up the program in a way that allows providers across Region 2 to take advantage of the social media platforms and content that will be created.

Project goal(s). Implement innovative evidence based health promotion strategies including innovations in social media and messaging for targeted populations. Sub-project 1 will include health promotion and information/care coordination needs tailored to individual UTMB patients, with the goal of reaching at least 20% of the UTMB population with at least 6 contacts each by DY5, with programs focused on improved health promotion and prevention (e.g. through promotion of healthy lifestyles), improve uptake and delivery of care (e.g. through active reminders to patients of preventive care needs), and improve the impact of care (e.g. through reminders of steps that patients should take after their out-patient or hospital care visit). Sub-project 2 will include general health promotion messages addressing key health needs for the general Galveston County population, with the goal of reaching at least 5,000 people in the county. Sub-project 3 will include a healthy pregnancy and postpartum program, with a goal of increasing rates of breastfeeding through 6 months post-partum, which is anticipated to result in many health benefits for mothers and babies alike.

Anticipated challenges. Anticipated challenges include:

- Identifying appropriate health topics and sub-populations that will be responsive to social media initiatives. Response: We plan to not only review research literature on the topic, but also gather lessons from others actively engaged in social media campaigns.
- Identifying the most effective social media platforms for specific health issues and sub-populations. Response: In addition to reviewing existing research literature, we plan to implement, document and test approaches for targeted populations.
- Linking with and maintaining engagement with sub-populations. Response: social media campaigns will be built on patient populations, starting with UTMB and expanding to other local providers (e.g. Coastal Health and Wellness and St. Vincent's House) and regional providers.
- Developing content that can be effectively delivered through social media. Response: In addition to literature review and examination of successful social media efforts, small pilots will be used to refine approaches.

The 5-year expected outcome(s). The 5-year expected outcomes include establishment of social media platforms tailored for supporting patients to address specific health issues, health behaviors, and social determinants of health ; development of content to be fed through those

social media platforms for a number of initiatives; improvement in patient satisfaction among social media adopters/users; improved uptake of preventive care services among social media users; increased breastfeeding among new mothers, with subsequent health benefits to them and their babies; and documentation and dissemination of lessons learned.

Regional goals. This project contributes to two of the Regional Goals, particularly: Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that include health promotion and disease prevention; and improve the quality of patient care through learning collaboratives that promote best practices and the development of innovative solutions.

Starting Point/Baseline. Currently, UTMB's social media efforts are sporadic and uneven, with no central coordinating structure nor coordinated focus on supporting health promotion of patients based on priority issues and evidence-based strategies. There is no documentation of how many efforts are occurring, their effectiveness in promoting health and increasing utilization of preventive care services, their population reach, nor impact on patient satisfaction.

Rationale

Relation between Project Choices and Community Needs. Because this is a new project, and one that requires significant coordination and planning, we have selected a number of Process Milestones that focus on building the program and improve quality over time, culminating in an Improvement Milestone focused on reaching larger audiences.

In **DY2**, Process Milestone 1: P-1: Conduct an assessment of health promotion programs that involve social media and electronic communication at local and regional level. Metric: Document regional assessment, including information from all of the Region 2 performing providers. Baseline: No regional assessment has ever been conducted. Goal: Complete assessment to guide planning. Data Source: Performing Provider assessment and summary of findings. Rationale/Evidence: The importance of this milestone is to identify, support and compliment already existing resources in the community for health promotion programs with the goal of building an evidence-based, coordinated initiative focused on priority health needs in Region 2, especially for Medicaid and Uninsured populations.

In **DY2**, Process Milestone 2: P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. Metric: Document innovational strategy and plan. Baseline: No documentation exists of evidence-based projects targeting high priority needs identified in the Needs Assessment. Goal: Development of projects that 1) address the health and/or care needs of at least 2 patient populations that could reach at least 20% of UTMB's patient population (approximately 2,600 individuals) through social media programs that follow individual patients longitudinally with tailored messages related to their care, including at least 6 contact experiences within a one year period; and 2) addresses priority health and/or care needs (based on the needs assessment) of the Galveston County population, that could reach at least 5,000 individuals within the general population within a one year period. Data Source: Performing Provider evidence of innovational plan, including information on size of target population. Rationale/Evidence: Evidence-based planning is essential to project implementation and successful achievement of goals.

In **DY3**, Process Milestone 3: P-3 Implement, document and test impact of at least two evidence-based innovative projects for specific targeted populations and one project for the general community population. Metric: Document implementation strategy and testing outcomes. Goal: Validate project approaches and/or identify opportunities for improvement and lessons learned. Data Source: Documentation of implementation of the projects, testing including number of individuals reached and number of messages/interactions occurring; as well as documentation of impact, e.g. through interviews and/or surveys with a statistically significant number of patients/individuals receiving the intervention, through evidence of impact shown in patient medical record, and/or other validated and appropriate evaluation methodologies TBD in DY2. Rationale/Evidence: Testing projects supports improvements and increases opportunities to achieve goals.

In **DY4**, Process Milestone 4: P-4 Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. Metric: Document learning and diffusion strategic plan. Goal: Provide strategy for testing, spread and sustainability of best practices and lessons learned, with goal to develop plans appropriate for broader Region 2 populations identified above as well as other interested Region 2 providers. Data Source: Documentation of learning and diffusion strategic plan and actions. Rationale/Evidence: Dissemination of information on best practices and lessons will support others to improve their own programs, and encourage reflection on our own lessons learned.

In **DY4 and DY5**, Improvement Milestones 5 and 6: I-8: Increase access to health promotion programs and activities using innovative project option. Metric: Increase percentage of population UTMB patients reached through social media and other electronic communication. Numerator: Number of individuals of target UTMB patient population reached by the innovative project. Denominator: Number of individuals in the target population. Baseline: No current UTMB patient populations are being targeted for specific health promotion/preventive care programs or activities. Goal: Demonstrate the reach to at least 10% of the UTMB patient population (approximately 2,600 individuals) in DY4 and at least 20% of the UTMB patient population (approximately 5,200 individuals) in DY5 of social media programs that follow individual patients longitudinally with tailored messages related to their health issues and/or information/care coordination, including at least 6 contacts each within a one year period. Data Source: Documentation of target population reached, as designated in the project plan. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching the targeted population.

In **DY5**, Improvement Milestone 7 will address sub-project 2: I-8: Increase access to health promotion programs and activities using innovative project option. Metric: Increase number of Galveston County residents reached through social media and other electronic communication. Baseline: No current UTMB patient populations are being targeted for specific health promotion/preventive care programs or activities. Goal: Demonstrate the reach to at least 5,000 Galveston County residents in DY5 of social media programs that address priority needs as identified in the Galveston County Needs Assessment. Data Source: Documentation of target population reached, as designated in the project plan. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching the targeted population.

This project addresses many needs specifically identified in the Galveston County Profile needs assessment summary. Specifically, the profile notes that while the region faces a number

of health burdens, Galveston County, specifically, fares worse for many. These include a number of cancers, infant mortality, access to care, uninsurance, and several communicable diseases. Additionally, social media approaches lend themselves to addressing the increasing number of chronic diseases and need for self-care and management, as well as prevention (e.g. weight management, healthy eating, exercise) and smoking cessation, all of which are needs specific to our County. In the focus groups held for the Galveston County Profile, respondents noted that lack of education in the general population about diseases, health and medicine in general, and available resources are a major barrier to improving the population's health status. The community suggested community-based educational and related support services as one avenue to be pursued. Finally, social media campaigns can be effectively scaled up to become a resource for the region.

Starting point. Because this project essentially represents a new project in terms of a coordinated, evidence-based approach to social media (see below), we will begin with an assessment of existing and potential resources in order to build an efficient, effective structure on which initiatives can be built in the future.

Unique Community Need Identification numbers. Because this social media initiative will have an emphasis on promoting healthy lifestyles, it will help compensate for some of the specific challenges of our region related to the lack of access to primary care as well as health problems modifiable through lifestyle and primary prevention strategies. Related Regional Community Needs include:

CN.1 Access Barriers: Lack of Personal Resources
CN.2 Access Barriers: Lack of Insurance
CN.3 Primary Care Physician Shortage
CN.8 Mid-Level Provider Shortage
CN.12 Chronic Diseases: Diabetes
CN.13 Chronic Diseases: Obesity
CN. 18 Cancer Incidence (all)

New Project, Expansion or enhancement. This is a new project in the sense that it will offer a coordinated, evidence-based approach to social media at UTMB. Though some efforts currently exist, they do not meet the basic requirements of this project (e.g. evidence-based, documentation of impact, etc). No projects are funded by the U.S. Department of Health and Human Services.

Related Category 3 Outcome Measures

Category 3 Outcome Measures are aimed at 1) (IT-8.9) Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery) (non-standalone measure) and 2) (IT-6.1) Percent improvement over baseline of patient satisfaction scores (standalone measure) through social media and other electronic and communications activities.

These two outcome measures are particularly appropriate for the social media activities we will pursue. Social media can support issues such as health promotion during and following pregnancy through improved rates of breastfeeding as well as uptake of preventive care, improved patient self-management during pregnancy, information on nutritional needs during pregnancy, warning signs to alert patients to seek medical care during pregnancy, earlier detection of disease, decreased infectious disease, and prevention of life-threatening conditions. Social media also has the potential to benefit broad populations of patients

especially in relation to timely and targeted delivery of health promotion messages, sharing among patients with similar health challenges, improved communication with providers, improved appointment monitoring and care coordination, and other pathways.

Outcome Measure 1: (IT-8.9) Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)

In **DY2**, the initiative will pursue (P-1) Project planning, including to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. This project planning will provide the structure to develop a creative, coordinated initiative to improve patient satisfaction through the use of social media. Metric: Development of plan. Data source: Documentation of plan. Goal: Complete Plan.

This planning will be followed in **DY3** by efforts to (P-3) Develop and test data systems to support our ability to link with appropriate populations, deliver content effectively, and monitor our effectiveness. Metric: Functionality of data systems. Data source: Results of piloting patient satisfaction among social media users. Goal: Ensure adequate data system for reliable monitoring of improvement targets.

In **DY3** we will also (P-2) Establish baseline rates to allow monitoring of improvements related to our IT goal. Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at 6 months postpartum between November 6 of the year prior to the measurement year and November 5 of the measurement year. Data source: EHR. Goal: Establish baseline rates.

In DY4 we will (P-4) Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. This will be especially important for ensuring achievement of the IT goal, as it will allow us to identify weaknesses in our approach and correct them. Metric: Plan resulting from PDSA cycle. Data source: Documentation of plans resulting from PDSA cycles. Goal: Conduct 2 PDSA cycles.

In **DY5** we will (P-5) Disseminate findings, including lessons learned and best practices, to stakeholders. Such sharing will support Regional Partners as well as others to implement their own evidence-based approaches efficiently and effectively. Metric: Paper and/or presentation. Data source: Documentation of paper or presentation. Goal: Develop 1 paper or presentation and disseminate to stakeholders.

Finally, in **DY4 and DY5,** we will monitor achievement of IT-8.9 Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery). Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at 6 months postpartum between November 6 of the year prior to the measurement year and November 5 of the measurement year. Data source: EHR. Goal: increase breastfeeding rates at 6 months post-partum by an amount TBD in DY3, based on baseline rates established in DY3. Rationale: While the benefits of breastfeeding to mothers and babies is well established in the literature and rates of breastfeeding at birth often average over 75%, rates of breastfeeding by 6 months post-partum generally decline to under 50%.[5] While Texas' "ever breastfed" average is over

[5] CDC (2013) "Breastfeeding Report Card 2012, United States: Outcome Indicators." http://www.cdc.gov/breastfeeding/data/reportcard2.htm.

80%, monthly rates among WIC mothers in Galveston County ranged between 56% and 76% in 2012.[6] The Needs Assessment indicates that Galveston also has worse rates than the national average for births to teen mothers (4.2 % vs. 3.4 %) and prenatal care in the first trimester (63.9% vs. 70.8%), and worse rates than both state and national averages for low birth-weight babies (8.6 compared to 8.4 and 8.2, respectively), pre-term birth rates (14.2 compared to 13.6 and 12.5, respectively), and infant mortality (7.5 compared to 6.2 and 6.9, respectively). These rates also demonstrate disparities for Medicaid and Uninsured populations, which increasingly have access to social media. Social media tools can enhance health promotion activities such as breastfeeding, and may be effective in supporting other issues related to healthy pregnancies and healthy births, such as improved patient self-management during pregnancy, information on nutritional needs during pregnancy, healthy weight management, warning signs to alert patients to seek medical care during pregnancy, earlier detection of disease, decreased infectious disease, and prevention of life-threatening conditions, among other opportunities.

Outcome Measure 2: (IT-6.1) Patient Satisfaction (Standalone)

In **DY2**, the initiative will pursue (P-1) Project planning, including to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. This project planning will provide the structure to develop a creative, coordinated initiative to improve patient satisfaction through the use of social media. Metric: Development of a plan or plans for the use of social media and electronic communication initiatives that will target at least 20% of the UTMB patient population (approximately 5,200 people). Data source: Documentation of plan. Goal: Complete Plan.

This planning will be followed in **DY3** by efforts to (P-3) Develop and test data systems to support our ability to link with appropriate populations, deliver content effectively, and monitor our effectiveness. Metric: Functionality of data systems. Data source: Results of piloting patient satisfaction among social media users. Goal: Ensure adequate data system for reliable monitoring of improvement targets. In **DY3** we will also (P-2) Establish baseline rates to allow monitoring of improvements related to our IT goal. Metric: Patient Satisfaction. Data source: Patient survey to be administered. Goal: Establish baseline rates.

In DY4 we will (P-4) Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. This will be especially important for ensuring achievement of the IT goal, as it will allow us to identify weaknesses in our approach and correct them. Metric: Plan resulting from PDSA cycle. Data source: Documentation of plans resulting from PDSA cycles. Goal: Conduct 2 PDSA cycles.

In **DY5** we will (P-5) Disseminate findings, including lessons learned and best practices, to stakeholders. Such sharing will support Regional Partners as well as others to implement their own evidence-based approaches efficiently and effectively. Metric: Paper and/or presentation. Data source: Documentation of paper or presentation. Goal: Develop at least 1 paper or presentation and disseminate to stakeholders.

Finally, in **DY4 and DY5,** we will work on IT-6.1 Percent improvement over baseline of patient satisfaction scores. Numerator: Number of patients indicating improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Data source: Patient survey. Goal: for DY4, to demonstrate improvement in patient satisfaction

[6] Galveston County Health District, citing DSHS data, February 15, 2012.

over the baseline for at least 20% of the target UTMB patient population surveyed (20% of 5,200 patients = approximately 1,040 individuals); for DY5, to demonstrate improvement in patient satisfaction for at least 30% of the target UTMB patient population surveyed (30% of 5,200 patients = approximately 1,560 individuals). Rationale: This Improvement Target was chosen because social media can effectively serve patients' health information needs through "pushed" information, connecting them to other patients with similar health challenges, and improving communication with caregivers. By carefully targeting specific sub-populations, and building communication structures suited to particular information and communication needs, we can create a more responsive health care system that not only provides the right care at the right time in the right setting, but also supports primary prevention and healthy lifestyles and behaviors.

Relationship to other Projects

This project's focus on patient education using technology and emphasis on chronic disease ties to these Category 1 and 2 projects in our RHP: 112706003.2.5, 094092602.2.9, 096166602.2.8. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP

This project focuses on implementing a health promotion program along with these other Category 2 projects in our RHP: 112706003.2.5- Implement Evidence-based Health Promotion Programs..

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.9	2.6.1	2.6.1	SOCIAL MEDIA	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure	094092602.3.21a 094092602.3.21b	IT-6.1 IT-8.9	**Percent improvement over baseline of patient satisfaction scores and Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Conduct an assessment of health promotion programs that involve social media and electronic communication at local and regional level. Metric: Document regional assessment. Baseline: No assessment has been performed. Goal: Complete assessment to guide planning. Data Source: Performing Provider assessment and summary of findings. Rationale/Evidence: The importance of this milestone is to identify already existing resources in the community for health promotion programs with the goal of building an evidence-based, coordinated initiative focused on priority health needs in Region 2, especially for Medicaid and Uninsured populations. Milestone 1 Estimated Incentive Payment *:* $595,093 Milestone 2	Milestone 3 P-3 Implement, document and test impact of at least one evidence-based innovative project for specific targeted population and one project for general (community) population. Metric: Document implementation strategy and testing outcomes. Goal: Validate project approaches and/or identify opportunities for improvement and lessons learned. Data Source: Documentation of implementation, as well as documentation of impact, e.g. through interviews and/or surveys with patients receiving the intervention, through evidence of impact shown in patient medical record, and/or other appropriate evaluation methodologies TBD in DY2. Rationale/Evidence: Documentation of implementation strategy and testing outcomes. Milestone 3 Estimated Incentive Payment: $804,159		Milestone 4 P-4 Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. Metric: Document learning and diffusion strategic plan Goal: Provide strategy for testing, spread and sustainability of best practices and lessons learned, with goal to develop plans appropriate for broader Region 2 populations identified above as well as other interested Region 2 providers. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider. Rationale/Evidence: Documentation of learning and diffusion strategic plan and actions. Milestone 4 Estimated Incentive Payment: $372,626 Milestone 5 I-8: Increase access to health promotion programs and activities using innovative project option. Metric: Increase percentage of	Milestone 6 I-8 Increase access to health promotion programs and activities using innovative project option. Metric: Increase percentage of UTMB patients reached through social media and other electronic communication. Numerator: Number of individuals of target UTMB population reached by the innovative project. Denominator: Number of individuals in the target population. Baseline: No current UTMB patient populations are being targeted for specific health promotion/preventive care programs or activities. Goal: . Demonstrate the reach to at least 20% of the UTMB patient population (approximately 5,200 individuals) of social media programs that follow individual patients longitudinally with tailored messages related to their health issues and/or information/care coordination, including at least 6 contacts each within a one year period. Data Source: Documentation of

094092602.2.9	2.6.1	2.6.1	SOCIAL MEDIA	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure	094092602.3.21a 094092602.3.21b	IT-6.1 IT-8.9	**Percent improvement over baseline of patient satisfaction scores and Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community Metric: Document innovational strategy and plan. Baseline: No documentation exists of evidence-based projects targeting high priority needs identified in the Needs Assessment. Goal: Development of projects that 1) address the health and/or care needs of at least 2 patient populations that could reach at least 10% of UTMB's patient population (approximately 2,600 individuals) through social media programs that follow individual patients longitudinally with tailored messages related to their care, including at least 6 messages within a one year period; and 2) addresses priority health and/or care needs (based on the needs assessment) of the Galveston County population, that could reach at least 5,000 individuals within the general population with			UTMB patients reached through social media and other electronic communication. Numerator: Number of individuals of target UTMB population reached by the innovative project. Denominator: Number of individuals in the target population. Baseline: No current UTMB patient populations are being targeted for specific health promotion/preventive care programs or activities. Goal: . Demonstrate the reach to at least 10% of the UTMB patient population (approximately 2,600 individuals) of social media programs that follow individual patients longitudinally with tailored messages related to their health issues and/or information/care coordination, including at least 6 contacts each within a one year period. Data Source: Documentation of target population reached, as designated in the project plan. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching it	target population reached, as designated in the project plan. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching it targeted population. Milestone 6 Estimated Incentive Payment: $256,958 Milestone 7 I-8: Increase access to health promotion programs and activities using innovative project option. Metric: Increase number of Galveston County residents reached through social media and other electronic communication. Baseline: No current UTMB patient populations are being targeted for specific health promotion / preventive care programs or activities. Goal: Demonstrate the reach to at least 5,000 Galveston County residents in DY5 of social media programs that address priority needs as identified in the Galveston County Needs Assessment.

094092602.2.9	2.6.1	2.6.1	SOCIAL MEDIA	
The University of Texas Medical Branch at Galveston				**094092602**
Related Category 3 Outcome Measure	**094092602.3.21a** **094092602.3.21b**	**IT-6.1** **IT-8.9**	**Percent improvement over baseline of patient satisfaction scores and Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
at least 3 messages within a one year period. Data Source: Performing Provider evidence of innovational plan, including information on size of target population. Rationale/Evidence: Documentation of innovational strategy and plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $ $595,094			targeted population. Milestone 5 Estimated Incentive Payment *(maximum amount):* $372,626	Data Source: Documentation of target population reached, as designated in the project plan. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching the targeted population. Milestone 7 Estimated Incentive Payment: $256,958
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,190,187	Year 3 Estimated Milestone Bundle Amount: $804,159		Year 4 Estimated Milestone Bundle Amount: $745,252	Year 5 Estimated Milestone Bundle Amount: $513,916
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,253,513				

Project Option: 2.10.1 Implement a Palliative Care Program to Address patient with End-of-Life Decisions and Care Needs

UNIQUE RHP PROJECT IDENTIFICATION NUMBER*: 094092602.2.10-Pass 2*
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston /094092602

Category Project Area
1.6 Implement evidence-based health promotion programs

Title of project: Palliative Care Program

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: We will fully develop the business case for establishing interprofessional palliative care consult service will enable UTMB to fiscally broaden their reach to patients experiencing end of life issues and allow for the holistic care of the patient's needs.
NEED FOR THE PROJECT: While we estimate as much as three times as many needs, the single palliative care physician at UTMB who has been providing palliative services has been able to provide no more than 149 consults annually. Most of the challenges experienced to date have been a result of lack of resources such as evening, weekend and vacation coverage; education and counseling support and the ability to manage hospice transitions effectively. There is also a dearth of certified palliative physicians and, this effort will increase UTMB's ability, as an academic medical center, develop a residency in palliative care.
TARGET POPULATION: The Center to Advance Palliative Care (CAPC) has long-recommended a case statement for palliative care projecting no more than 60% of deaths to benefit from palliative care – in fiscal year 2012, there were 279 inpatient deaths across 11 DRGs. In the same period there were over 2800 cases in unique MS-DRGs shown to be amenable to palliative care services across many chronic illnesses. We believe that by the end of four years of this proposal we could reach up to 15% of these patients (420 encounters annually).
During fiscal 2012, our single palliative care physician provided consultation for 149 patients (Figure 1 below).

	DY1	DY2	DY3	DY4	DY5
Palliative Care Encounters	374	375	525	525	794

RHP2 has a high incidence of chronic disease and some of the highest healthcare costs in the US. Chronic Diseases Incidences on the rise.
CATEGORY 1 EXPECTED PATIENT BENEFITS: This project will enable UTMB to create a stable and responsive interdisciplinary infrastructure for palliative care services and, ultimately, enhance the quality of end-of-life or advanced illness care that UTMB patients receive – to enhance their symptom relief, including pain management; and reduce unnecessary or

unwanted care. We believe that over the course of the four years of this proposal we could reach up to 15% of the patients outlined in the target population above.

CATEGORY 3 OUTCOME: IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213

Project Area: 2.10 Use of Palliative Care Programs

Project Goal:

A comprehensive palliative care team approach will better enable a holistic approach to the care of patients with advanced illness – meeting physical, psychosocial, and spiritual needs of patients. We will be able to reach more patients and in a timely way, to assist care teams in all clinical services to help clarify patient goals, revise plans accordingly, and provide symptom relief.

Project Option/Project Component:

2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

Project Description:

As a result of this initiative we will fully develop the infrastructure to sustain a interprofessional palliative care consult service for UTMB. We anticipate the patients with advanced illness will match UTMB service generally, with broad regional draw, but heavy usage in Galveston and Brazoria counties. Using CAPC experience, we anticipate that this service will be able to serve up to 167 patients who die in our care, and as many as an additional 420 cases from among the 2800 unique MS-DRGs shown to be amenable to palliative care services across many chronic illnesses – e.g. CHF, COPD, Cancer.

Project Core Components and Milestones:

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

P-1 Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program. We will develop a business plan for palliative services using the standard UTMB framework for service line business plans, drawing on a board-certified palliative care physician expert, financial decision support staff and administrative leadership.

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility

P-3 Implement palliative care education and training programs for providers (physicians, RNs, PAs, NPs, etc.) that incorporates management of non-cancer patients. In order to promote the benefits of advance illness care, we will use aforementioned plans to target clinical services for education and support – both to recruit more aggressive consultation, but also to promote comfort of all providers with basic symptom management.

P-4 Develop an EHR/system (e.g. a rounding tool or a registry or software) that analyzes the palliative care system data to determine if the program is effective. We will modify

documentation in the Epic electronic medical record in order to capture patient goals of therapy, the assessment and management of symptoms for patient with advanced illness, and the creation, generation and distribution of reports from the analytic repository to drive growth and change of palliative care services.

P-8 Document the conditions for which palliative care is consulted. We will capitalize on the reports from the EMR to assist the palliative care team to evaluate clinical care and opportunities for growth and outreach.

Improvement Core Components and Milestones:
I-11 Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care:
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.

I-11.2 Pain assessment (NQF-1637) - Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

I-11.4 Dyspnea treatment (NQF-1638) - Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.

Anticipated challenges
Much groundwork has already been laid as a foundation for this effort.
As experienced by palliative care services nationally, there is some minor resistance to outside expert consultation by some select services (e.g. perception that palliative care is incompatible with intensive treatment or a sign of "failure"). Much of this resistance has already been turned around by our single provider at UTMB, and with this program we will be able to provide education and support, and to communicate persuasive results and patient/family experience after consultation.
Most of the challenges experienced to date have been a result of lack of resources (e.g. evening, weekend and vacation coverage; education and counseling support; ability to manage hospice transitions effectively) that will be ameliorated by the infrastructure that will be designed with this programmatic effort.

5-year expected outcome(s)
We will establish and sustain a functional interprofessional palliative care consult service with 24/7 operation that includes a palliative care trained physician, APRN, LCSW, administrative support, and others as needed.

An increase in palliative care inpatient unique patient consults and patient visits and, ultimately, the growth of ambulatory palliative clinic visits and the earlier introduction with the diagnosis of chronic illness of future options for palliative care services in advanced illness.

Infrastructure – data registry, EMR documentation integration, and quantification of the impact of active palliative care services – clinical and operational.

The development an initial implementation of plans for dedicated inpatient unit to better facilitate patient- and family-centered services at the end of life using consistent expertise.

Regional goals

The work of this collaborative directly supports Region 2-wide goals

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through learning collaboratives that promote best practices and the development of innovative solutions.
- Grow the health system resources for our region by expanding and enhancing training of the healthcare workforce at all levels of our future healthcare system.

Starting Point/Baseline:

A single physician, board-certified in palliative medicine, with limited internal backup has been providing direct services for palliative care medicine at UTMB over the past four years. In 2012 she had 374 palliative encounters/visits.

During 2012, we cared for more than 2800 unique patients who had discharge codes suggested by the Center to Advance Palliative Care to potentially be able to benefit from advance illness care. We believe that over the course of the four years of this proposal we could reach up to 15% (420) of these patients.

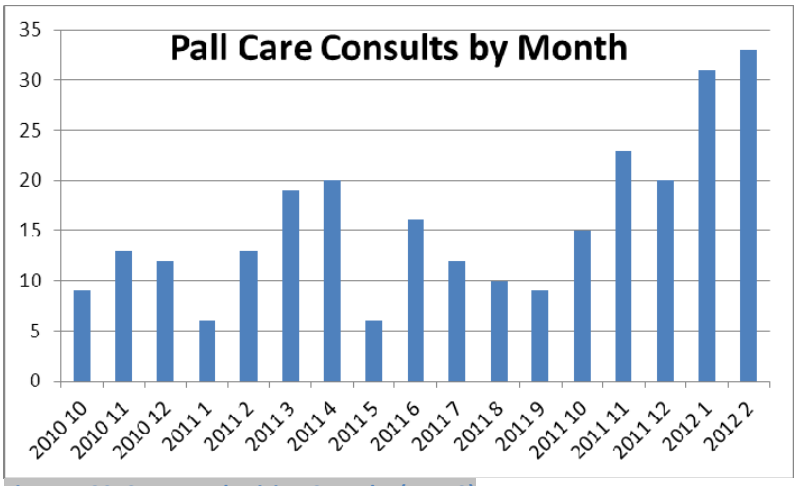


Figure 1 2012 UTMB Physician Consults (n=149)

Rationale:

Today people receive end-of-life care for a number of other conditions, such as congestive heart failure, other circulatory conditions, COPD, and dementia. Further, some experts have suggested that palliative and hospice care could be more widely embraced for many dying patients. It seems clear that improving care coordination near the end of life can improve care for patients with chronic conditions and reduce the cost of care.[71] It is widely accepted in the field that planning activities are necessary to establish successful palliative care programs.

[71] Arch Intern Med. 2008;168(16):1783-1790

All primary care specialties are involved with chronic diseases and the associated chronic symptoms and management of these symptoms but may not have specific expertise in palliative care programs and planning. As the goal of this palliative program is to provide resources to patients and families to improve patient experiences, the education programs will also consider the use of palliative care medicine for health care personnel (including ancillary staff).

A study of 2021 hospitals showed that the quality of care provided improved among all types of hospitals that implemented a form of EHR.[72]

Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.[73]

Effective treatment for dyspnea is available, but not consistently administered. Evidence-based treatments include pharmacologic interventions such as opioids and inhaled bronchodilators, and non-pharmacologic interventions including oxygen for hypoxic patients, pulmonary rehabilitation and exercise in COPD, and drainage of pleural effusion.

Relation between Project Choices and Community Needs

Our region has a high incidence of chronic disease and some of the highest healthcare costs in the US. Hospital readmission has been shown to be related to chronic illness self-management efficacy (including mental health and substance use issues), patient resources, access to primary and specialty care. In addition, especially considering Galveston, Nacogdoches, Orange, and Jefferson counties have higher 30 day all cause readmission rates than Texas as a whole. As a key service line for the organization and southeastern Texas, this software is a crucial component to meet the episode management demands for pregnancy care through delivery.

Unique Community Need Identification numbers

CN.4	**Specialty Care Physician Shortage**
CN.14	**Chronic Diseases: Heart & Vascular Related Diseases & Disorders**
CN.15	**Chronic Diseases: Pulmonary Diseases**
CN.18	**Cancer Incidence (all)**

Expansion or enhancement

This project significantly enhances the current scope of palliative care services at UTMB – both by adding additional provider support hours, but also by adding interdisciplinary expertise to the team. A more comprehensive service will be able to reach more patients with advanced illness, consult with patients who have a chronic earlier in their course of care to introduce discussions about goals of therapy as well as alternatives, and to improve symptom control of inpatients. As an Academic Medical Center in

[72] Center to Advance Palliative Care Palliative Care Consultation Service Metrics: Consensus Recommendations. JOURNAL OF PALLIATIVE MEDICINE. Volume 11, Number 10, 2008

[73] Manfredi PL, Morrison RS, Morris J, Goldhirsch SL, Carter JM, Meier DE. Palliative care consultations: how do they impact the care of hospitalized patients? J Pain Symptom Manage 2000;20:166-73.

Region 2, we expect to establish a residency in palliative care which will contribute to the development of palliative care expertise and build the supply of specialists in acute and community settings.

Within four years, we also expect to launch plans for a dedicated inpatient palliative care space and personnel within the UTMB hospital.

Related Category 3 Outcome Measures

Process Milestones 1 - 3 (DY2 and DY3)

P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. This milestone was chosen because participating in business/project planning meetings will be crucial to the development of appropriate, realistic, measurable outcomes.

P-2 Establish baseline rates. This milestone was chosen because measurement is a vital first step to improvement.

P-3 Develop and test data systems. This milestone was chosen because periodic reporting is a necessary step to guide team/program direction, improvement and maintenance of goals.

Outcome Improvement Target (DY4 and DY5)

IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213). This improvement target was chosen because using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

We have reason to believe that our standard measures of patient satisfaction and experience are not reaching patients who move residence frequently or the homeless. In this proposal we will use alternatives to traditional mail surveys to measure and document the experience of patients with advanced illness and their families, for the purposes of driving improvements.

Relationship to other Projects:

This project's focus on palliative care and emphasis on patient-centered treatment goals ties to these Category 1 and 2 projects in our RHP: 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.10. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the implementation of a palliative care program along with these other Category 2 projects in our RHP: 112706003.2.2- Implement a Palliative Care Program to Address Patient with End-of-Life Decisions and Care Needs

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.10	2.10	2.10.1 (A-D)	IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.22	IT- 13.4	Proportion admitted to the ICU in the last 30 days of life (NQF 0213) (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] (2.10.1.a) Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program Metric [P-1.1]: Business case Goal: Submission of business case Data Source: Business case write-up; documentation of planning activities Milestone 1 Estimated Incentive Payment *(maximum amount):* $391,157	**Milestone 2** [P-3] Implement palliative care education and training programs for providers (physicians, RNs, PAs, NPs, etc.) that incorporates management of non-cancer patients. Metric [P-3.1]: Palliative care training and education for other providers Goal: Provide training and education curriculum to 15 target primary care and specialty providers. Data source: Database that tracks type and number of training and education sessions by health professional category (physicians, RNs, PAs, NPs, etc). Milestone 2 Estimated Incentive Payment: $195,207 **Milestone 3** [P-4]: Develop an EHR/system (e.g. a rounding tool or a registry or software) that analyzes the palliative care system data to determine if the program is effective (including 2.10.1.b the transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility.) Metric [P-4.1]: EHR system implementation with capacity for		**Milestone 4** [P-8]: Document the conditions for which palliative care is consulted. Metric [P-8.1]: Breadth of conditions for which palliative care is utilized. Baseline: 149 unique patients consults across all MS DRGs during FY 2102 Goal: 10% increase in total referrals across all MS DRGs above baseline FY 2012 (to 165 patients). Numerator: Number of chronic conditions for which the palliative care patients are consulted Denominator: Total number of patients admitted with chronic conditions or MCC Data source: EHR, palliative care database Milestone 4 Estimated Incentive Payment: $536,084	**Milestone 5** [I-11] Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care (requires 2.10.1.c the implementation of a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time). Metric [I-11.2]: Pain assessment (NQF-1637) - Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Baseline: TBD in DY 3 Goal: 2% improvement over DY3 baseline Numerator: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. Denominator: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.

094092602.2.10	2.10	2.10.1 (A-D)	IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.22	IT- 13.4	Proportion admitted to the ICU in the last 30 days of life (NQF 0213) (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)
	palliative care registry and metric analysis. Goal: EHR system changes implemented to support the palliative care program. Data Source: Vendor agreement, documentation of EHR capacity and use Milestone 3 Estimated Incentive Payment: $195,207			Exclusion: Patients with length of stay 1 day in palliative care or 7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator. Metric [I-11.4]: Dyspnea treatment (NQF-1638) - Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening. (part of 2.10.1.d Conduct quality improvement for project using rapid cycle improvement methods). Baseline: TBD in DY 3 Goal: 2% improvement over DY3 baselineNumerator: Patients who screened positive for dyspnea who received treatment within 24 hours of screening. Denominator: Patients enrolled in hospice for 7 or more days OR patients receiving palliative care who report dyspnea when dyspnea screening is done on the admission evaluation / initial encounter. Exclusion: Palliative care patients with length of stay 1 day or hospice patients with length of stay 7 days,

094092602.2.10	2.10	2.10.1 (A-D)	IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS	
The University of Texas Medical Branch at Galveston				**094092602**
Related Category 3 Outcome Measure(s):	**094092602.3.22**	**IT- 13.4**	**Proportion admitted to the ICU in the last 30 days of life (NQF 0213) (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)**
				patients who were not screened for dyspnea, and/or patients with a negative screening. Milestone 5 Estimated Incentive Payment: $448,884
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $391,157	Year 3 Estimated Milestone Bundle Amount: $390,414		Year 4 Estimated Milestone Bundle Amount:$536,084	Year 5 Estimated Milestone Bundle Amount: $448,884
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,766,540				

PROJECT OPTION 2.11.1 **–** Conduct Medication Management – Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

UNIQUE RHP PROJECT ID*: 094092602.2.11-Pass 2*
PERFORMING PROVIDER NAME/TPI – The University of Texas Medical Branch at Galveston/ 094092602

Provider*:* UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured. UTMB has 36,900 Emergency Department visits annually. The number of yearly admissions to the hospital is 26,545.
Intervention(s): The goal of this project is to pilot a program that would utilize a clinical pharmacist in the Emergency Department. Addition of a clinical pharmacist to the patient care team is a systems-level patient safety intervention that serves to make it difficult for medication errors to occur and to absorb errors before harm. The metric would be to establish evidence based criteria for medication management for medication error reduction, medication management counseling and medication reconciliation. Patients who consistently adhere to their medication regimen maintain better control of their medical conditions. Medication error reduction would be monitored via the UHC Patient Safety Net (PSN) system with before and after data analysis as well as through the EPIC Ivent system that would track near misses. Impact of adherence to the patient medication regimen and medication reconciliation would be measured by Emergency Department and/or Inpatient readmissions.
Need for the project: The Emergency Department is known to be a high risk environment with the strong potential for medication errors. The Institute of Medicine once reported that the Emergency Department has the highest rate of preventable adverse events among clinical environments that have been studied. In the Emergency Department, the physicians usually are not familiar with the patient and they often do not have access to the patient's complete medical record. They are not knowledgeable about the patient's medications, medical history, or allergies. At times, medication is dispensed directly without a prospective review of medication orders by a pharmacist. The clinical pharmacist would target the geriatric, pediatric and frequent visit populations. Annually, the ED provides services for 1731 geriatric patient encounters (>65 years of age) and 2599 pediatric patient encounters (<18 years of age). There are 180 patients with frequent ED visits as defined by four (4) or more visits annually. Base line intervention and medication error data for FY12 ED is 202 and 33, respectively.
Target Population: This program would target high risk populations including pediatric patients, geriatric patients and patients with frequent visits. Geriatric Patient = 3.6 medication orders/ED encounter; Pediatric patient = 1.9 medication orders/encounter; Frequent visit patient = 43 medication orders/Patient/year (across visits).
Category 1 or 2 expected patient benefits: Patients who consistently adhere to their medication regimen maintain better control of their medical conditions. Establishment of evidence based criteria for medication management will positively impact the patient's medical

condition. The project seeks to provide 50% increase in the number of clinical interventions in DY3, and 75% increase in DY4 and a 100% increase in DY5.

Category 3 outcomes Our goal is to decrease current ED readmissions from by 2% DY5.

Project Description:

The goal of this project is to pilot a program that would utilize a clinical pharmacist in the Emergency Department. Addition of a clinical pharmacist to the patient care team is a systems-level patient safety intervention that serves to make it difficult for medication errors to occur and to absorb errors before harm. The metric would be to establish evidence based criteria for medication management for medication error reduction, medication management counseling and medication reconciliation. *Patients who consistently adhere to their medication regimen maintain better control of their medical conditions.* Medication error reduction would be monitored via the UHC Patient Safety Net (PSN) system with before and after data analysis as well as through the EPIC Ivent system that would track near misses. Impact of adherence to the patient medication regimen and medication reconciliation would be measured by Emergency Department and/or Inpatient readmissions.

This project will address:

- The need for pharmacist expertise in medication management in the ED which is known to be a high risk environment with the strong potential for medication errors.
    - The pharmacist will verify orders in the ED and document interventions into the EPIC system as an Ivent.
    - Analysis of existing Ivent data shows that two-thirds (2/3rd) of the interventions are near misses or preventable medication errors.
- The need for targeted intervention for patients at highest risk for medication errors. This includes the geriatric and pediatric population.
    - Geriatric population – defined as >65 years of age. This population is at risk for poly-pharmacy that can result in medication errors as well as lack of adherence to the treatment regimen. Adherence to the treatment regimen can be impacted by the patients understanding of their medication and the intended use as well as the ability to pay for the prescription. Medication reconciliation and counseling by a pharmacist would positively impact patient adherence to their prescribed regimens.
        - 12.6% (6,204/49,110) of the ED medication orders are for Geriatric patients
        - 3.6 medication orders/geriatric patient visit
    - Pediatric population – defined as <18 years of age. This population is at risk for medication errors due to dosing miscalculations. Decimal point errors can occur when ordering medication for this population.
        - 10.2% (5,010/49,110) of the ED medications orders are for Pediatric patients
        - 1.9 medication orders/pediatric patient visit
- The need for targeted intervention for patients at highest risk for repeated ED visits and/or inpatient admissions.

- Frequent Visit Patients – defined as > 4 visits per year.
    - 180 patients
    - 15.6% (7,641/49,110) of the ED medication orders are for the 180 frequent visit patients
    - 43 medication orders/patient/year

Goals and Relationship to Regional Goals:

The goal of this project is to impact the medication management of the high risk patients seen in the ED department. Positively impacting the medication regimen, understanding and adherence to the regimens will result in better management of the medical conditions. Better management of the medical condition will result in decreased costs to Emergency Departments and Hospitals throughout the region.

Project Goal(s):

- Establish evidence based criteria for medication management to reduce medication errors
- Perform medication reconciliation for the targeted populations: geriatric, pediatric, and frequent visit patients.
- Provide medication management counseling to the targeted populations: geriatric, pediatric and frequent visit patients.
- Document this activity in the EPIC Ivent system to provide data as metrics for success as well as opportunities for process improvement.

This project meets the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the healthcare workforce.

Challenges:

This program would be targeted at high risk populations which would include pediatric patients, geriatric patients and patients with frequent visits. Some of the challenges to implementation will be finding a clinically trained pharmacist with experience in the Emergency Department setting. Additionally, matching the working hours to the high volume, high risk patient volume to maximize the use of the clinical pharmacist will be a challenge.

These challenges will be overcome by offering a unique opportunity for the right individual to develop this innovative program. This type of clinical pharmacist position is highly sought. The type of clinical pharmacist who will be attracted to this position is one with ASHP-accredited residency training and years of clinical experience that can be applied to the ED setting.

The 5-year expected outcome(s) for Provider and Patients:

UTMB Health expects to see improvement in the medication management of the targeted patient populations. This improvement should positively impact the patients medication condition and understanding and participation in their health care. This should result in fewer ED visits especially for the frequent visit population. The interventions by a pharmacist before the medication is administered should decrease the number of medication errors or misadventures that reach the patient. We expect the number of interventions to increase to prevent near misses. The intervention provides an opportunity to interface and educate the provider. The intervention documentation allows for cumulative data to be reviewed to identify potential system improvement opportunities.

Starting Point/Baseline:

The project will start with the following baseline information:

- Number of medication errors for FY12
- Number of pharmacist interventions (Ivents) for FY12
- Number of medication orders and patient encounters for geriatric patients for FY12
- Number of medication orders and patient encounters for pediatric patients for FY12
- Number of medication orders for the frequent visit patients for FY12

Patient Type	# Patient/Pt Encounter	# Medication Orders	# Med Orders/Patient
Geriatric >65 yr of age	1731	6204	3.6
Pediatric <18 yr of age	2599	5010	1.9
Frequent Visits >4/yr	180	7641	42

Rationale:

Medication management is challenging for many patient populations. The geriatric patient population often receives prescriptions from multiple providers from primary to specialty care. The greater the number of medical conditions, typically the greater the number of medications prescribed. With an increase number of medications, the patient is at risk for medication errors due to duplications of therapy and/or significant drug-drug interactions. These risks can be positively impacted with the skill and expertise of a clinically trained pharmacist.

Medication management for the pediatric population is also challenging, but for a different set of reasons. When prescribing medication for a pediatric patient, the provider must dose the medication in units per patient weight measurements. Often the dosage forms commercially available are intended for the adult population. Misadventures can occur when using adult formulations of medications for pediatric patients. These risks can be positively impacted with the skill and expertise of a clinically trained pharmacist.

Medication management for the frequent ED visit patient is often multifold and requires time and special attention. The ED environment is often not the most conducive for getting to the root cause of the frequent visits. A dedicated clinically trained pharmacist could spend the time to get to the root cause of any medication management related challenges and develop a plan of action to positively impact each patient.

Project Option: 2.11.1 – Conduct Medication Management – Implement interventions that put in place the teams, technology and processes to avoid medication errors.

Project Components:
UTMB Health System's proposal to implement interventions that put in place the teams, technology, and processes to avoid medication errors will meet all the required core components:

a) **Develop criteria and identify targeted populations – pediatric and adult patient populations presenting to the emergency department that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services.**
    - **a.** Geriatric patients as defined by >65 years of age
    - **b.** Pediatric patients as defined by <18 years of age
    - **c.** Frequent visit patients as defined by > 4 ED visits per year

b) **Develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error.**
    - **a.** Use medication reconciliation tools available in EPIC to assure there are no duplicate medications or any medication combinations with significant drug-drug interactions.
    - **b.** Any identified duplicates or drug-drug interactions would be identified by the pharmacist. The pharmacist would intervene and discuss the medication regimen with the provider and offer recommendations for an improved medication regimen.
    - **c.** The final medication regimen would be provided to the patient with the appropriate verbal and written interaction to assure understanding of their regimen. Additionally, the pharmacist role would include understanding the patient's ability to obtain the medication upon discharge.

c) **Conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes.**
    - **a.** Medication errors would be identified via the PSN (Patient Safety Net) system. Each error would be assessed for system and people improvement opportunities. Cumulative data would also be assessed for trends, system and people improvement opportunities.
    - **b.** Pharmacist interventions (near miss medication errors) would be documented in the EPIC Ivents. Data would be reviewed monthly for common themes such as high risk medication (anticoagulants, narcotics, etc). Identified opportunities for improvement would be addressed using a multidisciplinary approach including all care providers.

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.**

   a. Quality improvement opportunities would be identified via PSN for medication errors and via Ivents for pharmacist interventions which documents near miss data.

   b. P-1.1 Metric: Program elements

      - Documentation of program, including people, processes and technologies.
      - Data Source: Written medication management plan including workflow.
      - Rationale/Evidence: A delivery system with a written medication management plan that is consistently followed by all providers can reduce medication errors and increase patient compliance with their medication regimens.

   c. P-2.2 Metric: Written medication management plan(s)

      - Numerator: Number of patient in targeted patient population that consistently receive medication management counseling.
      - Denominator: Number of patients in targeted patient population
      - Data Source: Paper or electronic health record citing medication management counseling provided; medication reconciliation documented in paper or electronic health record.
      - Rationale/Evidence: Patients in targeted population who consistently receive medication management counseling and medication reconciliation are more likely to consistently adhere to their medication regimen and maintain better control of their medical condition.

   d. P-4.1 Metric: Written plan to provide medication reconciliation as part of the transition from acute care to ambulatory care

      - Documentation of program policies and procedures that ensure medication reconciliation upon admission and discharge at each care setting for all patients.
      - Data Source: Medication management plan.
      - Rationale/Evidence; Patients who receive medication reconciliation as part of the transition from acute to ambulatory care are more likely to have and adhere to an appropriate medication regimen.

<u>Unique Community Need Identification numbers:</u>

- CN.9 – Pharmacist Shortage – Patients seen at UTMB in the ED come from areas across the region. Positively impacting the high risk patients will result in fewer medications being prescribed as duplications or significant drug-drug interactions.

The ED pharmacist would have the time to reconcile the medication regimen and educate the patient. This is time that another pharmacist in the region may not have due to the pharmacist shortage.

- CN.11 – 30 Day Readmission Rates - Patients who consistently adhere to their medication regimen maintain better control of their medical conditions. Better control of their medical conditions will result in a decrease readmission rate. Adherence to medication regimens can be positively impacted with education provided via patient medication counseling and medication reconciliation.

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

This is a pilot program. UTMB Health currently employees seven (7) clinical pharmacists in the following areas: Medical Intensive Care Unit (MICU), Surgical Intensive Care Unit (SICU), ISCU/Pediatrics (Infant Special Care Unit), Transplant Services, Infectious Disease Services, Oncology Services and Internal Medicine. Placing a clinical pharmacist in the Emergency Department would be a new initiative for UTMB Health.

Related Category 3 Outcome Measure(s):

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

IT-3.1 All cause 30 day readmission rate – NQF 1789 [250] (Standalone measure)

Reasons/rationale for selecting the outcome measures:

Patients who consistently adhere to their medication regimen maintain better control of their medical conditions. Better control of their medical conditions will result in a decrease readmission rate. Adherence to medication regimens can be positively impacted with education provided via patient medication counseling and medication reconciliation.

Relationship to other Projects:

This project's focus on medication management and emphasis on the emergency department ties to these Category 1 and 2 projects in our RHP: 135222109.1.4, 094092602.2.11. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on medication management through providing for a clinical pharmacist in the Emergency Department. There are no other related Category 2 similar projects in our RHP.

This project focuses on the implementation of one or more pilot intervention(s) in care transitions targeting a defined patient population along with these other Category 2 projects in our RHP: 139172412.2.2- Implement one or more pilot interventions in care transitions targeting one or more patient care units; 094092602.2.6 - Implement care transitions program; 109372601.2.1-Implement EpicCare link to improve clinical communication between UTMB and referring providers; 094092602.2.11- Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population .

Plan for the Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the

region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.11	2.11	2.11.1 (A-D)	Conduct Medication Management	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.23	IT-3.1	All cause 30 day readmission rate – NQF 1789 [250] (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]**:**Implement/expand a medication management program and/or system. Metric 1 [P-1.1]: Program elements Goal: Develop implementation plan for medication management program by 9/30/13. Data Source: Written medication management plan including workflow for providers. Rationale: A delivery system with a written medication management plan that is consistently followed by all providers can reduce medication errors and increase patient compliance with their medication regimes. Milestone 1 Estimated Incentive Payment (maximum amount): $0	**Milestone 2** [P-2]: Develop criteria and identify target population. Metric 1 [P-2.2]: Written medication management plan(s). Goal: 33% of target population that receives medication management counseling and medication reconciliation. Data Source: Paper or EMR citing medication management counseling provided; medication reconciliation documented in paper or EMR. Rationale: Patients in targeted patient population who consistently receive medication management counseling and medication reconciliation are more likely to consistently adhere to their medication regimen and maintain better control of their medical condition. Milestone 2 Estimated Incentive Payment: $183,618 **Milestone 3** [P-4]: Implement an evidence based program based on		**Milestone 4** [I-14]: Metric 1 [I-14.1]: Numerator: # of ED interventions for targeted patient populations for medication management via medication counseling and medication reconciliation Denominator: number of patient encounters for the targeted population Data Source: EPIC Willow Intervention data (Ivents) Rationale/Evidence: Consistently providing medication reconciliation at the time of discharge form a hospitalization enhances the likelihood of patients adhering to an appropriate medication regimen and allows for the reduction of medication errors that may result from the lack of medication reconciliation when a patient transitions from one care setting to another.	**Milestone 5** [I-14]: Metric 1 [I-14.1]: Numerator : # of ED interventions for targeted patient populations for medication management via medication counseling and medication reconciliation Denominator: number of patient encounters for the targeted population Data Source: EPIC Willow Intervention data (Ivents) Rationale/Evidence: Consistently providing medication reconciliation at the time of discharge form a hospitalization enhances the likelihood of patients adhering to an appropriate medication regimen and allows for the reduction of medication errors that may result from the lack of medication reconciliation when a patient transitions from one care setting to another.

094092602.2.11	2.11	2.11.1 (A-D)	Conduct Medication Management	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.23	IT-3.1	All cause 30 day readmission rate – NQF 1789 [250] (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)
	best practices for medication reconciliation to improve medication management and continuity between acute care and ambulatory setting. Metric 1 [P-4.1]: Written plan to provide medication reconciliation as part of the transition from acute care to ambulatory care. Goal: Documentation of program policies and procedures that ensure medication reconciliation upon admission and discharge at each care setting for all patients in target population by 9/30/14. Baseline: # of ED interventions for targeted patient populations for medication management via medication counseling and medication reconciliation/ number of patient encounters for the targeted population Data Source: EPIC Willow Intervention data (Ivents)		Goal: 50% of patients in the target population receive medication reconciliation Milestone 4 Estimated Incentive Payment: $315,815	Goal: 75% of target population receives medication reconciliation. Milestone 5 Estimated Incentive Payment: $245,994

094092602.2.11	2.11	2.11.1 (A-D)	Conduct Medication Management	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.23	IT-3.1	All cause 30 day readmission rate – NQF 1789 [250] (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 3 Estimated Incentive Payment: $183,619			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $0	Year 3 Estimated Milestone Bundle Amount: $367,237		Year 4 Estimated Milestone Bundle Amount: $315,815	Year 5 Estimated Milestone Bundle Amount: $245,994
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $929,046				

PROJECT OPTION 2.12.2 - Implement Care Transitions Program between EMS, UTMB ED, and Greater Houston Healthconnect Health Information Exchange (HIE)

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 094092602.2.12-Pass 2

PERFORMING PROVIDER NAME/TPI – The University of Texas Medical Branch at Galveston /094092602

Project Summary:

This project will utilize the Greater Houston Health Connect Health Information Exchange (HIE) as the communication tool that underlies the process improvement for the patient experience. Emergency Medical Service (EMS) providers and UTMB emergency department (ED) staff will communicate critical patient information before a patient arrives in the ED. This will allow EMS providers to provide better quality care in transit with this additional information, and it will also allow for streamlining the arrival process for patients in the ED.

Project Description:

UTMB Health proposes to create an information system exchange between ambulance providers, UTMB emergency department, and Greater Houston Healthconnect Health Information Exchange to communicate key patient clinical and other information for patient care.

The project would work with the Greater Houston Healthconnect Health Information Exchange (GHH) and EMS providers to exchange select EMS clinic data elements to the Hospital EMR while the patient is in transit to the emergency department and then communicate specific key clinical outcome information from the emergency department/hospital back to the EMS providers through the Greater Houston Healthconnect. Additionally, the emergency department would be able to connect with Greater Houston Healthconnect HIE to query its master patient index to obtain continuity of care documents (historical clinical information) for the patient from those providers participating in the GHH exchange in a 20 county region.

This project will address:

- Better "hand-off" communications between EMS to ED and ED/Hospital to EMS and other providers through a common patient electronic health information exchange infrastructure.
- Increase patient safety through avoidance of medication contraindications and duplications.
- Better visibility of patients' past (medications, allergies, problem summary list, and past treatment information) which will increase quality of care.
- Reduction of duplicate tests and imaging which will reduce unnecessary acute care costs.

- Improved tracking of outcomes and other follow up data points for the participant providers of the Greater Houston Healthconnect.

Patients transported to UTMB Health Emergency Department by ambulance. During the period from 9/1/11 to 8/31/12, there were 7,629 patients transported by EMS to the emergency department of which 1,995 were Medicaid or uninsured from Galveston County. We plan to target a total of 1,500 patient regional health information queries by the end of DY5.

Goals and Relationship to Regional Goals:

The goal of this project is to use Galveston EMS, UTMB care managers, nurses, registration staff and physicians to collaborate in the communication of patient electronic health information to ensure safe and effective patient care transitions from one health care provider to another.

Patients arriving to UTMB via Galveston EMS will be provided with the option of having their Continuity of Care Documents (CCD) components (i.e. payer information, advanced directives, support, functional status, problems, family history, social history, alerts (e.g. allergies/adverse events), medications, medical equipment, immunizations, vital signs, results, procedures, encounters, and plan of care) available to the health care team in order to provide timely and appropriate care that will decrease the chance of test and/or procedure duplication.

Project goal(s):

1. Increase the number of patients arriving via ambulance to UTMB Health's emergency department with patient electronic health information transmitted before arrival.
2. Increase the number of patients seen in UTMB Health's emergency department where physicians and hospital staff query the Greater Houston Healthconnect HIE for non-UTMB patient electronic health information to be utilized in the emergency department in making clinical treatment decisions.
3. UTMB Health identify the patient specific clinical data fields/elements to be shared with Greater Houston Healthconnect to then be exchanged with participating providers in the HIE for patient treatment.
4. Reduce emergency department visits for target patient population by making their electronic health information available to participating providers in the region in order to better coordinate care for the patient.
5. Decrease hospital readmissions for target patient population by making their electronic health information available to participating providers in the region in order to better coordinate care for the patient.
6. Decrease the cost for duplicate tests for target patient population by exchanging patient electronic health information.
7. Decrease the average cost per emergency department visit for defined target population.

This project meets the following regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services.
- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Challenges:

- Legal and compliance issues surrounding patient consent process.
- Securing sufficient EPIC and UTMB IT resources.
- Physician and staff training to incorporate outside clinical information into emergency department workflow and how to document in the medical record the use of outside clinical information in caring for the patient.
- Deciding what data clinical data elements to share with the regional HIE.

The 5-year expected outcome(s) for Provider and Patients:

To pilot the exchange of EMS and non-EPIC/non-UTMB Health patient electronic health information and to collaborate with hospitals throughout a territory reaching from Galveston to Greater Houston (HIE covers a 20 county area) and the counties we serve. Hospitals will be able to enhance patient safety and continuity of care through access to critical information from a broad range of community providers. By connecting to the health information exchange, hospitals will also eliminate the need for multiple interfaces. The use of this technology will enhance our connectivity and accountable care efforts. UTMB Health would use this project as a pilot in the Emergency Department with the intent to implement the exchange of electronic patient health information from GHH as a component of patient care in all areas of the health system in the future.

Starting Point/Baseline:

Our starting point is to develop systems mapping, process flows, interfaces, consent forms, etc. to exchange patient electronic health information through Greater Houston Healthconnect HIE. Currently, we are not exchanging any patient electronic health information between EMS, Greater Houston Healthconnect, and UTMB Emergency Department.

Rationale:

Patients often arrive to UTMB Emergency Department via ambulance. Often these patients have gone to other area Emergency Departments within the last 24 to 72 hours. At this time, EMTs and physicians care for these patients not knowing which medications, tests or procedures were performed recently at other institutions unless the patient is able to disclose that information. A study conducted in Indiana found that "during a one year study period, 288,696 patients made 471,640 Emergency Department (ED) visits within the Indiana Network for Patient Care collaboration -- accounting for 92% of all Indianapolis ED visits. Overall 25% of the patients with more than one visit also visited one of the other five hospital systems, accounting for 19% of all visits".(1)"The Institute of Medicine report suggests regional computer based patient records could result in both time and cost savings for both the patient and physician. A community clinical data exchange network may well reduce diagnostic testing

and its attendant discomfort and cost, better prescribing, as well as the epidemiologic research and outcomes management opportunities." (2),(3)

References:

(1) Finnell JT, Overhage JM, Dexter PR, Perkins SM, Lane KL, McDonald CJ. Community Clinical Data Exchange for Emergency Medicine Patients. AMIA 2003 Symposium Proceedings: 235-238

(2) Dick A, Steen E, (eds). The computer based patient medical record. Washington, DC: National Academy Press; 1991.3.

(3) GAO, Systems MA. Automated medical records hold promise to improve patient care; 1991.

EMTs will receive calls from patients needing their assistance. The EMT will be able to locate the patient's record and be able to connect with the emergency department. Physician and Nurse Care Manager will be able to begin planning the care of the patient before they arrive and anticipate patient discharge needs much earlier in the treatment plan. Patients with psychiatric issues will benefit from this information exchange as care givers will be able to begin developing the plan of care and possible psychiatric transfer as soon as the information is received.

EHR Incentive Program

Due to the nature of this project, there is the potential that this project will have a close relation to the Meaningful Use Stage 2 provision of funding to offset costs in the establishment of an electronic exchange with an EHR of a different developer. That being the case, it is important that this project focus on the operational planning, execution and measurement of this initiative. The EHR will certainly be an enabler to helping us accomplish project objectives, but it is the work flows and processes around better communication hand-offs and of patient information to improve the quality of patient care that will create innovation in this project.

Project Components:

2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. This project does not have any required core components.

Unique Community Need Identification numbers:

This project will address the high ED utilization rates, 30 day readmission rates, and reduce the average cost per emergency department visit by coordinating the hand off communication of care for patients transported by ambulance to the ED and ensuring the patient's clinical outcome information from the emergency department and hospital are shared with the regional health information exchange so that participating hospitals, EMS, federally qualified health centers, safety net providers, nursing homes, etc. will have access to patient electronic health information in a timely manner.

- CN.10- High ED Utilization Rates
- CN.11 – 30 Day Readmission Rates
- CN. 6- Mental/Behavioral Health Facility Shortage

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: The ability to exchange patient electronic health information between EPIC (UTMB Health's EMR system) and other Houston EPIC providers exists today through *EPIC Care Everywhere – EPIC provider module*. This project builds on this functionality by participating in a pilot intervention that includes the Galveston and Houston EMS services to connect patient electronic health information contained in the ambulance electronic health information (ESO Solutions, a software services company that provides electronic record capability for EMS providers) with the hospital based emergency department team through a common infrastructure provided by the Greater Houston Healthconnect HIE plus provide the ability for UTMB emergency room to access non-EPIC/non-UTMB Health patient electronic health information by implementing *EPIC Care Everywhere – Non-EPIC provider module* which will connect our system to Greater Houston Healthconnect HIE to provide the functionality to query their master patient index to obtain patient electronic health information from any providers in a 20 county region that are participating in the HIE.

Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting

IT-9.2 ED Appropriate Utilization (Standalone measure)

Reduce emergency department visits for Galveston County patients transported to UTMB emergency department by ambulance.

OD-5 Cost of Care

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Non-standalone measure)

Reduce the average cost per emergency department visit for Galveston County patients transported to UTMB emergency department by ambulance by accessing ambulance and non-UTMB patient electronic health information in the emergency room at the point of care.

Reasons/rationale for selecting the outcome measures:

In 1999, the Institute of Medicine published its report To Err is Human: Building a Safer Health System. In this report, they claimed that preventable medical error results in about 98,000 deaths per year in the United States and it cost about $29 billion annually in lost income, lost household production, disability, and additional health care costs.4 The report stated that a major cause of these errors is the inability of providers to have access to complete patient data at the point of care. Increasing the availability of information to EMS and ED providers has the potential to improve efficiency, decrease medical errors and cost in addition to decreasing admissions.

Relationship to other Projects:

This project's focus on health information/data sharing for care transitions and emphasis on the emergency department ties to these Category 1 and 2 projects in our RHP: 094092602.1.9, 094148602.2.2, 139172412.2.1, 139172412.2.2, 094092602.2.4, 094092602.2.5, 109372601.2.1, 094092602.2.11, 112706003.2.4. All required reporting domains in Category 4 will be measured and reported on by the provider. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:`
This project focuses on the implementation of one or more pilot intervention(s) in care transitions targeting a defined patient population along with these other Category 2 projects in our RHP: 139172412.2.2- Implement one or more pilot interventions in care transitions targeting one or more patient care units; 094092602.2.6 - Implement care transitions program; 109372601.2.1-Implement EpicCare link to improve clinical communication between UTMB and referring providers; 094092602.2.11- Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population .

Plan for the Learning Collaborative:
Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.

- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.2.12	2.12	2.12.2	Implement Care Transitions Program between EMS, UTMB Emergency Department, and Greater Houston Healthconnect HIE
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	**094092602.3.24** **094092602.3.25**	**IT-9.2** **IT-5.1**	**ED Appropriate Utilization (Standalone measure)** **Improved cost savings: Demonstrate cost savings in care delivery (Non-standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-7]**:** Develop a staffing and implementation plan to accomplish the goals/objectives of the ED, EMS and GHH care transitions program. Metric 1 [P-7.1]: Documentation of the staffing and implementation plan. Goal: Finalize staffing and implementation plan by 9/30/13. Data Source: Staffing and implementation plan. Rationale: The staffing and implementation plan identifies and describes the types and number of staff, information technology, and staff training needs. Milestone 1 Estimated Incentive Payment (maximum amount): $1,427,982	**Milestone 2** [P-2]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transitions policies and procedures. Goal: Submission of policies and procedures. Data Source: Policies, guidelines, and procedures of care transitions program materials. Rationale: In order to allow for system adoption of the ED, EMS and GHH care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. Milestone 2 Estimated Incentive Payment: $603,464 **Milestone 3** [P-6]: Train/designate more ED case managers, RN's,	**Milestone 4 [P-12]**: Participate in face-to-face meetings at least twice per year with other providers. Metric [P-12]: Participate in face-to-face meetings at least twice per year organized by the RPH with EMS and Greater Houston Healthconnect HIE. Goal: Identify initiatives or improvements. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Rationale: Promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 5Estimated Incentive Payment: $525,067 **Milestone 5** [I-14]: Implement standard care transition processes in	**Milestone 6** [I-14]**:** Implement standard care transition processes in specified patient populations – Galveston County patients being transported to UTMB Level 1 Emergency Room by ambulance. Metric 1 [I-14.1]: Measure adherence to processes. Numerator: Number of patients in defined population receiving care according to standard protocol. Denominator: Number of population patients discharged . from the ED. Data Source: Hospital administrative data and the patient medical record. Goal: Implement standard care transition process from EMS to UTMB Emergency Department and query Greater Houston Healthconnect HIE for electronic patient health information and incorporate health information into ED care for a total of 1,500 patient queries of Galveston County patients being transported to

094092602.2.12	2.12	2.12.2	Implement Care Transitions Program between EMS, UTMB Emergency Department, and Greater Houston Healthconnect HIE	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	094092602.3.24 094092602.3.25	IT-9.2 IT-5.1	ED Appropriate Utilization (Standalone measure) Improved cost savings: Demonstrate cost savings in care delivery (Non-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)
	hospital unit clerks, ED physicians on care transition process. Metric 1 [P-6.1]: Number of trained and/or designated ED case managers /RN's, HUC's/registration staff, and Physicians over baseline. Goal: Train 100% of ED case managers, 100% of RN's,100% of HUC's/registration staff, 100%of ED physicians. Baseline: None trained Data Source: HR, job descriptions, training curriculum. Milestone 3 Estimated Incentive Payment: $603,464		specified patient populations – Galveston County patients being transported to UTMB Level 1 Emergency Room by ambulance. Metric 1 [I-14.1]: Measure adherence to processes. Numerator: Number of patients in defined population receiving care according to guidelines. Denominator: Number of population patients discharged from the ED. Data Source: Hospital administrative data and the patient medical record. Goal: Implement standard care transition process from EMS to UTMB Emergency Department and query Greater Houston Healthconnect HIE for electronic patient health information and incorporate health information into ED care for Galveston County patients being transported to UTMB ED by ambulance. The goal is to query at least 530 patients during this period.	UTMB ED by ambulance. UTMB patient care information will then be pushed back out to the EMS software solution so that the ambulance staff will always have the most up to date patient health information. Milestone 5 Estimated Incentive Payment: $

094092602.2.12	2.12	2.12.2	Implement Care Transitions Program between EMS, UTMB Emergency Department, and Greater Houston Healthconnect HIE	
The University of Texas Medical Branch at Galveston				094092602
Related Category 3 Outcome Measure(s):	**094092602.3.24** **094092602.3.25**	**IT-9.2** **IT-5.1**	**ED Appropriate Utilization (Standalone measure)** **Improved cost savings: Demonstrate cost savings in care delivery (Non-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)**
			UTMB patient care information, if available, will then be pushed back out to the EMS software solution so that the ambulance staff will always have the most up to date patient health information. Milestone 5Estimated Incentive Payment: $525,068	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,427,982	Year 3 Estimated Milestone Bundle Amount: $1,206,928		Year 4 Estimated Milestone Bundle Amount: $1,050,135	Year 5 Estimated Milestone Bundle Amount: $614,674
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $4,299,719				

PROJECT OPTION: 2.12.2 Implement web based EMR portal to improve clinical communication between UTMB and referring community providers

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 109372601.2.1-Pass 2
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston, Physician Group Practice/109372601

PROVIDER: Within the UTMB Structure the Faculty Group Practice (FGP) is a premier academic multi-specialty medical group with more than 500 physicians providing specialty care and primary care for the entire family. The FGP is affiliated with UTMB, an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
INTERVENTIONS: By implementing the physician portal there will be improved continuity of patient care within the region. This project provides physician access to their patient's medical records within the inpatient setting. The facilitates better sharing of information and allows primary care physicians to monitor patient progress and provide more comprehensive post discharge care to their patient. This improved communication vehicle creates smoother hand-offs and synergy between primary and specialty care. This, in turn, will improve referring provider satisfaction and the overall patient experience.
NEED FOR THE PROJECT: Currently, a web based portal program doesn't exist for community providers. This project is needed to address the need of structured "hand off" communication plans with subsequent providers for specialty care transitions for the target population served by this project.
TARGET POPULATION: UTMB'S target population is the medically underserved areas with in Galveston and Brazoria counties. Within Galveston County, there are 8 census tracts that are federally designated as Medically Underserved Areas and in Brazoria County there are 6 large areas designated as Medically Underserved Areas.
CATEGORY 1 EXPECTED PATIENT BENEFITS: EpicCare Link will provide a benefit to the Medicaid population in Galveston in Brazoria counties by providing improved communication between specialty and primary care providers, thus improving the continuity of care for the patient. EpicCare Link improves the coordination of care for the patient. Timely communication to primary care providers of labs results, progress and consult notes directly affects and improves patient care. Sharing patient clinical information helps referring community providers follow the progress of care for the patients they refer to UTMB and improves the ability to coordinate ongoing care in an efficient and timely manner.
A Project Manager and staff are needed to implement and grow the project. Without personnel to educate and train community referring providers the program will not be successful. As more referring community providers are educated and trained on EpicCare Link, the greater benefit to the Medicaid patient population in Galveston and Brazoria counties. The goal through the term of the waiver is to educate as many community referring providers as possible in order to reach and benefit as many patients as possible. Maintaining relationships

with these community referring providers and making sure they receive quality feedback on their patients is an important component in making sure the patients receive improved continuity of care between all of their providers.

This project will improve the health of our the target population by ; expanding and coordinating access to specialty care service and chronic disease management; improving the quality of patient care through data collection, analysis, reporting and continuous process improvement; and, growing the health system resources in our region by expanding and enhancing training of the health care workforce.

CATEGORY 3 OUTCOME: I.T-6.2 Other Improvement Target – Percent Improvement over Baseline of Referring Community Provider Satisfaction Scores

PROJECT DESCRIPTION:

This web-based portal provides referring community providers secure access to information about the care UTMB provides to their patients. With this web based portal, external providers can access progress notes, lab results, discharge instructions, consult notes and other portions of the patient's Epic electronic medical record. Sharing patient clinical information helps referring community providers follow the progress of care for the patients they refer to UTMB and improves the ability to coordinate ongoing care in an efficient and timely manner.

Patient events (i.e. encounters, emergency department visits, and hospital admissions) can trigger generic e-mail notifications to the community provider portal users that alert them to log in to the system to access their patient's UTMB electronic medical record. Patient privacy is maintained by sharing medical records with community referring providers only when they have a recorded relationship in Epic (UTMB's EMR) such as referring the patient for an appointment. Secure messaging functions allow external physicians to offer electronic consults. Procedure order entry allows external physicians to electronically request laboratory and radiology studies. The portal also makes the entire referral process faster and more efficient, giving users' convenient features for submitting referral requests and scheduling appointments.

UTMB will develop and implement a community referring provider trainer/educator team to educate referring providers on UTMB's referral processes and referral communication via the web based provider portal. This team will include education trainers as well as information technology software and implementation personnel. The following outlines the project's hiring plan:

- DY 2 – Hire program manager (January 2013) to help develop the program and hire trainer/educator (April 2013).

The estimated product cost for the IT component is $290,200 including software, professional services, ITS Labor, and training as a one-time cost. (See attached EpicCare Link IT project submission form). Estimated recurring cost are $83,500, including software and post implementation support hours for ITS. (See attached EpicCare Link IT project submission form).

- DY 3 – Add additional trainer/educator and an analyst to help continue to grow and develop the program.
- DY 4 – Add an additional educator/trainer.

- DY 5 - Add additional trainer/educator and an analyst to help continue to grow, develop the program, and analyze data.

This project will CQI (conduct quality improvement) through lessons learned as we train community referring providers on the EpicCare Link system. We will implement the "hand off" communication plans with receiving providers by giving them access to their patient's medical record when they refer them to a UTMB specialist. In turn, this will improve the patient's continuity of care across all caregivers. By hiring staff to build and foster the relationships with community referring providers, we will learn what is working and what is not. We will learn ways to improve notification of results to the referring provider resulting in better healthcare and an improved experience for the patient. Collective learning will help in the transformation of our region toward better health and improved coordination as well as in the identification of best practices across the region.

Project goal(s):

- Develop a staffing and implementation plan for the rollout of the web-based EMR portal.
- Integrate web-based EMR portal into the current Epic EMR workflow.
- Secure portal for referring providers to utilize in obtaining clinical information for their UTMB patients.
- Ability to access portions of the patient's electronic medical record (progress notes, lab results, etc.)
- Establish eMail tickler information functionality when patient events/clinical information becomes available in web-based EMR portal.
- Potential to improve patient safety and quality of care through improved communication with community referring primary care providers and tertiary providers.

Anticipated challenges:

One of the challenges for this project includes establishing a reasonable/timely implementation timeline given the tight information technology staff and the prioritization of other competing IT projects. Another challenge will be identifying receptive community referring providers that would like to take the time to be trained and utilize the new web-based EMR portal functionality and incorporate into their practice workflow. A final challenge looking into the future will be to establish linkages with community organizations that care for patients post hospital discharge and establishing policies, responsibilities and procedures for allowing organizations like nursing homes and LTAC's to access the patients UTMB electronic medical record.

The 5-year expected outcome(s):

The expected outcome is to improve provider satisfaction, in turn improving the continuity of patient care within the region.

Regional goals:

- Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.
- Improve health of our region by expanding and coordinating access to specialty care service and chronic disease management.
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement.
- Grow the health system resources in our region by expanding and enhancing training of the health care workforce.

Starting Point/Baseline:

Currently, a web based portal program doesn't exist for community providers. Therefore, the baseline for the number of participating community referring providers and number of patients whose community referring providers can access their UTMB EMR's is zero in DY2.

Rationale

Relation between Project Choices and Community Needs:

When a patient's transition is less than optimal, the repercussions can be far-reaching – hospital admission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnosis, medication and treatment after an appointment with a specialist, a patient's primary care provider can't fully follow-up and understand their patient's medical condition and advise them on their plan of care. It is important for the community referring primary care providers to have timely access to the patient's clinical information in order to effectively manage their patient's care.

Unique Community Need Identification numbers:

- CN.10 – High ED Utilization Rates
- CN.11 – 30 Day Readmission Rates

Expansion or enhancement

The implementation of the web-based EMR portal program will enhance community referring provider satisfaction as well as improving continuity of care for patients.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction:

IT-6.2 We will measure referring community provider satisfaction with the EpicCare Link product. In turn, this will improve patient satisfaction as the continuity of their care is optimized. Improvement of community referring provider satisfaction scores related to access to UTMB electronic medical records in a timely manner. Community referring providers using the web-based EMR portal will be given a preliminary survey measuring current satisfaction regarding current referral processes and referral communication. After using the portal for approximately 1 year, the community referring provider will be re-surveyed to measure post satisfaction regarding referral processes and communication.

Rationale:

When a patient's transition is less than optimal, the repercussions can be far-reaching. Without sufficient information and an understanding of their diagnoses, medication, and self-care

needs, patients cannot fully participate in their care. Additionally, poorly designed referral processes create unnecessary stress for providers causing failed communications, rework, and frustrations. A comprehensive and reliable provider web based portal can improve health outcomes, and ensure quality transitions of care from one health care setting to another.

Relationship to other Projects:

This project's focus on integrating primary and behavioral health and emphasis on underserved communities ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the integration of primary and behavioral health care services along with these other Category 2 projects in our RHP: 135222109.2.1- Integrate primary and behavioral health care services in Brazoria/Galveston county; 109372601.2.2 - Expanding integrated primary care and behavioral/mental health care access using APC; 136367307.2.2- Design, Implement and Evaluate Projects that Provide Integrated and Behavioral Health Care Services.

Plan for Learning Collaborative:

Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health

care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity--Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.2.1	2.12	2.12.2	Implement Web-Based EMR portal to Improve Clinical Communication between UTMB and Referring Community Providers
The University of Texas Medical Branch at Galveston			109372601
Related Category 3 Outcome Measure(s):	109372601.3.4	IT 6.2	Percent improvement over baseline of community referring provider satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program (implementation of web-based EMR portal). Metric 1 [P-7.1]: Documentation of the staffing and implementation plan. Baseline: New program, no baseline information available. Goal: Develop the staffing and implementation plan and hire project manager and provider trainer/educator. Data Source: Completed staffing and implementation plan. Documentation of new hires from human resources records. Milestone 1 Estimated Incentive Payment (maximum amount): $660,548	**Milestone 2** [P-2]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transitions policies and procedures. Install new web-based EMR portal to improve clinical communications between UTMB and referring community providers. Goal: Submission of policies and procedures that define responsible parties, activities, timelines, and anticipated outcomes related to the sharing of patient clinical information with their referring community provider. Implement new web-based EMR portal software by 9/30/14. Data Source: Policies and procedures of care transitions program materials. Documentation of web-based EMR portal implementation. Milestone 2 Estimated Incentive	**Milestone 4** [P-X]: Train community referring providers on web-based EMR portal. Metric 1 [P-X.1]: Number of trained community referring providers over baseline. Baseline: No community referring providers trained on new program. Goal: Train an additional 25 community referring providers over baseline. Data Source: Training curriculum and other referring provider training documentation. Milestone 4 Estimated Incentive Payment: $737,172	**Milestone 5** [P-X]: Train community referring providers on web-based EMR portal. Metric 1 [P-X.1]: Number of trained community referring providers over baseline. Baseline: No community referring providers trained on new program. Goal: Train an additional 25 community referring providers over baseline. Data Source: Training curriculum and other referring provider training documentation. Milestone 5 Estimated Incentive Payment: $356,122 **Milestone 6** [I-14]: Implement standard care transition processes in specified patient populations.

109372601.2.1	2.12	2.12.2	Implement Web-Based EMR portal to Improve Clinical Communication between UTMB and Referring Community Providers	
The University of Texas Medical Branch at Galveston				109372601
Related Category 3 Outcome Measure(s):	109372601.3.4	IT 6.2	Percent improvement over baseline of community referring provider 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)
	Payment: $344,548 **Milestone 3** [P-X]: Train community referring providers on web-based EMR portal. Metric 3 [P-X.1]: Number of trained community referring providers over baseline. Baseline: No community referring providers trained on new program. Estimate approximately 250 providers in surrounding counties to target. Goal: Train 25 community referring providers over baseline. Data Source: Training curriculum and other referring provider training documentation. Milestone 3 Estimated Incentive Payment: $344,548			Metric 1 [I-14.1]: Measure adherence to processes. Goal: 10% of all UTMB specialists have patient's medical record signed off and ready for viewing in the web-based EMR portal for referring providers to view within 7 days of service. Data Source: Hospital administrative data and the patient medical record Milestone 6 Estimated Incentive Payment: $356,121

109372601.2.1	2.12	2.12.2	Implement Web-Based EMR portal to Improve Clinical Communication between UTMB and Referring Community Providers
The University of Texas Medical Branch at Galveston			109372601
Related Category 3 Outcome Measure(s):	109372601.3.4	IT 6.2	Percent improvement over baseline of community referring provider satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $660,548	Year 3 Estimated Milestone Bundle Amount: $689,095	Year 4 Estimated Milestone Bundle Amount: $737,172	Year 5 Estimated Milestone Bundle Amount: $712,243
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $2,799,058			

PROJECT OPTION: 2.15.1 Integrate primary and behavioral services

UNIQUE RHP PROJECT IDENTIFICATION NUMBER: 109372601.2.2
PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston, Physician Group Practice/109372601

Provider: Within the UTMB Structure the Faculty Group Practice (FGP) is a premier academic multi-specialty medical group with more than 500 physicians providing specialty care and primary care for the entire family. The FGP is affiliated with UTMB, an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.
Interventions: The purpose of this project is to add behavioral/mental health services to the primary care practice of the UTMB's Brazoria County Indigent Health Clinic by bring an on-site behavioral/mental health counselor to the practice 1 day per week. . The current practice provides comprehensive primary care services to uninsured adults with complex chronic health problems with increased risk of poor health outcomes due to behavioral/mental health problems, poverty, low education, low social support, and/or minority status. Data from a year of providing primary care to this population suggests that at least 25% of patients have an expressed need for or would benefit from counseling for mental or behavioral health problems. Current services are delivered by advanced practice clinicians and supported by a partnership between Brazoria Countyand UTMB. The new behavioral/mental health services will be provided by Family Services Center.
Need For the Project: The importance of simultaneously addressing the physical health needs and the behavioral health/mental needs of individuals is well established with screening (and treatment) for depression a standard of care for most common chronic health problems, e.g. type 2 diabetes, obesity, and chronic lung disease. The need for integrated care models is further increased in vulnerable populations, e.g. living in poverty or people of color. It has clearly been established that being poor and/or a member of a racial or ethnic minority in this country means that you are much more likely to have poorer quality of care and poorer health outcomes in all areas of care, including primary care and treatment for chronic illnesses (AHRQ, 2005a).
Target Population: The population serviced will be adults enrolled in the Brazoria County Indigent Care Program. At least 180 patients are enrolled in the program for 6 month intervals. With patients dropping off the program and new ones being added, over 300 unduplicated patients are seen in the clinic each year. Over the 5 years of this project, a conservative estimate would be that over 1000 individuals will be exposed to the practice. Eligibility for enrollment in the County Indigent Health Program includes being uninsured and having an income at or below 50% of the federal poverty level. Both practice sites (Alvin and Angleton) have been designated Medically Underserved Populations by the Texas Dept of HHSC.

Category 1 Expected patient Benefits: Increased numbers of patients with chronic illness will be screened for depression and referred for treatment. Patients who receive treatment will experience improved depression as measured by the (PHQ-9) on patients in the program.

Category 3 Outcome: IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression and IT-1.9 Depression management: Depression Remission at Twelve Months

PROJECT DESCRIPTION:

The purpose of this project is to expand health care services provided at the UTMB Brazoria County Indigent Health Clinic by integrating behavioral health services to the practice. The practice serves adults with complex chronic health problems with increased risk of poor health outcomes due to behavioral/mental health problems, poverty, low education, low social support, and/or minority status. Current primary care services are delivered by advanced practice clinicians and supported by a partnership between Brazoria County, and UTMB the behavioral/mental health services will be provided by Family Services Center. This integrated model has been implemented by UTMB at the St. Vincent's Nurse Managed Health Center (STV-NMHC) which has provided high quality, comprehensive primary care to uninsured adults with chronic health problems for over 3 years. In the last 18 months the clinic has provided mental health to patients through a partnership with the Family Services Center. Family Services Center provides on-site behavioral/mental health services using Master's prepared social workers (LCSW). The current practice at STV-NMHC meets the criteria for a "Close Collaboration in a Partly Integrated System" and is rapidly moving to "…Full Integration" in both the electronic health record and "structured team management" of patients. At STV-NMHC an additional partnership with the UTMB Department of Psychiatry provides medical management of patients with complex mental health problems requiring pharmaceutical treatment. The STV-NMHC also has a partnership with the Gulf Coast Center; they refer Gulf Coast clients with severe and persistent mental illnesses and who need a health care home, to the clinic for primary care. All of these partnerships reflect the foundation of expertise on which this project is built. The intent of this project in future phases will be to replicate the proposed integrated practice in other communities in RHP2, thereby improving access to primary care and behavioral mental health service in the many RHP2 communities with limited primary care and/or mental health services. The focus of all practices will be to offer quality integrated health care to the many vulnerable adults who present with a complex mixture of multiple chronic physical and mental health problems complicated by poverty, minority status or other factors, such as low education, that negatively impact health.

Project goal(s*):*

The concept of a health care home which is designed to address the needs of the whole person has been implemented by nurse-managed centers for many years. Today this concept is increasingly recognized as a key in improving access to care, continuity of care, and improved outcomes. The importance of simultaneously addressing the physical health needs and the behavioral health needs of individuals is well established with screening (and treatment) for depression a standard of care for most common chronic health problems, e.g. type 2 diabetes, obesity, and chronic lung disease. The need for integrated care models is further increased in vulnerable populations, e.g. living in poverty or people of color. It has clearly been established that being poor and/or a member of a racial or ethnic minority in this country means that you

are much more likely to have poorer quality of care and poorer health outcomes in all areas of care, including primary care and treatment for chronic illnesses (AHRQ, 2005a).

Although all chronic health problems are associated with poor mental health the greatest body of research exists in patients with type 2 diabetes. Extensive research supports a correlation between the presence of depression and poor diabetes control (Lustman, PJ, et al, 2000; Anderson, R.J., 2001, et. al.; Nichols & Brown, 2003). The nature of the relationship is unclear but studies show that factors associated with increased risk for diabetes, such as obesity (McElroy, et al, 2004) and metabolic syndromes (Kinder, et al, 2004) are also associated with increased risk for depression. The negative effect of depression on diabetes outcomes and risk factors for diabetes can be expected to be compounded in patients who are poor or who are members of an ethnic or racial minority (Institute of Medicine, 2003). The management of chronic diseases is rapidly becoming the major component of primary care. Nurse practitioners (NPs) are particularly well qualified to provide chronic disease management due to their ability to address the multi-factorial nature of chronic health problems. Successful interventions for optimal outcomes in the care of chronic diseases are composed of complex sets of actions that address mental health, psychosocial, and lifestyle issues as well as the physical problem per se. (Institute of Medicine, 2003). As noted earlier, the intent of this project is to increase access to primary care services and to address the complex needs vulnerable populations (rural, living in poverty, minorities) by integrating behavioral health services into the primary care practice. Advanced practice clinicians, particularly nurse practitioners and mental health counselors are the foundation of the project, providing both primary care and behavioral health on-site with services supplemented with physicians via telecommunication. Based on the Project Director's (Fiandt, 2007a; 2007b) significant expertise in the area, the Chronic Care Model will be used as the organizational framework for both delivery system design and quality improvement.

Agency for Healthcare Research and Quality (AHRQ). (2005a). *National Healthcare Disparities Report.* Rockville: US Dept HHS.

Anderson, R.J., Freedland, K.E., Clouse, R.E., & Lustman, P.J. (2001). The prevalence of co-morbid depression in adults with diabetes: A meta-analysis. *Diabetes Care*, *24* (6), 1069-1078.

Fiandt, K. (2007a). The Chronic Care Model: Description and application for practice. *Topics in Advanced Practice Nursing (ejournal), 6*(4), www.medscape.com/viewarticle/549040.

Fiandt, K. (2007b). *Quality improvement for nurse-managed health centers.* Okemos, MI: Institute for Nursing Centers.

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in healthcare.* Washington: National Academy Press.

Kinder, L.S., Carnethon, M.R., Palaniappan, L.P., King, A.C., Fortmann, S.P. (2004). Depression and the metabolic syndrome in young adults: Findings from the Third National Health and Nutrition Examination Survey. *Psychosomatic Medicine*, 66, 316-322

Lorig, K. & Holman, H.R. (2003a). Self-management education: History, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine*, 26 (1), 1-7.

Lorig, K., Ritter, P., & Gonzalez, V. (2003b). Hispanic chronic disease self-management: A randomized community-based outcome trial. *Nursing Research, 52* (6), 361-369.

Lustman, P.J., Anderson, R.J., Freedland, K.E., Groot, M.de., Carney, R.M., & Clouse, R.E. (2000). Depression and poor glycemic control: A meta-analytic review of the literature. Diabetes Care, 23 (7), 934-942.

McElroy, S.L., Kotwal, R., Malhotra, S., Nelson, E.B., Keck, P.E., & Nemeroff, C.B. (2004). Are mood disorders and obesity related? A review for the mental health professional. *Journal of Clinical Psychiatry*, 65, 634-651.

Nichols, G.A. & Brown, J.B. (2003). Unadjusted and adjusted prevalence of diagnosed depression in type 2 diabetes. *Diabetes Care*, 2 (3), 744-750.

Anticipated challenges:

Challenge 1. Access to sufficient behavioral health clinicians

Response a: Contract with local agencies for portions of clinicians

Response b: when appropriate use telemedicine

Challenge 2: Access to psychiatrists for medical management of disease

Response a: use IMPACT model of integrated primary care.

Response b: use of tele-psychiatry

The 5-year expected outcome(s):

Given the nature and the goals of the project; we project the following outcomes: Increased numbers of patients with chronic illness will be **screened for depression and referred for treatment. Estimated 5 year outcome: Over 900 program participants will be screened for depression. Based on depression screening or other identified behavioral/mental health need, an estimated 225 (25%) people will be referred for treatment.**

Patients who receive treatment will experience **improved depression** as measured by the (PHQ-9) on patients in the program (OD-1 Primary Care and Chronic Disease Management; IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression and IT-1.9 Depression management: Depression Remission at Twelve Months. **Estimated 5 year outcome: at least 25% of participants identified as depressed and referred for treatment (N=56) will have depression remission at 12 months**

Regional goals:

The following RHP 2 goal will be the focus of this project:

Improve the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

STARTING POINT/BASELINE:

At any point in time, 180 patients are participating in the Brazoria Indigent Health Clinic Program. The clinic meets every Tuesday in Alvin, TX and every Thursday in Angleton. Averages of 8-12 patients are seen at each site weekly. This number is kept deliberately low to allow the nurse practitioner the time needed to address the chronic health problems and the psychosocial problems identified. In addition to access to specialty services at UTMB via a

separate county contract, the nurse practitioner/s at the practice have build up partnerships with multiple community resources to increase patients' access to services needed. The Brazoria County program pays for three prescriptions per month and provides staff to assist with Pharmacy Assistance Programs paperwork; complementing that, the nurse practitioner/s are careful to prescribe low cost medication as appropriate. The practice has a physician oversight; she visits each site once every three months and reviews on-line, 10% of charts. Currently some Brazoria patients are referred to STV-NMHC to see the counselors there. The need is clearly present but patients have a great deal of difficulty traveling from Brazoria County to Galveston and these patients strain the counselor's already heavy schedules. Baseline data have been collected at Brazoria County via *Survey Monkey* and include: chronic health problems, obesity (as measured by BMI), health status (specifically blood pressure, low density lipoprotein, random glucose, and A1c). The program is set up to allow for longitudinal tracking of these clinical measures as measures of change in health status over time. Data regarding specialty referral are collected. Solid estimates suggest that the population is about 50% male and 50% female with an average age of 48. The following health problems are each present in at least 20% of the population with many patients suffering from at least 50% of this health problems: depression, obesity, hypertension, hepatitis C, chronic back pain, and type 2 diabetes. Data on race/ethnicity, acculturation, social support, and lifestyle (smoking, alcohol use, and substance use) are also collected.

RATIONALE:

Relation between Project and Community Needs:

This project addresses multiple community needs identified in RHP2. These include lack of access to care due to limited resources and un-insurance, the need for more primary care providers ("physicians and "midlevels"), and the need to mental health services. The project also builds on the high incidence of obesity and chronic illness, both health problems that are highly correlated with mental and behavioral health problems.

Project Option 2.15.1 design, implement, and evaluate this project.

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.

PLAN: The Brazoria site is identified. As we move forward in future DSRIP projects we will identify additional communities in RHP 2 who may be interested in implementing this model

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

PLAN: We plan to expand our current partnership with the Family Services Center to contract for Masters prepared mental health counselors to be on-site at least two days per month per site (for a total on one day/week in Brazoria).

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.

PLAN: A model for referral, communication and data sharing will be formalized based on current practice models. Meetings with providers will take place to review and revise protocols and process to assure that they fit into current practice and that they support data sharing.

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.

PLAN: As noted earlier mental health provide will be contracted. In the current integrated practice at STV-NMHC, the mental health providers are employed by the Family Services Center and contracted to provide services on site at St. Vincent's. This allows for optimal flexibility will integrating the practice.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:

PLAN: Regular consultative meetings between physical health and behavioral health practitioners will occur. Once patients are shared, case conferences will be conducted on a regular basis to share plans for care. Provider training will be integral to program success and will focus on providing the primary care providers in the practice and referring providers in the community with skills to assess patients who would benefit from referral. Self-management support strategies will be included in the program, to include innovative practice strategies such as pre-visits, group visits, and self-management group sessions. (Lorig & Holman. 2003; Lorig, Ritter, & Gonzalez, 2003)

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.

PLAN: The process for collecting longitudinal outcome data is established with pre-existing Survey Monkey tools that are used in the Brazoria County model. These make for easy data entry with subsequent transfer of data to an SPSS file for analysis. It will also allow practice to receive regular profiles of the practices to inform Quality Improvement. Data sharing on the level of an HIE is much more challenging and will not be pursued in this project except as part of another project or pre-existing data sharing exchange.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.

PLAN: Because this project is based on two existing practices, model legal agreements already exists and will be modified only as needed. The UTMB Office of Legal Affairs has extensive experience developing collaborative practice agreements of this type.

h) Arrange for utilities and building services for these settings

PLAN: This will be done as necessary. Ideally, pre-existing clinical space will be used to avoid the expense of large modification.

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the healthcare outcomes of individual treated in these integrated service settings.

PLAN: The UTMB Office of County Affairs is will be an essential partner in this practice, making appointments and tracking referrals. In addition, the Survey Monkey tool is set up to identify utilization data such as the level of the visit and services performed. The tool is easily modified to add data such as mental health visit codes.

j) 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.

PLAN: A cross-practice QI committee is under development between St. Vincent's Nurse Managed Health Center and the Brazoria Indigent Primary Care Clinic. The group will be lead by Dr. Kate Fiandt, the director of this project. Dr. Fiandt has extensive experience in quality improvement, including having written a broadly used "Quality Improvement for Nurse-Managed Centers" (2007b). All projects will be data driven and use a PDSA improvement cycles. The patient population targeting in the project is inherently vulnerable and "culturally competent" quality improvement will be an integral consideration in all QI projects.

Fiandt, K. (2007b). *Quality improvement for nurse-managed health centers.* Okemos, MI: Institute for Nursing Centers.

Relationship to other Projects:

This project's focus on integrating primary and behavioral health and emphasis on underserved communities ties to these Category 1 and 2 projects in our RHP: 135222109.1.1, 135222109.1.2, 135222109.1.3, 135222109.1.4, 135222109.1.5, 096166602.1.1, 096166602.1.2, 136367307.1.1, 136367307.1.2, 081844501.1.1, 135222109.2.1, 096166602.2.1, 096166602.2.2, 096166602.2.3, 096166602.2.4, 096166602.2.5, 096166602.2.6, 136367307.2.1, 109372601.2.2, 136367307.2.3. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP:

This project focuses on the integration of primary and behavioral health care services along with these other Category 2 projects in our RHP: 135222109.2.1- Integrate primary and behavioral health care services in Brazoria/Galveston county; 109372601.2.2 - Expanding integrated primary care and behavioral/mental health care access using APC; 136367307.2.2- Design, Implement and Evaluate Projects that Provide Integrated and Behavioral Health Care Services.

Process Measures:

As noted in the Rationale Section and described in Table A, because the project involves expansion within a known community, initial process activity will focus on implementing the project. Standards will have to be developed to optimize the intervention and the model will need to be adapted to meet the needs and the resources in the community (P-3). This included making use of pre-existing services and practice sites (P-4, P-5). It will also require culturally and community sensitive negotiations to assure that the best use of current resources are made rather than usurped or replaced. All physical sites must meet state and federal guidelines (P-6). Quality improvement processes (P-7, P-8) will be implemented from Day 1 assuring that, while holding faithful to the core components of the model, the practice it is adapted for best practices in the context of each environment.

Improvement Measures:

Improvement measures will include all Improvement measures recommended and are described in detail in Table A. With a data collection processes already established, additional patient specific improvement data, including patient satisfaction (I-12) will be added in Year 2 as appropriate to the project and will continue to include Health Metrics (I-11). Year 2 data will

serve as baseline for indication of improvement in future years. Additional descriptive improvement measures will include the number of individuals receiving both physical and behavioral health care (I-8) and no show appointments (I-10). In Year 3 analysis of improvement will begin comparing baseline data to data collected at future points. The broad scope of these data will indicate impact of the practice on health and acceptability of services. When these data are correlated with patient participation in services (e.g. number of encounters for "dose effect") it will be possible to determine the differences between sporadic users and patients who take full advantage of the program. In addition to individual specific measures, a critical improvement measure will be the degree to which the integrated practice is actually "integrated" through coordination of care (I-9). Given the anticipated nature of the patients seen, the majority of patients will fit into high physical complex category with multiple confounding factors such as behavioral mental health problems as well as social factors such as minority status and/or poverty. . As a result, the integration goal for this practice will be a Close Collaboration in a Fully Integrated system.

Unique Community Need Identification numbers:

CN: 3, CN: 5, CN: 8, CN: 12, CN:13, CN:14, CN:15, CN:16

Expansion or enhancement:

This project is projected to be an enhancement of the Brazoria Indigent Health Primary Care practice setting by bringing in mental health services. We plan to expand the model to additional counties in RHP2 in future proposals. Currently there is no DHHS funding for this project.

RELATED CATEGORY OUTCOME MEASURE(S):

For this project, two Category 3 outcome measures will be used from the Outcome Domain Primary Care and Chronic Disease (OD-1). Due to the nature of the project and the established relationship between depression and chronic illness, the outcome measures will be IT-1.8: Screening and Treatment Plan for Clinical Depression: a *Non- standalone measure) and IT-1.9*: Depression Remission at Twelve Months, a *Standalone measure, will be used.* Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients.

For both outcome measures*, the PHQ-9* will be used. _This measure is a highly effective screening tool that has the advantage of also serving of a measure of clinical change. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient at each visit.

RELATIONSHIP TO OTHER PROJECTS:

It is anticipated that multiple other DSRIP projects will be used as a part of this program. Chief among them will be telemedicine for consultation with physicians and a partnership with the Chronic Disease and Community Health Program to supplement the primary care and behavioral services.

PROJECT VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.2.2	2.15.1	2.15.1 (A-J)	Expanding Integrated Primary Care and Behavioral/Mental Health Care Access using Advanced Practice Clinicians
The University of Texas Medical Branch at Galveston			TPI 109372601
Related Category 3 Outcome Measure(s):	**109372601.3.5 109372601.3.6**	**IT-1.8 IT-1.9**	**Depression Management: Screening and Treatment Plan for Clinical Depression Depression Remission at Twelve Months**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 P-3. Milestone: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. P-3.1. Number and types of referrals that are made between providers at the location a. Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results P-3.2. Number of referrals that are made outside of the location a. Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results P-3.3. Number of referrals which follow the established standards a. Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results **Milestone 1: At the end of Year 2, referral and information sharing**	**Milestone 5** P-7. Milestone: Evaluate and continuously improve integration of primary and behavioral health services. P-7.1. Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles a. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) **Milestone 5: At the end of Year 3 the full of integration of primary and behavioral/mental health care will be completed through QI processes.** Milestone 5. Estimated Incentive Payment (maximum amount): $156,533.75 **Improvement milestone 6** I-9. Milestone: Coordination of Care I-9.1. Metric: 10% of Individuals with	**Milestone 9** P-8. Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation should include: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing (PDSA cycles) it in the week to come. P-8.1. Metric: Documentation to demonstrate participation in at least bi-weekly meetings, conference calls, or webinars organized by the RHP or group of providers. **Milestone 9: At the end of Year 4, biweekly QI meetings result in significant improvement in the integrated practice model and evidence that Level 5 collaboration has been achieved.** Milestone 9. Estimated Incentive	**Improvement Milestone 11** I -8 Integrated Services 1-8.1 Metric number of individuals receiving both physical and behavioral health care at the established location a. Numerator: number of individuals receiving both physical and behavioral health care in project site b. Denominator: Number if individuals receiving services at project site c. data source: project data, medial records **Milestone 11: At the end of Year 5, over 300 patients will have received integrated care at the Brazoria Clinics.** Improvement Milestone 1. Estimated Incentive Payment *(maximum amount):* $647,168

109372601.2.2	2.15.1	2.15.1 (A-J)	Expanding Integrated Primary Care and Behavioral/Mental Health Care Access using Advanced Practice Clinicians	
The University of Texas Medical Branch at Galveston				TPI 109372601
Related Category 3 Outcome Measure(s):	**109372601.3.5 109372601.3.6**	**IT-1.8 IT-1.9**	**Depression Management: Screening and Treatment Plan for Clinical Depression Depression Remission at Twelve Months**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
processes are developed and implemented. Milestone 1. Estimated Incentive Payment (maximum amount): $150,049 **Milestone 2** P-6. Milestone: Develop integrated behavioral health and primary care services within collocated sites. (Alvin and Angleton) P-6.1. Metric: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). a. Data Source: Project data P-6.2. Metric: Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system) a. Data Source: Project data **Milestone 2: At the end of Year 1, 50% of primary care and behavioral/mental health providers participating in the project will be interacting at Level 4.** Milestone 2. Estimated Incentive Payment (maximum amount):	a treatment plan developed and implemented with primary care and behavioral health expertise a. Numerator: Number of individuals with treatment plans developed and implemented with primary care and behavioral health expertise b. Denominator: Number of individuals receiving services at project sites. c. Data Source: Project data; claims and encounter data; medical records **Milestone 6: At the end of Year 3, 10% of patients in the practice will have an integrated physical and behavioral/mental health treatments plan (N=60)** Milestone 6. Estimated Incentive Payment (maximum amount): $156,533.75 **Improvement milestone 7** I-11. Milestone: Health Metrics I-11.1. Metric: 20% Increase in Positive Results of Standardized Health Metrics, which		Payment *(maximum amount):* $334,909.50 **Improvement Milestone 10** I -8 Integrated Services 1-8.1 Metric number of individuals receiving both physical and behavioral health care at the `established location a) Numerator: number of individuals receiving both physical and behavioral health care in project site b) Denominator: Number if individuals receiving services at project site **c)** data source: project data, medical records **Milestone 10: At the end of Year 4, over 200 patients will have received integrated care at the Brazoria Clinics.** Improvement Milestone 10. Estimated Incentive Payment *(maximum amount):* $334,909.50	

109372601.2.2	2.15.1	2.15.1 (A-J)	Expanding Integrated Primary Care and Behavioral/Mental Health Care Access using Advanced Practice Clinicians	
The University of Texas Medical Branch at Galveston				TPI 109372601
Related Category 3 Outcome Measure(s):	109372601.3.5 109372601.3.6	IT-1.8 IT-1.9	Depression Management: Screening and Treatment Plan for Clinical Depression Depression Remission at Twelve Months	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$150,049 **Milestone 3** I-8. Milestone: Integrated Services I-8.1. Metric: X% of Individuals receiving both physical and behavioral health care at the established locations. a. Numerator: Number of individuals receiving both physical and behavioral health care in project sites b. Denominator: Number of individuals receiving services in project sites. c. Data Source: Project data; claims and encounter data; medical records **Milestone 3: At the end of Year 2, 50 patients (numerator) of 300 (denominator) will have received initial behavioral/mental health services**. Milestone 3. Estimated Incentive Payment (maximum amount): $150,059 **Milestone 4** I-10. Milestone: No-Show Appointments	may include : Objective health indicators such as Body Mass Index, glycated hemoglobin (A1c), blood pressure, and other specific blood assays, etc. **Milestone 7: At the end of Year 3, 20% of patients who participate in integrated treatment will have improved physical health metrics**. **Improvement milestone 8** Milestone: Improved Consumer satisfaction with Integrated Services I-12.1. Metric: 90% of People report satisfaction with integrated services a. Numerator: The number of individuals receiving integrated services that have expressed satisfaction with services. b. Denominator: The number of individuals receiving integrated services c. Survey data from CAHPS, MHSIP or other validated instrument. d. Data from completed consumer satisfaction surveys. **Milestone 8: At the end of Year 3, 90% of patients participating in the**			

109372601.2.2	2.15.1	2.15.1 (A-J)	Expanding Integrated Primary Care and Behavioral/Mental Health Care Access using Advanced Practice Clinicians
The University of Texas Medical Branch at Galveston			TPI 109372601
Related Category 3 Outcome Measure(s):	**109372601.3.5** **109372601.3.6**	**IT-1.8** **IT-1.9**	**Depression Management: Screening and Treatment Plan for Clinical Depression** **Depression Remission at Twelve Months**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
I-10.1. Metric: X% decrease the "no shows" for behavioral and physical health appointments. a. Numerator: Number of appointments for behavioral or physical health services that were not kept in the project sites. b. Denominator: Number of scheduled appointments for behavioral and physical health services in the project site. This would be measured at baseline and at specified time intervals throughout the project. c. Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data **Milestone 4: From the beginning of the project, the No Show rate is collected for each referral.** Milestone 4. Estimated Incentive Payment (maximum amount): $150,049	**Brazoria County Indigent Primary Care clinics will report positive satisfaction scores.** Milestone 8. Estimated Incentive Payment (maximum amount): $156,533.75		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $600,196	Year 3 Estimated Milestone Bundle Amount: $626,135	Year 4 Estimated Milestone Bundle Amount: $669,819	Year 5 Estimated Milestone Bundle Amount: $647,168
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,543,318			

UNIQUE RHP PROJECT IDENTIFICATION NUMBER 109372601.2.3-**Pass 2**

PERFORMING PROVIDER NAME/TPI: The University of Texas Medical Branch at Galveston, Physician Group Practice/109372601

TITLE OF PROJECT: Apply Process Improvement Methodology to Improve Hospital Efficiency

PROVIDER: UTMB is an academic health center comprised of a 442 bed acute care hospital, Level 1 Trauma Center, 53 community-based clinics, women's health program and an advanced telemedicine program, offering a full range of primary and specialty services covering all of Southeast Texas and beyond. UTMB is a safety net hospital and our payer mix includes 32% Medicaid and uninsured.

INTERVENTIONS: This project will improve hospital efficiency and throughput by developing and integrating three different computer system modeling methodologies (System Dynamics, Discrete-Event Modeling and Agent-Based Modeling). This new system will optimize the efficiency of inpatient utilization improvement efforts and eliminate waste and unintended consequences.

NEED FOR THE PROJECT: UTMB Galveston experiences a high rate of variation and utilization due to the inefficiency of current technology capabilities which have led to high ED utilization and readmission rates. While process improvement methodologies have demonstrated value in reducing/eliminating waste and non-value added activities, these are difficult to measure, quantify and use to make a business cases demonstrating a return-on-investment. Within RHP2:

- High ED Utilization Rates: Rate per 100,000:17,461 – 78,955
- 30 Day Readmission Rates: Medical: 16.0 – 18.3

TARGET POPULATION: Our target population is the medically underserved areas with in Galveston and Brazoria counties. This project also targets populations within RHP2 that suffer from chronic diseases. In fiscal 2012, for both Medicaid/Medicaid Pending or Uninsured, there were 20,274 Emergency Room Visits, 2,191 Day Surgeries, and 1,294 Major Surgical Cases at UTMB. If volumes stay flat, this equates to more than 95,00 patient encounters over DY2 – DDY 5.

		Medicaid / or Pending	Uninsured	Combined
EMERGENCY DEPT VISITS	**Individuals**	6,238	8,236	14,474
	Encounters	9,625	10,649	20,274
TOTAL INPATIENTS	**Individuals**	11,978	1,351	13,329
	Encounters	13,257	1,572	14,829
INPTS ADMITTED THROUGH ED	**Individuals**	949	1,181	2,130
	Encounters	1,251	1,333	2,584
ALL OTHER ADMISSIONS	**Individuals**	11,029	170	11,199
	Encounters	12,006	239	12,245

		Medicaid / or Pending	Uninsured	Combined
OBSERVATION PTS (EXCLUDING AWH)	**Individuals**	1,299	771	2,070
	Encounters	1,546	827	2,373
ALL SURGERIES	**Individuals**	2,463	503	2,966
	Encounters	2,895	590	3,485
DAY SURGERIES	**Individuals**	1,847	105	1,952
	Encounters	2,083	108	2,191
MAJOR SURGICAL CASES	**Individuals**	616	398	1,014
	Encounters	812	482	1,294

CATEGORY 1 EXPECTED PATIENT BENEFITS: This project aims to improve quality and efficiency by utilizing the three modeling methodologies, which will reduce patient waiting times and waste. Overall the process improvement methodologies will improve patient flow throughout the health system.

CATEGORY 3 OUTCOME: IT-5.3: Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1).

Project Goal:

The goal of this project is to improve the efficiency of hospital bed capacity and throughput by developing and validating a fully integrated data model of UTMB Health's inpatient and emergency department utilization and patient flow. Using three systems modeling methodologies (System Dynamics, Discrete-Event Modeling, and Agent-Based Modeling) we aim to optimize the efficiency of inpatient utilization improvement efforts at UTMB and to eliminate sub-optimization (waste) and unintended consequences. The whole systems modeling in this project will provide sophisticated analyses and statistically derived forecasts that systematically identify bottlenecks and can be used to smooth flow.

Project Option/Project Component:

2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.

Project Description:

P-9 We will map the value stream and target specific workflows or processes and/or clinical areas to improve (optimize) using rapid cycle improvement methods. During this initial step, we will provide just-in-time training on value stream and rapid cycle change methodologies to clinical and administrative stakeholders, and engage them in identifying suggestions for improvement to a "future state" map and targets for improvement (components 2.8.1 a, b, and d).

P-1 We will apply three modeling paradigms in an integrated way: (1) Use System Dynamics paradigm to model the system at a macro, strategic level and determine where constraints with the greatest impact are located. (2) Use Discrete-Event Modeling paradigm (including value stream map for perioperative care and other key processes) to simulate and

optimize (relieve) identified constraints at a meso, operational level. We will cycle between (1) and (2) until whole system is balanced – in order to maximize throughput. (3) We will use an Agent-Based Modeling paradigm at the micro, behavioral level to investigate the effects of decisions and work patterns of groups (e.g., ED and surgical teams) and individuals. [1] (component 2.8.1 e).

P-2 From among the existing efficiency measures currently reported, or new measures identified unique to vulnerable workflows surfaced during P-1 above, we will specify metrics to measure the impact of process improvement efforts and establish baseline performance (component 2.8.1 c). Measures of efficiency currently reported in the perioperative area are outlined in the following "starting point/baseline" section below.

P-14 The improvement team will review whole system project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This may include observation data, quick tallies, as well as adjustments to the OR Controls and other EMR system data. (component 2.8.1 f).

I-14 From among available metrics or new process metrics specified for vulnerable workflows, we will measure and report efficiency to operations and clinical leadership in order to evaluate and course-correct performance improvement efforts.

Anticipated challenges

There will no doubt be a learning curve of iterative trials of modeling and validation in the development of a comprehensive mode. This is expected and has been accounted for in the infrastructure design. Core quality staff will receive training in the simulation software and new modeling tools. Operations leaders will receive training in how to apply the results of these new tools in their respective areas of responsibility.

UTMB is also migrating from Siemens revenue cycle systems to an Epic revenue cycle system platform in April, 2013. As a result, the extraction of Admission/Discharge/Transfer (ADT) data from the new analytical repository and mapping prior historical data and prospective data from the two source systems will be required in order to mine sufficient data. A reporting team is already commissioned to manage data aggregation across historical and future data and will be available to troubleshoot any challenges encountered.

5-year expected outcome(s)

After a comprehensive model is established for the whole system, we expect to be able to simulate the effects of changes in staffing, patient scheduling, and changes in the physical geography or workflows. In preparation for UTMB occupying a new physical plant in 2016, we anticipate the use of the model to simulate changes from current state to future state location and workflows to best smooth flow and maximize the patient experience of care.

Regional goals

The work of this collaborative directly supports a Region 2-wide goal:

[1] "Multimethod Modeling Software," XJ Technologies, http://www.anylogic.com/multimethod-modeling {11 Dec 2012}; "Multi-Method Simulation Modeling using AnyLogic," Andrei Borshchev, INFORMS Roundtable Fall Meeting, Seattle (3-4 Nov 2007); "From System Dynamics and Discrete Event to Practical Agent Based Modeling: Reasons, Techniques, Tools," Andrei Borshchev and Alexei Filippov, Proceedings of the 22nd International Conference of the System Dynamics Society, July 25–29, 2004, p. 45ff; "The three methods in simulation modeling," {2nd section of Introduction chapter} Simulation Modeling with AnyLogic: Agent Based, Discrete Event and System Dynamics Methods, http://www.anylogic.com/upload/Big%20Book%20of%20AnyLogic/The_three_methods_in_simulation_modeling.pdf {11 Dec 2012}

- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement – *through regional capability-building*

Starting Point/Baseline:

We have traditionally used annual or periodic summaries of inpatient volumes to project an annual budgeted census, supplemented by occasional analyses of admission, discharge, and transfer data within each unit by time of day and day of week. Working to improve one part of a system at a time will almost always result in "sub-optimization" of the whole system.

In 2012, we installed a perioperative workflow control system called OR CONTROL (Healthcare Control Systems, Inc. - HCS) for the management of day of surgery operations – a unique workflow control system combining the use of a real-time staff, equipment, and patient location system with an enhanced ability to communicate adjustments in schedule and for operational reporting. Reported movements will provide the information needed to make operational decisions "on the fly" to improve OR throughput. This project will allow us to exploit the accumulated data for modeling and improvement.

A number of perioperative and Emergency Department measures that may be sourced for outcome measures in this project follow:

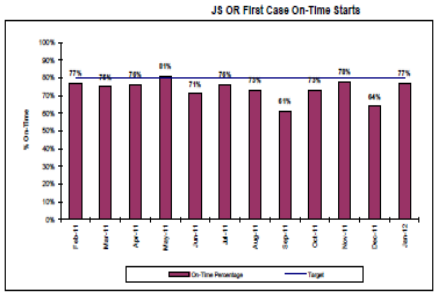
Operating Room Governance Committee Dashboard - January 2012

JS OR First Case On-Time Starts

Definitions:

On-Time Start: Briefing occurs within 15 minutes of scheduled time for first cases of the day (Monday-Friday)

Exclusions: Pediatric cases and delay reasons "Transport ICU" & "Anesthesia Transport"



	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12
Free World	74%	77%	75%	81%	69%	75%	74%	61%	72%	79%	62%	77%
TDC	85%	68%	79%	79%	82%	83%	69%	61%	69%	69%	67%	78%

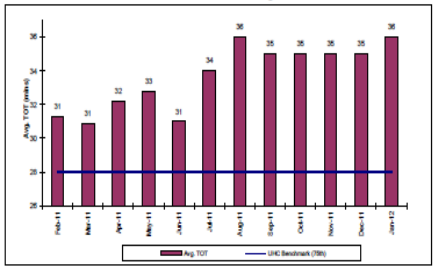
JS OR Avg Turn Over Time (TOT) - Mins

Definitions:

Turn Over Time: Duration between patient out to next patient in for all scheduled cases during prime time.

Proposed Target: 28 minutes (90th Percentile of UHC benchmark)

Note: Turnovers greater than 60 minutes receive a value of 60



Date	12/8/2012	12/9/2012	12/10/2012	12/11/2012	12/12/2012	12/13/2012	21/14/20122	Running Totals		
Day of Week	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Mtd	FYtd	Metric
Total ED Registrations	107	106	128					1146	10775	Total ED Registrations
Overall ALOS	3:25	4:49	3:36					4:09	4:32	Overall ALOS
Total Treated	97	100	124	0	0	0	0	1084	10277	Total Treated
Pts With Admit Orders	26	28	30					310	2972	Pts With Admit Orders
Admit Order Rate	27%	28%	24%					29%	29%	Admit Order Rate
ALOS Pts With Admit Order	5:58	9:06	6:19					6:43	7:55	ALOS Pts With Admit Order
ALOS Pts Without Admit Order	2:36	3:17	2:45					3:11	3:15	ALOS Pts Without Admit Order
Psych Transfer ALOS		25:57						18:18	15:48	Psych Transfer ALOS
Hours on Diversion	0	0	0	0	0	0	0	0	16.06	Hours on Diversion
Average Door to Roomed in Min	4.6	5.7	5.8					5.4	5.1	Average Door to Roomed in Min
Avg Boarded Time (BIC notified to ED Departure)	2:39	5:31	3:05							
Total Boarded Hrs	72	149	90					918	12675	*Total Boarded Hrs*
Count of Arrivals With >24 Hr Boarded Time	0	0	0	0	0	0	0	1	38	*Count of Arrivals With >24 Hr Boarded Time*
Count by Final Disposition										**Count by Final Disposition**
Dispo Not Yet Set	0	0	1					1	1	Dispo Not Yet Set
Admit	25	23	32					284	2572	Admit
Admit - ICU	1	5	0					22	266	Admit - ICU
AMA	0	1	1					8	96	AMA
Discharge	69	69	88					754	7143	Discharge
Eloped	0	1	2					5	86	Elope
Expired	1	0	0					3	15	Expired
LAFS/MSE Only	10	6	4					61	482	LAFS/MSE Only
LWBS	**0**	**0**	**0**					1	16	LWBS
Transfer	1	1	0					5	95	Transfer
LWBS Rate	0.0%	0.0%	0.0%					0.1%	0.1%	LWBS Rate
MSE Outcome										**MSE Outcome**
No EMC identified	10	8	13					111	1015	No EMC identified
Potential EMC	0	1	1					19	157	Potential EMC
LAFS/MSE Only	**10**	**6**	**4**	**0**	**0**	**0**	**0**	61	482	LAFS/MSE Only
Time in META	1:12	1:40	1:38					1:33	1:34	Time in META
META Count	14	17	26					218	2018	META Count
Mode Arrival										**Mode Arrival**
EMS	18	26	23					196	2131	EMS
Not EMS	89	80	105	0	0	0	0	950	8591	Not EMS
Pts With Admit Order										**Pts With Admit Order**
Sponsored	16	19	22					223	2133	Sponsored
Unsponsored	10	9	8					86	837	Unsponsored
Pts WithOut Admit Order										**Pts WithOut Admit Order**
Sponsored	57	54	67					541	5014	Sponsored
Unsponsored	24	24	31					294	2793	Unsponsored

Rationale:

Variation in OR productivity exists at UTMB, as reflected in variation in operating room start times and room turnover, length of stay, inpatient room turns, time from decision to admit of ED patients until they are placed in an inpatient bed. These represent variation in utilization and efficiency of current systems – a form of underuse of some services and overuse of other services.

By better managing flow and occupancy, and matching requirements with resources using such modeling efforts, we can drive a form of waste out of the UTMB system and be better stewards, preserving resources for more patient service.

Value stream mapping is a helpful method that can be used in Lean environments to identify opportunities for improvement in lead time. While process improvement methodologies have demonstrated value in reducing/eliminating waste and non-value added activities, these are difficult to measure, quantify and use to make a business case demonstrating a return-on-investment. As an innovative methodology, we propose only software implementation using sophisticated modeling tools because other core elements are already present.

System Dynamics Modeling (SDM) – a methodology and mathematical modeling technique for framing, understanding, and discussing the behavior of complex systems over time – can be used to evaluate the impacts of contemplated strategies and policy design – i.e., a macro system view. It helps describe how even seemingly simple systems display baffling nonlinearity.

Discrete Event Simulation (DES) – a methodology and mathematical modeling technique for representing the operation of a system as a chronological sequence of events – typically illustrates tactical and operational issues at the meso system level. Staff, rooms and equipment have different (specified) attributes. By investigating the effects of different quantities and varying attributes of entities and resources, the outcomes may be optimized.

Agent-Based Modeling (ABM) is a class of models for simulating the actions and interactions of multiple agents (hospital staff or groups) in an attempt to re-create and predict the appearance of complex phenomena. Algorithms will be created that generate realistic simulations of all aspects of the UTMB Perioperative Enterprise (virtual staff and supervisors, patients, facilities, supplies, etc.) and define their behaviors with a relatively few rules, and watch what happens.

Combining ABM with DEM and SDM, we will be able to investigate the effects on Case Volume, Utilization, Turnover Time, and Margin and the multi-factor interactions of such factors as: case mix and distributions of case durations; block time assignments – number, duration, days of week; allocation of various numbers of ORs for various procedures; scheduling of elective versus emergency cases; and "mixes" of staff on surgical teams as reflected in different task-based actions / durations / errors.

Relation between Project Choices and Community Needs

Our region has some of the highest healthcare costs in the US. Hospital readmission has been shown to be related to chronic illness self-management efficacy (including mental health and substance use issues), patient resources, access to primary and specialty care.

Unique Community Need Identification numbers

CN.10	High ED Utilization Rates
CN.11	30 Day Readmission Rates

Expansion or enhancement

During the course of this project, iterative models will allow us to extend our understanding of workflows across the health system to understand the "whole system." Once models have been identified, simulation of the impact of proposed changes can safely model outcomes of interventions. We will publish models so that others can benefit from replicating the process modeling. The sophisticate statistical modeling that will result from this proposal augment existing capabilities and, starting with core processes in the OR and the ED, will allow us to develop a whole system model to evaluate and improve patient flow throughout UTMB. All work prior to this have necessarily limited to local improvements.

Related Category 3 Outcome Measures: IT-5.3: Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). The baseline and goals for this improvement target will be established in DY2.

Reason/rationale for selecting outcome measure: IT-5.3 Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients

admitted to inpatient status (NQF 0497 strata ED 2.1). (Standalone measure)is the best measure that reflects the overall regional improvement area identified. In the effort to harmonize measures nationally, ED throughput has been reduced to key time targets. Here we focus on elapsed time for ED admission because efficiency in managing other resources in the hospital ultimately results in either efficient patient placement or bottlenecks for patients waiting in the emergency department. Since many patients without a medical home often seek care in the ED, any focus on improving efficiency and reducing expensive ED utilization will ultimately lower costs for the system.

Relationship to other Projects: This project's focus on using data systems to improve hospital efficiency and emphasis on emergency department and inpatient bed utilization ties to these Category 1 and 2 projects in our RHP: 094092602.1.9, 094092602.2.11, 094092602.2.8. All required reporting domains in Category 4 will be measured and reported on by the provider.

Relationship to Other Performing Providers' Projects in the RHP: This project focuses on designing, developing, and implementing a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency. There are no other related Category 2 similar projects in our RHP.

Plan for Learning Collaborative: Many of the projects chosen by RHP 2 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

To support our shared learning in RHP 2, we will participate in the regional learning collaborative that is based on similar health or system delivery challenges/projects and that focus on sharing knowledge, experience, and expertise. This learning collaborative will establish a venue via our regional social media capability, in-person, webinars, telephonically or what best accommodates the needs of the participants. The learning collaborative will establish its own schedule for meeting frequency with a minimum of meeting quarterly. The learning collaborative will be guided and facilitated by the regional anchor. The anchor and performing providers will work together to identify themes for the learning collaborative to focus on and improve. The learning collaborative will use data driven analysis to drive performance improvement and ultimately better serve the population in the region.

Project Valuation: Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.

- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.2.3	2.8.1	2.8.1 (A-F)	APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE HOSPITAL EFFICIENCY
The University of Texas Medical Branch at Galveston			094092602
Related Category 3 Outcome Measure(s):	**109372601.3.8**	**IT-5.3**	**IT-5.3 Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). (Standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-9]: Complete a value stream map, which is a detailed, real-time sequence of steps in a given process to identify value-added and non-value-added steps for the patient and staff Metric [P-9.1]: Value stream mapping Goal: Submission of completed value stream map for perioperative services Data Source: Value stream map Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,400,345 **Milestone 2** [P-1]: Target specific workflows, processes and/or clinical areas to improve Metric [P-1.1]: Prioritized processes for improvement. Goal: Submission of report with identified process priorities. Data Source: TBD Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,400,345	**Milestone 3** [P-2]: Identify/target metric to measure impact of process improvement methodology and establish baseline Metric [P-2.1]: Identification of impact metrics and baseline. Goal: Submission of UTMB efficiency reports Data Source: EMR, unit logs, OR Controls data system Milestone 3 Estimated Incentive Payment: $1,148,927 **Milestone 4** [P-14]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric [P-14.1]: Number of new ideas, practices, tools, or solutions tested by each provider. Goal: Quarterly project summary reflects progress on weekly data-driven tests of change. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Milestone 4 Estimated Incentive	**Milestone 5** [I-14]: Measure efficiency and/or cost Metric [I-14.1]: On-Time Start Goal: 80% of OR cases start on time. Numerator: OR cases in which briefing occurs within 15 minutes of scheduled time for first cases of the day (Monday-Friday) Denominator: all cases the same day (Monday-Friday) Data Source: OR logs, OpTime EMR data Exclusions: Pediatric cases and delay reasons "Transport ICU" & "Anesthesia Transport" Milestone 5 Estimated Incentive Payment: $2,460,274	**Milestone 6** [I-14]: Measure efficiency and/or cost Goal: 82% of OR cases start on time. Metric [I-14.1]: On-Time Start Numerator: OR cases in which briefing occurs within 15 minutes of scheduled time for first cases of the day (Monday-Friday) Denominator: all cases the same day (Monday-Friday) Data Source: OR logs, OpTime EMR data Exclusions: Pediatric cases and delay reasons "Transport ICU" & "Anesthesia Transport" Milestone 6 Estimated Incentive Payment: $2,127,877

109372601.2.3	2.8.1	2.8.1 (A-F)	APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE HOSPITAL EFFICIENCY
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 3 Outcome Measure(s):	**109372601.3.8**	**IT-5.3**	**IT-5.3 Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). (Standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Payment $1,148,926		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,800,689	Year 3 Estimated Milestone Bundle Amount: $2,297,853	Year 4 Estimated Milestone Bundle Amount: $2,460,274	Year 5 Estimated Milestone Bundle Amount: $2,127,877
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $9,686,693			

SECTION V:

E.Category 3:
Quality Improvements

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9, Right Care, Right Setting
Project Option: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure) Pressure (NCQA-HEDIS 2012, NQF 0018)[228]
Project Title: Extend Existing Pediatric Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER(S): 121805903.3.1
RHP PERFORMING PROVIDER/TPI: Angleton Danbury Medical Center/121805903

OUTCOME MEASURE DESCRIPTION:
Outcome Domain 9 Pediatric/Young Adult Asthma Emergency Department Visits was selected in conjunction with the chosen Category 1.1.2 Project of Expanding Existing Primary Care Services because offering increase availability and access to individuals to receive the appropriate care in the right setting and in a timely fashion can result in proper disease management and reduction in costly medical expenses.

The information collected for the baseline and measurement of this program will be from the Hospital Electronic Health Record. The numerator for this measurement is the percentage of patients with asthma who have greater than or equal to one visit in the ER for asthma during the measurement period. The denominator is all patients 2-20 diagnosed with Asthma during the measurement period. In DY 2 Project Planning (P-1) will be initiated as well as the establishment of baseline numbers (P-2). Planning documents will be used as a data source for the planning of the project and the Hospital EHR will be used to establish the baseline and rates. Since this is a new project, in DY 3 we will continue to collect data through our Hospital EHR to establish an accurate baseline numbers (P-2). In DY 4 and DY 5 our improvement target is to see a reduction in Pediatric/Young Adult Asthma Emergency Department Visits by an amount to be determined once our baseline is established. The improvement target will be measured in the same fashion as how the baseline information is collected. The numerator for this measurement is the percentage of patients with asthma who have greater than or equal to one visit in the ER for asthma during the measurement period. The denominator is all patients 2-20 diagnosed with Asthma during the measurement period.

RATIONALE:
In accordance with our Physician Development Plan, we have a critical, demonstrated need for additional primary care providers, particularly pediatricians. We currently only have one Angleton-based Pediatric Physician and he is quickly approaching retirement. We utilized several assessment tools to develop this Plan, including GMENAC (Graduate Medical Education Needs Assessment Council), external & internal surveys, Community Health Assessments as well as other statistical reports. There are a limited number of providers that accept new patients and not many that accept Medicaid. Our Angleton-based pediatrician attends to 50-60 patients daily with an active patient roster of about 2,500.

The Community Needs Assessment (CNA) reflects 44.2 Primary Care Physicians in the county versus the US average of 91 physicians per 100,000. We also identified that our county has several MUA 's and a high uninsured 0-18 population (Brazoria County 15.2 vs US average of 8.1 (CNA)). Angleton-Danbury Hospital District continuously works to ensure sustainable operations; yet, an ever increasing volume of no-pay patients and Medicaid makes this much more difficult for our already overburdened system.

Providing our pediatric population the Right Care in the Right Setting will ensure more appropriate utilization of services. Through the additional PCP we anticipate an increase from baseline in our patient volume by the end of the demonstration period.

Due to the overburdened primary care system in Brazoria County, a significant number of children are entering the emergency department for asthma related conditions. According to the Texas Department of Health Services Death Statistics, the mortality rate for Chronic Lower Respiratory Disease such as Asthma is 39.4-72.5 per 100,000.

Through proper management, education, and appropriate physician visits, we anticipate a decrease in the targeted pediatric asthma emergency room visits. Accurate information on these cases can be effectively pulled from the EHR in the Emergency Department.
Access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have better medical outcomes, thereby reducing unnecessary emergency department visits and preventable readmissions.
Our goal is to increase the pediatric patient volume over the established base line by the end of the demonstration period. This will be accomplished by the additional pediatrician practicing in the community. An additional pediatrician will provide a more cost effective patient experience with a focus on prevention, education, and management of various chronic diseases, therefore, reducing unnecessary costly emergency room visits and inpatient admissions.

Outcome Measure Valuation (Pediatric/Young Adult Asthma ED Visits)
The expansion of the pediatric clinic will fill the need for pediatric primary care services in community. Additional primary care services will allow individuals to receive services in a timely manner in the most appropriate setting. The project will promote education and chronic disease management so that individuals will be less likely utilizes more expensive healthcare option such as the ED, urgent care, or inpatient admissions.

Brazoria County is the 5th fastest growing and is among the largest counties in Texas. The current Angleton based pediatrician is a sole practitioner in the community and is near retirement age. His practice is at capacity and is open to see Medicaid patients. By adding an additional pediatrician to the community, individuals will be able to stay close to home while alleviating some of the demands on our current pediatrician.
The Community Needs Assessment clearly supports the needs for this project. Access Barriers (lack of personal resources and lack of insurance), primary care physician shortage, and high

chronic disease are proven factors within the community. Because of the demonstrated need of primary care, high Medicaid population, and explosive growth in the community – it was evident that this addition would add value to the community.

Providing the targeted population with proactive care early on in their chronic condition, this will result in savings if the condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring and treatment, ADHD anticipates a reduction in Pediatric Asthma Emergency Department Visits.

Currently, Angleton Danbury Hospital District is not receiving any additional federal funding to support this project.

121805903.3.1	IT-9.3	Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure)	
Angleton Danbury Hospital District			**121805903**
Related Category 1 or 2 Projects:	**121805903.1.1**		
Starting Point/Baseline:	**Establish Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project Planning Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 33,284	**Process Milestone 2 [P-2]** Establish Baseline Numbers Baseline cases of pediatric/young adult asthma emergency department visits: 63 visits Data Source: Hospital EHR Process Milestone 3 Estimated Incentive Payment: $42,868	**Outcome Improvement Target 1**[IT-9.3] [IT-9.3]: Pediatric/Young Adult Asthma Emergency Department Visits-NQF 1381 Improvement Target: Reduction in Pediatric Asthma Emergency Department Visits by 10% (57 visits) from baseline numbers established in DY 3. Data Source: EHR Numerator: Percentage of patients with asthma who have greater than or equal to one visit in the ER for asthma during the measurement period Denominator: All patients 2-20 diagnosed with Asthma during the measurement period. Goal: 57 pediatric asthma ED visits Estimated Incentive Payment*:* $62,187	**Outcome Improvement Target 2** [IT-9.3]:. [IT-9.3]: Pediatric/Young Adult Asthma Emergency Department Visits-NQF 1381 Improvement Target: Reduction in Pediatric Asthma Emergency Department Visits 20% (51 visits) from baseline numbers established in DY3 Data Source: EHR Numerator: Percentage of patients with asthma who have greater than or equal to one visit in the ER for asthma during the measurement period Denominator: All patients 2-20 diagnosed with Asthma during the measurement period. Goal: 51 pediatric asthma ED visits Outcome Improvement Target 3 Estimated Incentive Payment*:* $148,048
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $33,284	Year 3 Estimated Outcome Amount: $42,868	Year 4 Estimated Outcome Amount: $62,187	Year 5 Estimated Outcome Amount: $148,043

121805903.3.1	IT-9.3	Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381 (Standalone measure)	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects:	121805903.1.1		
Starting Point/Baseline:	Establish Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $286,382			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)
Project Title: Extend Existing Pediatric Primary Care Clinics-Primary Care Clinic Expansion

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 121805903.3.2

RHP PERFORMING PROVIDER/TPI: Angleton Danbury Medical Center/121805903

OUTCOME MEASURE DESCRIPTION:
There is a significant need for additional primary care services in the community. By opening a primary care clinic in the Angleton community we strive to provide services at the "Right Care, Right Setting". A business plan, architectural / construction documents, recruiting plan, and staffing plan will be developed to ensure the success of the project. A baseline will be established through the DY 1 and DY 2 data pulled from the EHR. With the additional primary care services in the community, chronic disease management, education, and services can be provided in the most appropriate setting in a timely manner.

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.

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 (Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059)

Diabetes is a costly and preventable disease. The community needs assessment has shown a demonstrated need for both primary care services and chronic disease management. Successful chronic disease management (OD-1) is key to lowering preventable healthcare cost and improving the quality of care of individuals diagnosed with these conditions. Easy access to healthcare, education, and effective management is essential for disease control. In DY 4 our improvement target will focus on Diabetes Care: HbA1c poor control (>9.0%) (IT-1.10). The numerator will be the percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. The denominator would be the members 18-75 years of age as of December 31 of the measurement year with diabetes (Type 1 or Type 2). This data will be collected through our EHR system. A baseline will be established. In DY5 IT-1.10 will continue to be measured. With the increase availability of primary care we anticipate seeing fewer individuals with poor A1c control in the targeted population. The goal for DY5 will be established once baseline rates are gathered.

Providing the targeted population with proactive care early on in their disease process will result in savings if the patient is managed and does not require expensive ED visits, impatient hospitalizations, or other extensive treatments. With proactive education, monitoring, and screening, ADHD anticipates fewer complications and better disease management in our targeted population.

Currently Angleton Danbury Hospital District is not receiving any additional federal funding to support chronic disease management.

121805903.3.2	3.IT-1.10	OD-1 IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects:	121805903.1.2		
Starting Point/Baseline:	Establish baseline for the number of Type 1 and Type 2 Diabetics for targeted population		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish Baseline Rates Metric: HbA1c Data Source: Clinic EHR Goal: Create data system to track A1c blood levels Rationale: Need to establish a baseline to show improvements Baseline: 153 targeted diabetic patients Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $16,642 **Process Milestone 2** [P-2]:Test Data Systems Data Source: EHR Metric: Data runs on EMR Goal: Consistent data mapping Rationale: This is a new metric to follow Process Milestone 2 Estimated Incentive Payment: $16,642	**Process Milestone 3 [P-4]** Conduct Plan Do Study Act cycles to improve data collection and intervention activities Data Source: **EHR** Process Milestone 3 Estimated Incentive Payment: $40,346	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 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: Diabetes is prevalent and costly with severe complications and can be controlled Outcome Improvement Target 1 Reduction of poor control of HbA1c of the targeted population of 153 (established in DY 2) by 20% - 30	**Outcome Improvement Target 2** [IT-1.10]:Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 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: Diabetes is prevalent and costly with severe complications and can be controlled Outcome Improvement Target 2 Reduction of poor control of HbA1c of the targeted population of 153 (established in DY 2) by 30% - 46

121805903.3.2	3.IT-1.10	OD-1 IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059	
Angleton Danbury Hospital District			**121805903**
Related Category 1 or 2 Projects:	**121805903.1.2**		
Starting Point/Baseline:	**Establish baseline for the number of Type 1 and Type 2 Diabetics for targeted population**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		patients. Estimated Incentive Payment*:* $62,187	patients. Estimated Incentive Payment*:* $148,043
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $33,284	Year 3 Estimated Outcome Amount: $40,346	Year 4 Estimated Outcome Amount: $62,187	Year 5 Estimated Outcome Amount: $148,043
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $283,860			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):

Outcome Measure: OD - 8 Perinatal Outcomes
Project Option: IT – 8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF#469) (Standalone measure)
Project Title: Extend Existing Pediatric Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 121805903.3.4 - PASS 3

RHP PERFORMING PROVIDER/TPI: Angleton Danbury Medical Center/121805903

OUTCOME MEASURE DESCRIPTION:
Outcome Domain 8 Perinatal Outcomes – IT-8.3 Early Elective Delivery was selected in conjunction with the chosen Category 1.1.2 Project of Expanding Existing Primary Care Services because offering increase availability and access to individuals to receive the appropriate care in the right setting and in a timely fashion can result in proper prenatal care management and reduction in costly medical expenses.

The information collected for the baseline and measurement of this program will be from the Hospital Electronic Health Record. The numerator is the number of patients with elective deliveries with a Principle Procedure Code or an Other Procedure Codes for one or more of the following:

1) Medical induction of labor as defined in Appendix A, Table 11.05 (manual.jointcommission.org) and
2) C-Section as defined in Appendix A, Table 11.06 while not in active labor or experiencing Spontaneous Rupture of Membranes (manual.jointcommission.org). The denominator is patients delivering newborns with >=37 and <39 weeks of gestation completed. Exclusions include: Principle diagnosis Code or Other Diagnosis Codes for conditions possible justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07, Less than 8 years of age, Greater than or equal to 65 years of age, Length of Stay > 120 Days, or Enrolled in clinical trials.

In DY 2 Project Planning (P-1) will be initiated as well as the establishment of baseline numbers (P-2). Planning documents will be used as a data source for the planning of the project and the Hospital EHR will be used to establish the baseline and rates. Since this is a new project, in DY 3 we will continue to collect data through our Hospital EHR to establish an accurate baseline numbers (P-2). In DY 4 and DY 5 our improvement target is to see a reduction in Early Elective Deliveries by an amount to be determined once our baseline is established. The improvement target will be measured in the same fashion as how the baseline information is collected. The numerator is the number of patients with elective deliveries with a Principle Procedure Code or an Other Procedure Codes for one or more of the following:

1) Medical induction of labor as defined in Appendix A, Table 11.05 (manual.jointcommission.org) and
2) C-Section as defined in Appendix A, Table 11.06 while not in active labor or experiencing Spontaneous Rupture of Membranes (manual.jointcommission.org). The denominator is patients delivering newborns with >=37 and <39 weeks of gestation completed. Exclusions include: Principle diagnosis Code or Other Diagnosis Codes for conditions possible justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07, Less than 8 years of age, Greater than or equal to 65 years of age, Length of Stay > 120 Days, or Enrolled in clinical trials.

OD: 8 IT – 8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone measure) Improvement Target: Reduction in Early Elective Deliveries by TBD from baseline numbers established in DY 2 and DY 3. Data Source: EHR

Numerator: Patients with elective deliveries with a Principle Procedure Code or an Other Procedure Codes for one or more of the following:

- Medical induction of labor as defined in Appendix A, Table 11.05 (manual.jointcommission.org)
- C-Section as defined in Appendix A, Table 11.06 while not in active labor or experiencing Spontaneous Rupture of Membranes (manual.jointcommission.org)

Denominator: Patients delivering newborns with >=37 and <39 weeks of gestation completed
Exclusions:

- Principle diagnosis Code or Other Diagnosis Codes for conditions possible justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay > 120 Days
- Enrolled in clinical trials

RATIONALE:

In accordance with our Physician Development Plan, we have a critical, demonstrated need for additional primary care providers. We currently only have two Angleton-based OB/GYN Physicians who are both at and beyond capacity. We utilized several assessment tools to develop this Plan, including GMENAC (Graduate Medical Education Needs Assessment Council), external & internal surveys, Community Health Assessments as well as other statistical reports. There are a limited number of providers that accept new patients and not many that accept Medicaid. Our Angleton-based OB/GYNs attends to 30-50 patients daily.

The Community Needs Assessment (CNA) reflects 44.2 Primary Care Physicians in the county versus the US average of 91 physicians per 100,000. We also identified that our county has several MUA's and a high uninsured 0-18 population (Brazoria County 15.2 vs. US average of 8.1 (CNA)). Angleton-Danbury Hospital District continuously works to ensure sustainable

operations; yet, an ever increasing volume of no-pay patients and Medicaid makes this much more difficult for our already overburdened system.
Providing our population the Right Care in the Right Setting will ensure more appropriate utilization of services. Through the additional OB/GYN we anticipate an increase from baseline in our patient volume by the end of the demonstration period.

Through proper management, education, and appropriate physician visits, we anticipate a decrease in the targeted pediatric asthma emergency room visits. Accurate information on these cases can be effectively pulled from the EHR in the Emergency Department.

Access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have better medical outcomes, thereby reducing unnecessary emergency department visits and preventable readmissions.

Our goal is to increase the OB/GYN patient volume over the established base line by the end of the demonstration period. This will be accomplished by the additional OB/GYN practicing in the community. An additional OB/GYN will provide a more cost effective patient experience with a focus on prenatal care, education, and management, therefore, reducing unnecessary costly emergency room visits and inpatient admissions.

Outcome Measure Valuation (Early Elective Delivery (Medicaid Adult Core Measure/NQF #469))

The expansion of the OB/GYN clinic will fill the need for OB/GYN primary care services in community. Additional primary care services will allow individuals to receive services in a timely manner in the most appropriate setting. The project will promote education and prenatal care management so that individuals will be less likely utilizes more expensive healthcare option such as the ED, urgent care, or inpatient admissions.

Brazoria County is the 5th fastest growing and is among the largest counties in Texas. The current Angleton based OB/GYNs practices are at capacity and beyond capacity and is among the few open to see Medicaid patients. By adding an additional OB/GYN to the community, individuals will be able to stay close to home while alleviating some of the demands on our current OB/GYN practitioners.

The Community Needs Assessment clearly supports the needs for this project. Access Barriers (lack of personal resources and lack of insurance), primary care physician shortage, and high chronic disease are proven factors within the community. Because of the demonstrated need of primary care, high Medicaid population, and explosive growth in the community – it was evident that this addition would add value to the community.

Providing the targeted population with proactive care early on in their chronic condition, this will result in savings if the condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive prenatal education, monitoring and treatment, ADHD anticipates a reduction in Early Elective Deliveries. Currently,

Angleton Danbury Hospital District is not receiving any additional federal funding to support this project

121805903.3.4	3.IT-8.3	Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone measure)	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects:	121805903.1.3		
Starting Point/Baseline:	Establish Early Elective Deliveries NQF #469		
Year 2 (10/1/2012 – 9/30/2013)	**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 timeline s and document implementation plans Metric: Program planning guidelines Data Source: Planning documents Goal: Complete implementation plan Rationale: Multiple providers will need to assist in the implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $114,212 **Process Milestone 2** P-2: Baseline Numbers: Total Deliveries: 371, 121 deliveries >=37 and <39 weeks, 20 documented elective deliveries Metric: Early Elective Deliveries Data Source: Hospital EHR Goal: Create data system to track Early Elective deliveries Rationale: Process Milestone 2 Estimated Incentive Payment: $114,212	**Process Milestone 3** P-2: Establish Baseline Numbers Metric: Early Elective Deliveries Data Source: Hospital EHR Goal: Create data system to track Early Elective Deliveries Rationale: Need to establish a baseline to show improvements 5% reduction in documented elective deliveries >=37 and <39 weeks Process Milestone 3 Estimated Incentive Payment: $237,938 **Outcome Improvement Target 1** IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure) a Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded b Data Source: EHR, Claims Baseline: 100 mammography of Medicaid and uninsured.	**Outcome Improvement Target 2** IT-8.3: Early Elective Delivery (Medicaid Core Measure/NQF #469) Improvement Target: Reduction in Early Elective Deliveries by 7% from baseline numbers established in DY 2 Data Source: EHR Numerator: Patients with elective deliveries with a Principle Procedure Code or an Other Procedure Codes for one or more of the following: • Medical induction of labor as defined in Appendix A, Table 11.05 (manual.jointcommission.org) • C-Section as defined in Appendix A, Table 11.06 while not in active labor or experiencing Spontaneous Rupture of Membranes (manual.jointcommission.org)	**Outcome Improvement Target 2** IT-8.3: Early Elective Delivery (Medicaid Core Measure/NQF #469) Improvement Target: Reduction in Early Elective Deliveries by 10% from baseline numbers established in DY2 Data Source: EHR Numerator: Patients with elective deliveries with a Principle Procedure Code or an Other Procedure Codes for one or more of the following: • Medical induction of labor as defined in Appendix A, Table 11.05 (manual.jointcommission.org) • C-Section as defined in Appendix A, Table 11.06 while not in active labor or experiencing Spontaneous Rupture of Membranes (manual.jointcommission.org) Denominator: Patients delivering newborns with >=37 and <39 weeks of gestation completed

121805903.3.4	3.IT-8.3	Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone measure)	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects:	121805903.1.3		
Starting Point/Baseline:	Establish Early Elective Deliveries NQF #469		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Denominator: Patients delivering newborns with >=37 and <39 weeks of gestation completed Exclusions: • Principle diagnosis Code or Other Diagnosis Codes for conditions possible justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay > 120 Days • Enrolled in clinical trials Goal: Estimated Incentive Payment*:* $119,400 **Outcome Improvement Target 3** IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure) a Numerator: Number of	Exclusions: • Principle diagnosis Code or Other Diagnosis Codes for conditions possible justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay > 120 Days • Enrolled in clinical trials Goal Outcome Improvement Target 3 Estimated Incentive Payment*:* $238,483 **Outcome Improvement Target 5** *IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)* *a Numerator: Number of*

121805903.3.4	3.IT-8.3	Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Standalone measure)	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects:	121805903.1.3		
Starting Point/Baseline:	Establish Early Elective Deliveries NQF #469		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded b Data Source: EHR, Claims Goal: 20% increase from DY 3 to 120 mammography of Medicaid and underinsured Estimated Incentive Payment: $279,600	*women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded b Data Source: EHR, Claims* Goal: 40% increase from DY 3 to 140 mammography of Medicaid and underinsured Estimated Incentive Payment: $558,793
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $228,424	Year 3 Estimated Outcome Amount: $237,938	Year 4 Estimated Outcome Amount: $398,000	Year 5 Estimated Outcome Amount: $798,276
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,662,638			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Project Title: Expand Existing Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112671602.3.1

RHP PERFORMING PROVIDER/TPI: Brazosport Regional Health System - Lake Jackson Family Medicine Center (LJFMC); Brazosport Regional Urgent Care Center/112671602

OUTCOME MEASURE DESCRIPTION:
The outcome domain chosen for the project is OD-6, Patient Satisfaction. The Improvement target chosen to supplement the outcome domain is IT-6.1, Percent improvement over baseline of patient satisfaction scores. The project proposes adding evening and weekend hours to the LJFMC in order to better serve the community outside of traditional working hours. In Year 2, we will be establishing a baseline rate for patient satisfaction using a formal measurement tool such as Press-Ganey patient satisfaction survey. Years 3, 4 and 5 will add additional non-traditional hours, scaling up each year, as well as adding an additional provider in year 4, extended Brazosport Regional Urgent Care Center hours in year 4, resulting in patient satisfaction to increase over the previous years in years 4 and 5 (TBD once baseline information is determined).
The process milestone for year 2 will be to establish a baseline rate for patient satisfaction using a formal survey tool, such as Press-Ganey patient satisfaction survey (P-2). The metric is to establish a baseline number of patients who indicate that they were satisfied with the ability to make an appointment in a timely and convenient manner so as to receive care and information more quickly.

The second process milestone chosen for year 3 is to conduct Plan Do Study Act (PDSA) cycles to improve data collection and clinic processes (P-4). The achievement metric is to conduct the PDSA cycles to monitor data quality and the effects of using the patient satisfaction information to improve the manner in which the clinics provide care. The goal is to conduct a PDSA cycle once per quarter and have the information reported to the BRHS Performance Improvement Committee.

RATIONALE:

The outcome domain, Patient Satisfaction, was chosen because we are currently hearing from patients that it would be more convenient if they could make appointments outside of the normal workday so they wouldn't need to miss work in order to see a physician. We know that care is sometimes delayed for several days simply due to lack of capacity. We also see patients from the LJFMC in our Urgent Care Center and Emergency Room during these non-traditional hours, who would be better and more cost effectively served by their chosen primary care provider. With primary care resources nearly exhausted in the Brazosport Regional Health System service area, the additional Brazosport Regional Urgent Care Center hours, and possibly services and/or providers, will also serve to treat these primary care visits.

The process milestone to establish baseline rates for the project (P-2) is important because the baseline data must be correct in order for the goals to be attainable. Without accurate baseline data, the project cannot hope to create realistic goals.

Outcome Measure Valuation

The project outcome measure on patient satisfaction is an appropriate measure because the current lack of available appointment times in the clinic has caused difficulties for potential patients seeking care. Because the demand is high for primary care in the community, volume increases in both LJFMC and the Urgent Care Center can be reasonably expected. As such, monitoring only the volume, provider, and patient visit increases will not generate an overall picture of the project effectiveness. The demand is very evident in the community and patient satisfaction regarding the entire primary care experience, specifically appointment availability, along with the additional milestones will generate valid feedback on the entire primary care expansion project.

112671602.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Brazosport Regional Health System - Lake Jackson Family Medicine Center and Brazosport Regional Urgent Care Center			**112671602**
Related Category 1 or 2 Projects:	**112671602.2.1**		
Starting Point/Baseline:	**The clinic is not currently collecting patient satisfaction surveys, but from conversations with patients, we know that there is a need for evening and weekend hours.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 **P-2:** Establish baseline rates for patient satisfaction score for patients seen at the LJFMC. **Data Source:** LJFMC Patient Survey, LJFMC patient records/EMR **Rationale**: the baseline data must be correct in order for the goals to be attainable; information will also support Plan Do Study Act activities. **Process Milestone 1Estimated Incentive Payment:** $23,643	**Process Milestone 2** **P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** LJFMC Patient Survey, LJFMC patient records/EMR **Rationale**: the validity of the data collection process should be monitored and check periodically to evaluate clinic effectiveness, amending as necessary, and monitoring the effects of each change. **Process Milestone 2 Estimated Incentive Payment:** $11,659 **Outcome Improvement Target 1** **Outcome Domain OD-6**: Patient Satisfaction **Improvement Target IT 6.1**: Percent improvement over baseline of patient satisfaction scores. 1) Are patients getting timely care, appointments, and	**Outcome Improvement Target 2** **Outcome Domain OD-6 –** Patient Satisfaction **IT 6.1:** Percent improvement over baseline of patient satisfaction scores. 1) Are patients getting timely care, appointments, and information **Numerator:** Number of surveys indicating satisfactory scores. **Denominator:** Total number of surveys received. **Goal**: TBD, based on baseline **Data Source:** LJFMC and Brazosport Regional Urgent Care Center Patient Survey **Rationale**: By extending hours of LJFMC and Brazosport Regional Urgent Care Center into the evenings and on Saturday, we will be able to serve more patients at hours that are more convenient for them. We expect to see our satisfaction scores	**Outcome Improvement Target 3** **Outcome Domain OD-6 –** Patient Satisfaction **IT 6.1:** Percent improvement over baseline of patient satisfaction scores. 1) Are patients getting timely care, appointments, and information **Numerator:** Number of surveys indicating satisfactory scores. **Denominator:** Total number of surveys received. **Goal**: TBD, based on baseline **Data Source:** LJFMC and Brazosport Regional Urgent Care Center Patient Survey **Rationale**: By extending hours of LJFMC and Brazosport Regional Urgent Care Center into the evenings and on Saturday, we will be able to serve more patients at hours that are more convenient for them. We expect to see our satisfaction scores

112671602.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Brazosport Regional Health System - Lake Jackson Family Medicine Center and Brazosport Regional Urgent Care Center			**112671602**
Related Category 1 or 2 Projects:	**112671602.2.1**		
Starting Point/Baseline:	**The clinic is not currently collecting patient satisfaction surveys, but from conversations with patients, we know that there is a need for evening and weekend hours.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	information **Numerator**: Number of surveys indicating satisfactory scores. **Denominator**: Total number of surveys received. **Goal**: TBD, based on baseline **Data Source**: LJFMC Patient Survey **Outcome Improvement Target 1 Estimated Incentive Payment**: $11,659	rise by TBD. **Outcome Improvement Target 2 Estimated Incentive Payment:** $49,976	rise by TBD. **Outcome Improvement Target 3 Estimated Incentive Payment:** **$**153,944
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $23,643	Year 3 Estimated Outcome Amount: $23,319	Year 4 Estimated Outcome Amount: $49,976	Year 5 Estimated Outcome Amount: $153,944
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 250,882			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Project Title: Introduce, Expand, or Enhance Telemedicine/Telehealth

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112706003.3.4 - PASS 2

RHP PERFORMING PROVIDER/TPI: CHRISTUS Jasper Memorial Hospital/112706003

OUTCOME MEASURE DESCRIPTION:
Outcome Measure is IT-6.1 uses patient satisfaction surveys to report the percent improvement over baseline of patient satisfaction scores measuring whether patients are getting timely specialty care, appointments, and information.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. The improvement target will be determined based on baseline numbers established in DY3.
- DY5:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. The improvement target will be determined based on baseline numbers established in DY3.

RATIONALE:
This outcome measure for DY4-DY5 was selected because CHRISTUS considers enhanced patient satisfaction/experience to be one of its highest priorities. This outcome measure will provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on care provided by CHRISTUS' new clinics. The surveys will be designed to produce comparable data on the patient's perspective on care provided at the clinics that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting will serve to enhance public accountability in health

care by increasing the transparency of the quality of institutional care funded in part by public investment.

For DY2-DY3, Process milestones P-1 through P-3 were chosen due to the current lack of a survey instrument and other resources needed to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3, we will establish baseline numbers for patient satisfaction.

Outcome Measure Valuation: The valuation of the outcome measure takes into account the transformational impact of the outcome, the population served by the related project 1.1.1 (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree collaboration involved in the project, and the sustainability of the project. This outcome is related to a large project involving the opening of two clinics in underserved areas of the community. It is anticipated these clinics will have a large indigent volume with many patients suffering from chronic illnesses such as diabetes. Providing a medical home for these patients will improve their quality of life and reduce health care costs.

112706003.3.4	IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects:	112706003.1.1		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric: Planning documentation Baseline/Goal: Submit planning documentation Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment: $36,708 **Process Milestone 2**: P-3 – Develop and test data systems Metric: Planning and testing documentation Baseline/Goal: Submit planning and testing documentation Data Source: Planning and testing documents Process Milestone 2 Estimated Incentive Payment: $36,708	**Process Milestone 3:** P-2 – Establish baseline rates Metric: Documentation of baseline rates Baseline/Goal: Submit documentation of baseline rates. Data Source: Internal Documents and Patient Satisfaction Surveys	**Outcome Improvement Target 1**: IT-6.1 - Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD based on baseline numbers established in DY3. Data Source: Patient Satisfaction Surveys	**Outcome Improvement Target:** IT-6.1 - Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD based on baseline numbers established in DY3. Data Source: Patient Satisfaction Surveys

112706003.3.4	IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects:	112706003.1.1		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,416	Year 3 Estimated Outcome Amount: $85,240	Year 4 Estimated Outcome Amount: $136,241	Year 5 Estimated Outcome Amount: $327,721
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $622,618			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores.
Project Title: Establish more primary care clinics

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 138296208.3.1

RHP PERFORMING PROVIDER/TPI: CHRISTUS Hospital – St. Elizabeth/138296208

OUTCOME MEASURE DESCRIPTION:
Outcome Measure is IT-6.1 uses patient satisfaction surveys to report the percent improvement over baseline of patient satisfaction scores measuring whether patients are getting timely specialty care, appointments, and information.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. The improvement target will be determined based on baseline numbers established in DY3.
- DY5:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. The improvement target will be determined based on baseline numbers established in DY3.

RATIONALE:
This outcome measure for DY4-DY5 was selected because CHRISTUS' considers enhanced patient satisfaction/experience to be one of its highest priorities. This outcome measure will provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on care provided by CHRISTUS' new clinics. The surveys will be designed to produce comparable data on the patient's perspective on care provided at the clinics that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care funded in part by public investment.

For DY2-DY3, Process milestones P-1 through P-3 were chosen due to the current lack of a survey instrument and other resources needed to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3, we will establish baseline numbers for patient satisfaction.

Outcome Measure Valuation: The valuation of the outcome measure takes into account the transformational impact of the outcome, the population served by the related project 1.1.1 (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree collaboration involved in the project, and the sustainability of the project. This outcome is related to a large project involving the opening of two clinics in underserved areas of the community. It is anticipated these clinics will have a large indigent volume with many patients suffering from chronic illnesses such as diabetes. Providing a medical home for these patients will improve their quality of life and reduce health care costs.

138296208.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
CHRISTUS Hospital – St. Elizabeth			138296208
Related Category 1 or 2 Projects:	1382962081.1		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric: Planning documentation Baseline/Goal: Submit planning documentation Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment*:* $14,095.35 **Process Milestone 2**: P-3 – Develop and test data systems Metric: Planning and testing documentation Baseline/Goal: Submit planning and testing documentation Data Source: Planning and testing documents	**Process Milestone 3:** P-2 – Establish baseline rates Metric: Documentation of baseline rates Baseline/Goal: Submit documentation of baseline rates. Data Source: Internal Documents and Patient Satisfaction Surveys Process Milestone 3 Estimated Incentive Payment: $98,030	**Outcome Improvement Target 1**: IT-6.1 - Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD based on baseline numbers established in DY3. Data Source: Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $104,869	**Outcome Improvement Target:**: IT-6.1 - Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD based on baseline numbers established in DY3. Data Source: Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $113,988

138296208.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
CHRISTUS Hospital – St. Elizabeth			138296208
Related Category 1 or 2 Projects:	1382962081.1		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment: $14,095.35			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $140,953	Year 3 Estimated Outcome Amount: $163,383	Year 4 Estimated Outcome Amount: $262,173	Year 5 Estimated Outcome Amount: $626,936
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,193,445			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1 Primary Care and Chronic Disease Management
Project Option: IT – 1.7 Controlling High Blood Pressure
Project Title: Expand Existing Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 019053001.3.1

RHP PERFORMING PROVIDER/TPI: Galveston County Health District/Coastal Health & Wellness/019053001

OUTCOME MEASURE DESCRIPTION:
The outcome domain is OD-1, Primary Care and Disease Management.
The Improvement Target is IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018), a standalone measure. The goal is to improve the measure by 5% over baseline by the end of the 5 year project. The numerator is the number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator is: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The Data Source is the electronic medical record.

The starting point/base line for the IT is to be developed during year 2 using the new electronic health record. Past performance on this indicator has been approximated by chart audit for the clinic population and was 43% controlled for 2011 by audit of 70 records. We believe that a more accurate baseline will be set using the whole population in the electronic medical record. The milestone for DY2 is to establish a baseline rate. The metric is equal to the metric for the IT. The numerator is the number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator is: patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The data source is the electronic medical record of Coastal Health & Wellness.

The process milestones for DY2 and DY3 are:
P-2, Establish baseline rates DY2. The metric will be determined as above with the numerator and denominator defined above. The Data source is Coastal Health & Wellness Electronic Medical Record. The goal is to establish an accurate baseline based on data from the entire project population. The rationale is: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14

to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities (DY3). Metric: the committee assigned to this improvement project will propose and develop at least three interventions during DY3 designed to impact the outcome goal by lowering BP in the target population. These interventions will be tested and if effective, adopted for the whole population. The data source will be the minutes and written PDSA cycle notes of the responsible committee. The goal is to identify and implement processes and interventions to support control of patients' high blood pressure. The rationale is as above.

RATIONALE:

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

Outcome Measure Valuation

The project area is 1.1 Expand primary care. This will be accomplished through expanding primary care access by hiring primary health care providers and also by implementing a mobile clinic that will provide primary health care in underserved areas such as the remote Bolivar peninsula (no primary health care exists) and the Bayshore area. This project will support the recruitment of staff and funding staff as well as maintaining and supporting the mobile clinic (but not purchasing the mobile facility).

A. The valuation is affected by the target population. The Coastal Health & Wellness clinic serves any Galveston County resident. The Community Needs Assessment documents that there are identified access barriers including lack of personal resources 12.1%-22.6% living below the federal poverty level and 12.8%-28.3% who stated they could not see a doctor due to cost. Lack of insurance is documented at 13.2%-20.7% under 19 and 21.1%-29.9% under 65.The FQHC provides discounted primary care on a sliding fee schedule for uninsured patients. In 2011, Coastal Health & Wellness patient population was approximately 80% uninsured and 96% of patients were below 200% of federal poverty.
B. The valuation is affected by the severity. The community needs assessment documents that the hypertension mortality rate per 100,000 is 6.9-13.1. In 2011, of Coastal Health & Wellness patients, 2453 of 13,576 medical patients (18%) had a primary diagnosis of hypertension.

C. The valuation is affected by cost effectiveness. Coastal Health & Wellness, a federally-qualified health center, has functioned as a primary care clinic since 1970. The clinic currently has a high rate of productivity as compared to all community health centers nationally. Adding providers to the current clinic mix of staff will result in efficiency as there is enough infra-structure already present in terms of clinic space, nurses, billing staff and lab staff as well as Federal Tort Claims Act protection (liability protection). The project only proposes to add medical aides, one eligibility staff and a data specialist as well as three primary care providers.
D. The valuation is affected by community benefit as it will increase community access to health care as well as quality. The mobile component will add community benefit, especially to areas with little or no health care access at all.

019053001.3.1	IT – 1.7	Controlling High Blood Pressure	
Galveston County Health District/Coastal Health & Wellness			019053001
Related Category 1 or 2 Projects:	019053001.1.1		
Starting Point/Baseline:	Baseline will be created in DY 3 by measuring percentage of Controlled Blood Pressures vs. Total Target Patient Population		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates. Data Source: EMR Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $20,000	**Process Milestone 2** **[P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities. Data Source: EMR Process Milestone 2 Estimated Incentive Payment: $200,000	**Outcome Improvement Target 1** IT-1.7: Increase the number of patients whose most recent blood pressure is adequately controlled. Improvement Target: increase number of patients with controlled blood pressure by 2.5% over the baseline rate Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $250,000	**Outcome Improvement Target 3** [IT-1.7]: Increase the number of patients whose most recent blood pressure is adequately controlled. Improvement Target: increase number of patients with controlled blood pressure by 5% over 3 year rate baseline Data Source: EMR Outcome Improvement Target 3 Estimated Incentive Payment*:* $350,000
Year 2 Estimated Outcome Amount: $20,000	Year 3 Estimated Outcome Amount: $200,000	Year 4 Estimated Outcome Amount: $250,000	Year 5 Estimated Outcome Amount: $350,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $820,000			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET): Behavioral Health Alternative to
Outcome Measure: OD-9 Right Care, Right Setting
Project Option: IT-9.2 Emergency Department Appropriate Utilization
Project Title: Behavioral Health Alternative to Hospitalization: Crisis Respite Expansion to Brazoria County

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.1

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:
The Crisis Respite expansion project will provide a local resource for individuals requiring less intensive crisis intervention/stabilization services. Additionally, this facility will serve as a 'step-down' resource for those whom are not ready for community integration following discharge from an inpatient setting. The Crisis Respite program allows for a least restrictive environment thus reducing the number of emergency department visits. Will conduct regular stakeholder meetings to identify capacity and needed resources, determine timelines and document implementation plan. Utilize established spreadsheets and other encounter data so to assess and evaluate the quality of services provided. Compare internal data repository with statewide data collection repository. Stakeholders will participate in regular project meetings, and will participate in plan do study act cycles in an effort to improve data collection and intervention activities. Increased utilization of available crisis respite beds will help to aid in the reduction of Emergency Department visits and/or subsequent hospitalizations by 10% each funding year.

RATIONALE:
There is currently no intermediate respite service resource available in Brazoria County for adults with mental illness. This project provides a less restrictive environment for those requiring stabilization due to a behavioral health concern. Without this alternative, adults with mental illness are at risk of hospitalization and criminal justice involvement. This voluntary, short-term respite program affords individuals in need the opportunity for crisis resolution and 24/7 supervision facilitating stabilization prior to integration into the community; thus reducing the recidivism rates within the criminal justice and inpatient mental health system. The Center will also participate in at least twice annual meetings within the RHP to address 'lessons learned' and collaborative implementation of improvements within the region.

Outcome Measure Valuation
Population Affected: Assuming an average length of stay of seven days at the eight bed facility, there is a capacity of approximately 400 admissions per year; of which almost all will be primarily uninsured or on Medicaid.

Score: Total of 3 points for moderately-sized population affected (2) and the number of uninsured/Medicaid population to be served (1).

Severity: Per the June 2012 Qualitative Community Health Assessment for Brazoria County, almost 50% of responders stated that the increase to the number of places for mental health services was very important (highest ranking). The re-start of the proposed project (originally put into operating with a short term grant following Hurricane Ike) was specifically requested by Brazoria County elected officials and healthcare leaders. Currently there are no intermediate mental health respite resources available in Brazoria County for adults with mental illness.

Score: Total of 5 points for strong support on Community Needs Assessment (2) and the significant impact on population to be served by providing option not currently available and minimizing wait time for crisis respite for both the individual and family (3).

Cost-Effectiveness: Cost of an inpatient bed day at regional psychiatric hospital (GCC Contract) is approximately $470/bed day. Approximate cost of the proposed crisis respite bed day is projected to be $122/bed day or 74% less than the regional psychiatric hospital.

Score: Total of 5 points for very low cost per person; especially in comparison to regional psychiatric inpatient stay.

Community Benefit: The proposed project will improve access to services sooner when needed, improve overall quality of the service received by the consumer and family, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing a cost effective alternative, and will work in collaboration with other community resources including but not limited to the County Mental Health Deputies, local community hospitals, and NAMI Gulf Coast.

Score: Total of 4 points for its improvement of access (1), improvement of quality (1), improves costs (1), and collaboration (1).

135222109.3.1	IT-9.2	ED Appropriate Utilization(standalone measure)	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.1		
Starting Point/Baseline:	No crisis services available in Brazoria County		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Data source: Attendance records P-2 Establish baseline rates Data source: Established spreadsheets and other encounter data P-3 Develop and test data systems Data source: Compare internal data repository with statewide data collection repository	**Process Milestone 2 [P-4]** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data source: Meeting agenda records as well as sign-in/attendance records P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Data source: Meeting agenda records as well as sign-in/attendance records	**Outcome Improvement Target 2** **OD- 9 Right Care, Right Setting** **IT-9.2 ED appropriate utilization** ***(Standalone measure)*** • Reduce Emergency Department visits for target conditions o Behavioral Health/Substance Abuse **Starting Point/Baseline:** Currently there are no Crisis Respite services available in Brazoria County. **Metric:** Number of admissions to Crisis Respite facility. **Data Source:** Established spreadsheet and other encounter data. Outcome Improvement Target 2 Estimated Incentive Payment: $ 175,425	**Outcome Improvement Target 3** **OD- 9 Right Care, Right Setting** **IT-9.2 ED appropriate utilization** ***(Standalone measure)*** • Reduce Emergency Department visits for target conditions o Behavioral Health/Substance Abuse **Starting Point/Baseline:** Currently there are no Crisis Respite services available in Brazoria County. **Metric:** Number of admissions to Crisis Respite facility. **Data Source:** Established spreadsheet and other encounter data. Outcome Improvement Target 3 Estimated Incentive Payment: $ 327,969
Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 28,294	Process Milestone 2 Estimated Incentive Payment: $ 131,188		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each Milestone/outcome improvement target): $28,294	Year 3 Estimated Outcome Amount: $131,188	Year 4 Estimated Outcome Amount: $175,425	Year 5 Estimated Outcome Amount: $ 327,969
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 662,876			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores
Project Title: Wellness & Recovery for Youth

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.2

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:
Outcome Domain-6 Patient Satisfaction fits with the chosen Category 1 project "Wellness & Recovery for Youth" because the Improvement Target 6.1 Percent of Improvement over Baseline of Patient Satisfaction Scores directly measures satisfaction with access to expanded primary care capacity. Upon admission to Wellness & Recovery for Youth, a survey will be provided to establish a baseline of satisfaction with initial access of services. Additional data will be collected for each year of the project following the establishment of the baseline.

Numerator: Percent Improvement in targeted patient satisfaction domain
Data Source: Patient survey
Denominator: Number of patients who were administered the survey
1. Are patients getting timely care, appointments and information;
(Standalone Measure)
2. Patient's overall health status/functional status. (**Standalone Measure**)

Year Two will maintain the Process Milestone [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. A task force will assist in assuring the needs of the local community and school districts are considered, resources are best utilized, realistic timelines are considered and a documented implementation plan is reviewed. The Metric for the Process Milestone is to: Identify task force to provide feedback and guidance during project development using the data source of meeting minutes reviewing resources, capacity, timelines and implantation plan. The Project Goal for Year Two is the Youth Wellness & Recovery Task Force will address the interests of the local community to improve access to psychiatric medication services for youth while providing a wellness approach. In addition, Year Two will [P-2] Establish Baseline Rates utilizing the Metric of assessing the level of functioning of youth served. Youth Wellness & Recovery Project Goal will be to demonstrate overall improved level of functioning of youth consistently participating in services. Assessment of a youth's level of functioning will be made by an evidenced based tool selected for the project.

Year Three will involve the dissemination of findings, including lessons learned and barriers encountered, to stakeholders in the form of our previously developed task force. The Metric

for the Process Milestone is to: report development of the project's progress and barriers to the established task force. This report will include data regarding number of patients admitted and overall functioning of youth served. The goal for this year is to demonstrate projected completion of task focused steps to full development of project and demonstrate ability to overcome barriers to continue to improve project. Data Source will include timelines and task force meeting minutes.

For Years Four and Five, the Wellness & Recovery for Youth will utilize Outcome Domain – Patient Satisfaction. For Year Four, the Improvement Measure will be the percentage of improvement over baseline of patient satisfaction scores implementing the standalone measure as to whether or not patients are receiving timely care, appointments and information/education. The starting point for this improvement measure will be baseline satisfaction survey results using the metric of percentage of improvement in targeted patient satisfaction. Percentage improvement anticipated is approximately 10% improvement from baseline for this Improvement Measure. The data source is the patient surveys – CG-CAHPS3. . For Year Five, the Improvement Measure continues as percentage of improvement over baseline of patient satisfaction scores, however, the standalone measure will change for this year to patient's overall level of functioning. The starting point for this measure remains as the baseline satisfaction survey results. As with Year Four, the metric for this final year of the project will directly relate to the improvement in the targeted patient satisfaction domain to number of patients administered the survey. The Data Source is the patient surveys utilizing an instrument to be determined at a later date that will assess the youth's overall level of functioning to accompany our original satisfaction survey.

Data Source: CG-CAHPS3 or other developed evidenced based satisfaction assessment tool, available in formats and language to meet patient population

RATIONALE:

Many youth are in need of psychiatric care beyond what their Primary Care Physician is medically comfortable providing. The number of Board Certified Child & Adolescent Psychiatrists in our local area who accept Medicaid is limited. Further, youth in need of psychiatric medication services will benefit from a service promoting physical health as well as psychological health within one approach. Incorporation of subspecialist child and adolescent psychiatric care will facilitate identification of medical disorders that may impact psychiatric disorders and vice versa. (Please note for this project, outcome improvement targets will be determined in year two for implementation in year 3.)

Outcome Measure Valuation

Population Affected: The proposed project is directed towards children with Medicaid or CHIP, who have no place to transition to because of the lack of providers other than the Gulf Coast Center who will take Medicaid or CHIP, and/or their complex psychiatric history. Participation in the proposed project would be available to those served by the Gulf Coast Center, as well as community referrals.

Score: Total of 3 points for moderate-sized population affected (2) and the number of uninsured/Medicaid population to be served (1).

Severity: Per the June 2012 Qualitative Community Health Assessment for Brazoria County, almost 50% of responders stated that the increase to the number of places for mental health services was very important (highest ranking). Per the June 2012 Qualitative Community Health Assessment for Galveston County, one of the more commonly stated challenges to health was the lack of access to affordable / available health resources including behavioral health. Currently there are no available resources for children in services who are in need of a less restrictive level of care and promotion of physical health, to transition to.

Score: Total of 5 points for strong support on Community Needs Assessment (2) and the significant impact on population to be served by providing option not currently available and an opportunity for enhancement of the youth's complete overall functioning (3).

Cost-Effectiveness: Over the four year period, the proposed project is estimated to cost approximately $1.2 million, and serve over 325; for an estimated average cost of $3,690/youth served during the four year project – considered extremely cost efficient for the population served, and the services and supports proposed to be provided.

Score: Total of 4 points for low cost per person.

Community Benefit: The proposed project will improve access to youth to transition to less restrictive level of care services as soon as clinically appropriate, improve overall quality of services received and expand the services provided, is innovative and transformative to the services currently available for youth in Galveston and Brazoria counties diagnosed with a behavioral health issue, will work in collaboration with community medical resources, and will improve costs long term by transitioning youth who are ready to transition to more appropriate care thus allowing youth whose lower level of functioning requires the more intensive care of the Gulf Coast Center an opportunity into services – who otherwise cannot access needed Gulf Coast Center due to the lack of capacity or openings in Gulf Coast Center services.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), innovative (1), collaborative (1), and improves costs long term (1).

135222109.3.2	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.2		
Starting Point/Baseline:	**Starting point/baseline for first IT: Upon admission to services, a survey will be provided to establish a baseline of satisfaction with initial access of services.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Identify task force to provide feedback and guidance during project development. Goal: Youth Wellness & Recovery Task Force will address the interests of the local community to improve access to psychiatric medication services for youth while providing a wellness approach. Data Source: Meeting minutes reviewing resources, capacity, timelines and implementation plan. Process Milestone 1 ***Estimated*** Incentive Payment*:* $14,147 P-2 Establish baseline rates Metric: Assess level of functioning of youth served for improved status.	P-5 Disseminate findings, including lessons learned and best practices, to stakeholders. Metric: Report development of project's progress and barriers to task force. Report number of patients admitted and overall functioning of youth served. Goal: Demonstrate projected completion of task focused steps to full development of project and demonstrate ability to overcome barriers to improve project. Data source: Utilize timelines, and task force meeting minutes. Process Milestone 3 Estimated Incentive Payment: $131,188	Outcome Improvement Target 1 OD- 6 Patient Satisfaction IT- 6.1 40% Improvement over baseline of patient satisfaction scores. IT-6.1.1 Are getting timely care, appointments, and information *(Standalone measure)* Starting Point/Baseline: Baseline satisfaction survey results Metric: Percent improvement in targeted patient satisfaction domain / number of patients administered the survey. Data Source: Patient Surveys. Outcome Improvement Target 1 Estimated Incentive Payment*:* $175,425	Outcome Improvement Target 2 OD- 6 Patient Satisfaction IT- 6.1 60% Improvement over baseline of patient satisfaction scores. IT-6.1.1 Are getting timely care, appointments, and information *(Standalone measure)* Starting Point/Baseline: Baseline satisfaction survey results Metric: Percent improvement in targeted patient satisfaction domain / number of patients administered the survey. Data Source: Patient Surveys. Outcome Improvement Target 2 Estimated Incentive Payment*:* $327,929

135222109.3.2	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	**135222109.1.2**		
Starting Point/Baseline:	**Starting point/baseline for first IT: Upon admission to services, a survey will be provided to establish a baseline of satisfaction with initial access of services.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Goal: Demonstrate overall improved level of functioning of youth consistently participating in services. Data source: Select evidenced based assessment tool to use throughout project. Process Milestone 2 Estimated Incentive Payment: $14,147			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,294	Year 3 Estimated Outcome Amount: $131,188	Year 4 Estimated Outcome Amount: $175,425	Year 5 Estimated Outcome Amount: $327,969
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $662,876			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD – 9 Right Care, Right Setting
Project Option: IT– 9.1 Decrease in mental health admissions and readmissions to inpatient psychiatric
Project Title: Behavioral Health Alternative to Hospitalization: Ambulatory Detox hospitalization and/or criminal justice settings such as jails or prisons

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.3

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:

IT-9.1 Decrease in mental health admissions and readmissions to inpatient psychiatric hospitalization and/or criminal justice settings such as jails or prisons *(Standalone measure)*

The chosen process milestones are P-1 Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan; P-2 Establish baseline rates which will with review of jail and hospital reports; P-3 Develop and test data systems by implementing computer software or programming; P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities and provide means for quick response to needed changes; and P-5 Disseminate findings, including lessons learned and best practices, to stakeholders.

The measure for this outcome improvement target will be a numerator-the number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to psychiatric hospital unit or criminal justice setting (e.g. jail, prison, etc.) within the measurement period, and the denominator-the number of individuals receiving project intervention(s) Data Sources for determining the measures will be the claims, encounter and clinical record data, anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records with an improvement of 25% by the end of the waiver.

RATIONALE:
Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

There were 635 individuals admitted in 2012 to Psychiatric Unit or County Jail for Brazoria County and Galveston County who presented with a need for detoxification. Project will result in a 25% reduction in those admissions by admitting 159 participants to the Ambulatory Detox Program. The ongoing engagement of stakeholders will foster rapid change and utilization of Ambulatory Detox as an alternative to incarceration or hospitalization. The Center will also participate in at least twice annual meetings within the RHP to address 'lessons learned' and collaborative implementation of improvements.

Outcome Measure Valuation

Population Affected: Per Region 2's Health Partnership power point presentation with governmental data, it was reported that in Galveston County 17.8% of the population reported excessive drinking; which exceeds both the State and US percentages. In both the Galveston and Brazoria counties Qualitative Community Health Assessments, a large percentage indicated that alcohol and drug abuse treatment services were not available. The proposed project will be available for both Galveston and Brazoria counties to help address this identified need; and almost all will be either uninsured or on Medicaid.

> Score: Total of 4 points for relatively large population affected (3) and the number of uninsured/Medicaid population to be served (1).

Severity: In both the Galveston and Brazoria counties Qualitative Community Health Assessments, a large percentage indicated that alcohol and drug abuse treatment services were not available. Currently, there are only two residential detox beds available for a three county area (including the two counties in this project- Brazoria and Galveston County); and there are no Brazoria or Galveston County local residential detox slots for female clients; they currently have to travel to Houston to receive services separating them from their family support. Additionally, impacting behavioral health services and availability of limited psychiatric inpatient beds, is the fact that 75% of those admitted to the local mental health inpatient unit have a co-occurring disorder; with the substance abuse being the mitigating factor.

> Score: Total of 4 points for strong support on Community Needs Assessment (1) and the significant impact on population to be served by providing appropriate options not currently available for persons presenting with a substance abuse issue; and assuring the availability of limited psychiatric inpatient beds as needed for persons presenting with a mental illness issue as the mitigating factor (3).

Cost-Effectiveness: Cost of an inpatient bed day at regional psychiatric hospital (GCC Contract) is approximately $470/bed day. The proposed project is expected to cost approximately $255,000 per year; and serve around 350 persons a year...for an estimated four year total cost of $1 million serving 1,400, or $730 per person served. Compared to an average length of stay of seven days - the inpatient stay cost would be around $3,290 as compared to $730.

> Score: Total of 4 points for a low cost per person; especially in comparison to regional psychiatric inpatient stay.

Community Benefit: The proposed project will improve access to the right services sooner, improve overall quality of the service, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing a cost effective alternative, is a new and transformative initiative for behavioral health services by creating an immediately available alternative for someone presenting with a co-occurring disorder when the substance abuse

issue is the mitigating factor and identifying that issue up front; and will work in collaboration with other community resources including but not limited to the Mental Health Deputies, local law enforcement, local community hospitals, and NAMI Gulf Coast.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves long term costs (1), transformative (1), and collaboration (1).

135222109.3.3	IT-9.1	Right Care, Right Setting- Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.3		
Starting Point/Baseline:	Baseline will be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Data Source: Meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $9,431 **Process Milestone 2 P-2** Establish baseline rates Data Source: Jail & Hospital reports Process Milestone 2 Estimated Incentive Payment: $9,431 **Process Milestone 3 P-3** Develop and test data systems Data Source: Program reports Process Milestone 3 Estimated Incentive Payment: $9,432	**Process Milestone 4 P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities**]** Data Source: **Program reports** Process Milestone 3 Estimated Incentive Payment: $65,594 **Process Milestone 5 P-5** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: **Program reports** Process Milestone 3 Estimated Incentive Payment: $65,594	**Outcome Improvement Target 1** IT-9.1: Improvement Target: 15% Decrease in substance abuse/mental health admissions and readmissions to inpatient psychiatric hospitalizations and/or criminal justice settings such as jails or prisons *(Standalone measure)* Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to psychiatric hospital unit or criminal justice setting (e.g. jail, prison, etc.) within the measurement period Denominator: The number of individuals receiving project intervention(s) Data Source: Claims/ encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records Outcome Improvement Target 1 Estimated Incentive Payment*:* $175,425	**Outcome Improvement Target 2** IT-9.1: Improvement Target: 25% Decrease in substance abuse/mental health admissions and readmissions to inpatient psychiatric hospitalizations and/or criminal justice settings such as jails or prisons *(Standalone measure)* Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to psychiatric hospital unit or criminal justice setting (e.g. jail, prison, etc.) within the measurement period Denominator: The number of individuals receiving project intervention(s) Data Source: Claims/ encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records Outcome Improvement Target 2 Estimated Incentive Payment*:* $327,969

135222109.3.3	IT-9.1	Right Care, Right Setting- Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.3		
Starting Point/Baseline:	Baseline will be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,294	Year 3 Estimated Outcome *Amount*: $131,188	Year 4 Estimated Outcome Amount: $175,425	Year 5 Estimated Outcome Amount: $327,969
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $662,876			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
Project Option: IT-3.8 Behavioral Health /Substance Abuse 30 day Readmission Rate
Project Title: Telemedicine Access to ED and Adult MH routine services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.4

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:
IT-3.8 Behavioral Health /Substance Abuse 30 day Readmission Rate

The use of telepsychiatry services in the local emergency department(s) will ease the demand on the emergency department personnel when patients present to the ED with psychiatric issues/crises. The use of Board Certified Psychiatrists to determine most appropriate level of care to include wide-range of pharmacological management options, and extensive community resource options with the help of on-site workers; thus, reducing the need for hospitalization or other higher level of care services unnecessarily. Having the telepsychiatry services available through an open access process in place for routine Adult Mental Health services can avoid unnecessary encounters to the ED due to prolonged wait times for access to needed services.

Readmissions to the hospital will be avoided through immediate telepsychiatric services in the ED to redirect the individual to a less restrictive environment or providing necessary outpatient treatment at that time. Hospital discharge clients receive an initial follow up appointment with the local outpatient provider, however the individual may need a more intensive follow up or follow along immediately following their hospital stay. Utilizing an open access model to telepsychiatric services within the Adult Mental Health intake department, individuals may resolve issues through the intake department prior to the need for additional encounters at local Emergency Departments.

Patient satisfaction will be measured to determine if the individuals needs and not just the overall communities needs are being met. It is expected that patient satisfaction of the services they are receiving will gradually increase as the project is implemented and the services improve. Individuals avoiding return admissions to the hospital and remaining in the community and the ability to be connected to long term outpatient services in a timely manner is also expected to indicate a growing satisfaction level. The level of patient satisfaction is expected to reach 75% by the end of the waiver.

In order to meet the needs of the community and determine the effectiveness of the project, scheduled stakeholder meetings and program staffing meetings will employ the use of Plan Do

Study Act cycles and rapid cycle change processes. Reviews and testing of the local data collection system and appointment schedules will also be conducted to ensure accuracy and timeliness in service provision. In partnership with local stakeholders, the project will also explore the expansion of telepsychiatry service provision in other areas of the Center's catchment area during subsequent funding years. The Center will also participate in at least twice annual meetings within the RHP to address 'lessons learned' and collaborative implementation of improvements.

RATIONALE:

Currently, there are no telepsychiatry services available within the 5 local Emergency Departments in the Center's 2-county catchment area. This project provides electronic psychiatric care services in Emergency Departments to increase patient access to mental health services and treatments. Without this access to an on-site specialist, some hospitalizations are likely to occur unnecessarily.

Currently the availability of Adult Mental Health Intake Department staff limits the access to ongoing outpatient mental health services. Due to limited resources there is a lengthy wait to be seen for specialty services and increases the risk for crisis episodes and undo hospitalizations. Through telepsychiatry services the wait time to be seen is reduced and access to services are expedited. Also, the ability to provide linkage from a hospital discharge to ongoing outpatient services for individuals needing more intense engagement will be available for the needed service and avoid additional encounters with ED staff and hospital readmissions.

One of the greatest challenges facing the U.S. healthcare system is to provide quality care to the large segment of the population, which does not have access to specialty physicians because of factors such as geographic limitations or socioeconomic conditions. The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care, particularly for communities located in rural and remote areas. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers. There are a large number of identified individuals currently waiting to access the local community adult mental health system. These individuals are awaiting access to a psychiatrist in order to determine eligibility and to receive outpatient services. Providing the telepsychiatry services in the ED and in the Intake department of the local outpatient Intake department, the number of hospital admissions and readmissions will be reduced.

For the past fiscal year in Brazoria County there were 61 initial Telemed Psychiatric evaluations through the MCOT crisis system. There were 100 screenings conducted by MCOT in the local Brazoria County ED. There were 45 crisis related follow-up physician appointments via telemed in Brazoria County. The Angleton Adult Clinic Intake program has had a need for approximately 20 Medicaid initial psychiatric evaluation appointments per month. This need is equal to 240 initial physician evaluation appointments per year. The reverenced 240 appointments

represents the Medicaid demand on the system, there are other payer sourced individuals and GR individuals that could also utilize the Intake program.

Increased performance and usage in the future.
The 100 screenings conducted in the ED could result in the distinct use of an embedded telemed initial psychiatric evaluation service. The use of the service with a psychiatrist could divert individuals from an acute inpatient stay by determining alternative treatment options not always readily realized by ED departments. The use of the telemed evaluations will likely increase once the telemed service in the ED is made known to local stakeholders. An example of likely increased usage will be from the areas of local law enforcement officials whom are more likely to utilize the service for rapid psychiatric evaluations located in the locally based ED and divert from the expensive travel distances to an inpatient facility.
The 61 initial and 45 follow-up psychiatric appointments will likely increase with the increased availability of the telemed equipment and services provided in the clinic and local ED. Historically serving approximately 450 individuals annually for ED visits, telemed evaluations, follow up telemed appointments, and outpatient intake Medicaid clients, in Brazoria County, the 4 year project total would approach 2000 individuals. The Potentially Preventable Readmissions would decrease by approximately 15% by the end of DY4 and 30% by end of DY5.

Outcome Measure Valuation
Population Affected: By stationing telemedicine equipment and qualified mental health personnel directly in Emergency Departments, and at the front door of services for the Gulf Coast Center as proposed in this project, there will be significant impact on a relatively large portion of the populations. Starting with a key community hospital in Brazoria County is critical, especially considering that the lack of access to community resources specifically mental health care in Brazoria County is below that of not only the State average, but also that of the US - as indicated in RHP2's Community Needs Assessment (CNA). Of those that will be impacted by this proposed project, almost all will be either uninsured or on Medicaid.

Score: Total of 4 points for relatively large population affected (3) and the number of uninsured/Medicaid population to be served (1).

Severity: Per the June 2012 Qualitative Community Health Assessment for Brazoria County, almost 50% of responders stated that the increase to the number of places for mental health services was very important (highest ranking). The severity of the situation is further stress by the lack of access to community resources specifically mental health care in Brazoria County is below that of not only the State average, but also that of the US - as indicated in RHP2's Community Needs Assessment (CNA). Additionally indicated in the CNA for Brazoria and Galveston counties is that there are long wait list for mental health care; and the rate of access to a psychiatrist in Brazoria County is also below not only that of the State average but also that of the US. Placing telemedicine equipment in the ED's as well as the Intake Department of the Center (consider the front door into services), would provide access to mental health clinicians and psychiatrics currently unavailable. Currently there are no telemedicine services for Behavioral Health provided in the Emergency Departments (ED) or the Center's Intake Department. The lack of this takes valuable ED personnel time from addressing physical health issues and emergencies, and delays appropriate response to the mental health issue that

brought the individual to the Emergency Department; and many times results in unnecessary inpatient psychiatric admissions for situations that could be treated on an outpatient basis or with substance abuse treatment or other community resources. Without immediate access to a psychiatrist at the Intake Department, delays assessment completion and entry into services.

Score: Total of 5 points for strong support on Community Needs Assessment (2) and the significant impact on the population to be served by providing this proposed service not currently available and minimizing the impact on Emergency Department personnel, and greatly improve the response to a mental health emergency for both the individual and family; and more timely assessment completion and referral to services (3).

Cost-Effectiveness: The Texas Council of Community Centers presented in their 2011 Mental Health Funding Savings report to the Texas LBB that the cost of an Emergency Department visit for a person presenting with a Mental Health crisis was $1,256 per visit. The estimated total four year cost of the proposed program is approximately $1 million; and over 2,000 individuals during the four year period projected to be served by the program for an approximate per person cost of $516 or only 40% of an ED visit.

Score: Total of 5 points for very low cost per person.

Community Benefit: The proposed project will improve access to appropriate services sooner when needed, improve overall quality of the service provision by minimizing Emergency Department wait time or being placed on a wait list, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing a cost effective alternative, is an innovative approach to addressing the lack of access to mental health services, and will work in collaboration with other community resources including but not limited to local community hospitals and emergency departments, the County Mental Health Deputies, local law enforcement, and NAMI Gulf Coast.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves costs (1), innovative (1), and collaboration (1).

135222109.3.4	IT-3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.4		
Starting Point/Baseline:	**Starting Point/Baseline: Currently there are no psychiatric telemedicine services available in the ED or for routine access to adult mental health services.**		
Year 2 (10/1/2012 – 9/30/2013)	**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 plan. Data Source: Attendance sign-in sheet. Process Milestone 1 Estimated Incentive Payment: $10,641 **Process Milestone 2** P-2 Establish Baseline Rates Data Source: Hospital admission and discharge data reports and local electronic encounter reporting system. Process Milestone 2 Estimated Incentive Payment: $10,641 **Process Milestone 3** P-3 Develop and test data systems Data Source: Local data collection system and appointment schedule Process Milestone 3 Estimated Incentive Payment: $10,641	**Process Milestone 4** P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Data Source: Attendance sign-in sheet. Process Milestone 4 Estimated Incentive Payment: $29,324 **Process Milestone 5** P-3 Develop and test data systems Data Source: Local data collection system and appointment schedule Process Milestone 5 Estimated Incentive Payment: $29,324 **Process Milestone 6** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Meeting agenda and sign in rosters. Process Milestone 6 Estimated Incentive Payment: $29,324	**Outcome Improvement Target 2** OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs) IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)* a. Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission. b. Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission	**Outcome Improvement Target 3** OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs) IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)* a. Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission. b. Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission Estimated decrease of 30% in readmissions by end of DY5.

135222109.3.4	IT-3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.4		
Starting Point/Baseline:	**Starting Point/Baseline: Currently there are no psychiatric telemedicine services available in the ED or for routine access to adult mental health services.**		
Year 2 (10/1/2012 – 9/30/2013)	**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 7 P-5 Disseminate findings, including lessons learned and best practices, to stake holders Data Source: Meeting agenda and sign in roster. Process Milestone 7 Estimated Incentive Payment: $29,324 **Outcome Improvement Target 1** OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs) IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)* *a* Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary	Estimated decrease of 15% in readmissions by end of DY4. **Data Source:** Hospital admission and discharge data reports and local electronic encounter reporting system. Outcome Improvement Target 2 Estimated Incentive Payment: $196,063	**Data Source:** Hospital admission and discharge data reports and local electronic encounter reporting system. Outcome Improvement Target 3 Estimated Incentive Payment: $366,553

135222109.3.4	IT-3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.4		
Starting Point/Baseline:	**Starting Point/Baseline: Currently there are no psychiatric telemedicine services available in the ED or for routine access to adult mental health services.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission. b Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission Total served to be estimated at 450 DY3. **Data Source:** Hospital admission and discharge data reports and local electronic encounter reporting system. Outcome Improvement Target 1 Estimated Incentive Payment: $29,325		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,623	Year 3 Estimated Outcome Amount: $146,621	Year 4 Estimated Outcome Amount: $196,063	Year 5 Estimated Outcome Amount: $366,553

135222109.3.4	IT-3.8	Behavioral Health /Substance Abuse 30 day readmission rate (Standalone measure)	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.1.4		
Starting Point/Baseline:	Starting Point/Baseline: Currently there are no psychiatric telemedicine services available in the ED or for routine access to adult mental health services.		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $740,860			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs) OD–9 Right Care, Right Setting
Project Option: IT–9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
Project Title: Behavioral Health Crisis Stabilization Alternatives to Hospitalization: Crisis Respite & Response – Intellectual & Developmental Disabilities (IDD)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.5

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:
Outcome Domain- 9 Right Care, Right Setting fits with the chosen Category 1 project 'Behavioral Health Crisis Stabilization Alternatives to Hospitalization: Crisis Respite &Response – Intellectual & Developmental Disabilities (IDD)' because the Improvement Target 9.1 directly addresses the situation at hand regarding unnecessary incarceration of people with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD/ASD) due to behavioral incidents directed toward their caregivers in Brazoria County and Galveston County:

Decrease in mental health admissions and readmissions to inpatient psychiatric facilities and/or criminal justice settings such as jails or prisons *(Standalone measure).* The metric will be to track the number of individuals with IDD/ASD receiving project intervention(s) who had a potentially preventable admission or readmission to a criminal justice setting (e.g. jail, prison, etc.) or psychiatric hospitalization within the measurement period/ The number of individuals receiving project intervention(s). The data source will be Claims/ encounter and clinical record data; regional community psychiatric hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records.

The Gulf Coast Center IDD and Crisis staff met with Brazoria County criminal justice representatives in 2012 at the request of the Brazoria County District Attorney due to County concern for the number of people with IDD/ASD jailed for behavioral incidents. Process measure P-1 Project planning will provide the means to engage stakeholders, identify current capacity and needed resources in the community, determine timelines and document implementation plan. Although the metric is not defined, it is anticipated that the metric will the establishment of regular meetings and wide representation of community participants. Data source will be attendance lists and meeting agenda with the goal to collaborate resources and to assess the best interventions to address behavioral health needs of persons with IDD/ASD requiring law enforcement or Mobile Crisis Outreach Team intervention. The rationale is that stakeholder involvement fosters commitment to a common goal.

It is anticipated that 12 people will be diverted from the jail and/or psychiatric hospitalization and participate in crisis respite interventions specific for people with IDD/ASD in year 3 and 4 and that by year 5, 18 people will be diverted which will be a 50% increase in services. Process measure P-2 will establish baseline rates. The project will implement P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities and P-5 to disseminate findings, including lessons learned and best practices, to stakeholders.

RATIONALE:

Brazoria County District Attorney's office and law enforcement officials met with Gulf Coast Center crisis services and IDD services in 2012 regarding need for alternative interventions for persons with IDD/ASD who have behavioral crises requiring that the person be removed from the home for their own protection or for the protection of caregivers. When a person with IDD/ASD has a behavioral crisis that cannot be resolved and places them at risk of harming themselves or others, they may be either incarcerated or hospitalized because more appropriate behavioral interventions are unavailable. It is estimated that 12 people with IDD will receive project interventions and be diverted from incarceration or inpatient hospitalization. Neither the jail nor the hospital is equipped or designed for people IDD/ASD whose crisis stems from behavioral outbursts. By intervening with certified applied behavioral analysts disruptive behavioral outbursts can be curtailed. Crisis respite specifically targeting severe behaviors can provide a setting in the community that can focus on the behaviors and thus avoid unnecessary psychiatric hospitalization and arrest. The Center will also participate in at least twice annual meetings within the RHP to address 'lessons learned' and collaborative implementation of improvements.

Outcome Measure Valuation

Population Affected: Though a relative small portion of the population will be served by this project (approximately 42 individuals over the four year period); all will be either uninsured or on Medicaid.

> Score: Total of 2 points for relatively small population affected (1) and the number of uninsured/Medicaid population to be served (1).

Severity: In both Brazoria and Galveston Counties Qualitative Community Health Assessments, the need due to the lack of behavioral healthcare support and services consistently was ranked as a high priority. And though persons with Intellectual and Developmental Disabilities (IDD) is not specifically noted; the need for additional supports and services - especially as it relates to providing crisis respite services - is critical. Local law enforcement and representatives from the counties District Attorney's offices, have identified this as a critical need. There are no short term emergency respite alternatives for persons with IDD; and as such, these individuals inappropriately end up in local jails or waiting in local emergency departments or hospitalized in a mental health psychiatric inpatient unit - and at a time when specialized care and attention is needed...exasperating their crisis situation, not providing appropriate care, and possibly creating disruption in or even loss of their living situation.

> Score: Total of 4 points for moderate support on Community Needs Assessment (1) and the significant impact on the fragile population to be served by not providing appropriate options during these times of emergency crisis (3).

Cost-Effectiveness: The proposed project is expected to cost approximately $250,000 per year or $1 million for the four year project; and serve an estimated total of 42 individuals...for an estimated $24,000 per person served. Whereas they may appear high, for the service provided and the savings within the community resulting from the diversion of an un-necessary incarceration or hospitalization; the cost is considered reasonable.
Score: Total of 2 points for high cost per person.
Community Benefit: The proposed project will improve access to appropriate services sooner when needed, improve overall quality of the services received by the individual and family, improve long term costs by reducing un-necessary hospital admissions or incarceration by providing an appropriate alternative upfront, is a new and transformative initiative for behavioral health services by creating an immediately available and appropriate alternative for someone with an intellectual disability presenting in crisis that would not result in immediate incarceration or inappropriate hospitalization, and will work in collaboration with other community resources including but not limited to the Mental Health Deputies, local law enforcement, local community hospitals, Mobile Crisis Outreach Team, and the Arc of the Gulf Coast.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves costs (1), transformative (1)and collaboration (1).

135222109.3.5	IT-9.1	Right Care, Right Setting	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	**135222109.1.5**		
Starting Point/Baseline:	**Met with Brazoria County criminal justice representatives in 2012**		
Year 2 (10/1/2012 – 9/30/2013)	**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: Attendance lists, meeting agenda Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,818 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program reports Process Milestone 2 Estimated Incentive Payment: $10,819	**Process Milestone 3 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Project reports Process Milestone 3 Estimated Incentive Payment: $ 60,192 **Process Milestone 4 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Project reports Process Milestone 4 Estimated Incentive Payment: $40,128	**Outcome Improvement Target 1 IT-9.1** Decrease in behavioral health admissions and readmissions to inpatient psychiatric facilities and/or criminal justice settings such as jails or prisons for people with IDD *(Standalone measure)* Improvement Target: 12 people with IDD to be diverted from inpatient psychiatric facilities and/or criminal justice settings through project interventions. Data Source: Claims/ encounter and clinical record data; inpatient psychiatric hospital records, criminal justice system records, local MH authority and state MH data system records Outcome Improvement Target 1 Estimated Incentive Payment*:* $134,148	**Outcome Improvement Target 2 IT-9.1** Decrease in behavioral health admissions and readmissions to inpatient psychiatric facilities and/or criminal justice settings such as jails or prisons for people with IDD *(Standalone measure)* Improvement Target: 18 people with IDD to be diverted from inpatient psychiatric facilities and/or criminal justice settings through project interventions. Data Source: Claims/ encounter and clinical record data; inpatient psychiatric hospital records, criminal justice system records, local MH authority and state MH data system records Outcome Improvement Target 2 Estimated Incentive Payment*:* $250,800
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $21,637	Year 3 Estimated Outcome Amount: $100,320	Year 4 Estimated Outcome Amount: $134,148	Year 5 Estimated Outcome Amount: $250,800
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $506,905			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9 Right Care, Right Setting
Project Option: IT-9.2 ED Appropriate Utilization
Project Title: Expand Existing Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 284333601.3.1 - PASS 2

RHP PERFORMING PROVIDER/TPI: Liberty Dayton Regional medical Center/284333601

OUTCOME MEASURE DESCRIPTION:
LDRMC plans to reduce non-urgent and chronic encounters in our ED by 5% by the end of the waiver period.

We selected 2 process milestones for this category. The first milestone is P-1 project planning. The second is P-2 establish baseline rates.

RATIONALE: We selected 2 process milestones for this category. The first milestone is project planning. By establishing a committee to develop guidelines and processes, it will be much easier for all stakeholders involved to stay focused on the overall goal and outcome. In order to measure our goal of reducing our non-urgent and chronic ED encounters by 5% over the waiver period, we must establish a baseline. Having guidelines that establish or identify a non-urgent or chronic patient is the first step in realizing our goal.

LDRMC plans to reduce non-urgent and chronic encounters in our ED by 5% by the end of the waiver period. We feel the best way to achieve this outcome is to plan a strategy with specific guidelines and processes and to establish a baseline in which to measure our goal. By recruiting medical providers and other ancillary medical professionals, we will be able to identify and transition these patients into a more appropriate setting or medical home. Improving the health of these patients and reducing the operating cost of the Hospital.

Outcome Measure Valuation: In order to put a value on this category, we believe it is imperative that we continue to retain the physicians and mid-levels we recruited in DY 2 and DY 3. The competition for these physicians and mid-levels, both statewide and nationally, will be fierce. Since LDRMC is located in a rural area, with limited capital and resources, it is imperative that we retain these providers. As we continue to transition these patients to our clinic, it will be necessary to have the space available to accommodate the increased traffic. By reducing the cost in the ED, it will help alleviate the burden on the indigent care funding sources, Liberty County Hospital District No. 1 and the County of Liberty. This will definitely have a positive impact on our community. We have placed a value of $3,537,416 for years 4 and 5 of the waiver period.

284333601.3.1	3.IT.9.2	ED Appropriate Utilization	
Liberty Dayton Regional Medical Center			284333601
Related Category 1 or 2 Projects:	284333601.1.1		
Starting Point/Baseline: DY 4	To Be Determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project Planning Data Source: Project Planning Documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 1** P-2: Establish Baseline Rates Data Source: ED Registry Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Outcome Improvement Target 2** IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Visits by 5% Data Source: ED Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,689,804.00	**Outcome Improvement Target** IT-9.2 ED Appropriate Utilization Improvement Target: Reduce ED Utilization by 5% over DY 4 Data Source: ED Registry Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,847,612.00
Year 2 Estimated Outcome Amount: $136,588	Year 3 Estimated Outcome Amount: $158,585	Year 4 Estimated Outcome Amount: $253,471	Year 5 Estimated Outcome Amount: $609,712
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,158,356			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-2 Potentially Preventable Admissions
Project Option: IT-2.10 Flu and pneumonia admission rate
Project Title: Expand Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 139172412.3.1

RHP PERFORMING PROVIDER/TPI: Memorial Medical Center of East Texas-Lufkin/139172412

OUTCOME MEASURE DESCRIPTION:

- DY2
  - Process Milestone P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- DY3
  - Process Milestone P-3 Develop and test data systems.
- DY4
  - Outcome Improvement Target 1 IT 2.10 Flu and pneumonia admission rate--improve/decrease admission rate for flu and pneumonia by 2%
- DY5
  - Outcome Improvement Target 1 IT 2.10 Flu and pneumonia admission rate--improve/decrease admission rate for flu and pneumonia by 4%

RATIONALE:
Rank for Health Outcomes for the 3 counties in Memorial Health System of East Texas' primary service area, Angelina, Polk and San Augustine, is 177, 220 and 214 of 221 respectively. Smoking rate for Angelina County is 24% and Polk County is 27% vs. State average of 19%. No data on smoking is available for San Augustine County.

DRG 194 Simple Pneumonia is the 5th most common admitting diagnosis for Texas. For the Lufkin Community DRG 194 is the number one diagnosis coded at discharge. It also makes up 33% of all discharges for the Lufkin Community using TMF data for Oct. 1, 2011 through March 31, 2012.

COPD and Asthma are the second and third most common Ambulatory Care Sensitive Conditions (ACSC). Both these underlying conditions, when not actively managed by a PCP have pneumonia as a direct sequel.

We do not expect to be able to develop infrastructure to allow us to track ACSC. However, with the implementation of the Paragon system and eClinicalWorks practice management, EHR software, we will be able to accurately track admissions and discharges for DRG 194.

Outcome Measure Valuation

The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

IT 2.10 Flu and pneumonia admission rate reduction

A. Population Affected
   - Measure: All adults over 18 years in primary service area (107,428).
   - Score: 3 points awarded for significant population affected, and 1 extra point for Medicaid/Uninsured population.
B. Severity
   - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.
C. Cost Effectiveness
   - Score: 4 points awarded for a low cost per person.
D. Community Benefit
   - Score: 4 points awarded; 1 for access; 1 for quality; 1 for cost; 1 for collaborative

139172412.3.1	IT-2.10	Flu and Pneumonia Admission Rate (standalone measure)	
Memorial Medical Center of East Texas-Lufkin			**139172412**
Related Category 1 or 2 Projects:	**139172412.1.1**		
Starting Point/Baseline:	**The baseline pneumonia admission rate is 17.3% and the baseline flu admission rate is TBD in DY2.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Planning documents. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $30,287.5 **Process Milestone 2**: P-3 Develop and test data systems Data Source: Internal testing documents and systems Process Milestone 2 Estimated Incentive Payment: $30,287.5	**Process Milestone 3:** P-4 Conduct PDSA cycles to improve data collection and intervention activities. Data Source: Internal documents and systems Process Milestone 3 Estimated Incentive Payment: $70,214	**Outcome Improvement Target 1:** IT 2.10 Flu and pneumonia admission rate. Data Source: EHR, Claims. Improvement Target: 2% reduction in admissions from baseline Outcome Improvement Target 1 Estimated Incentive Payment*:* $112,669	**Outcome Improvement Target 2:** IT 2.10 Flu and pneumonia admission rate. Data Source: EHR, Claims. Improvement Target: 4% reduction in admissions from baseline Outcome Improvement Target 2 Estimated Incentive Payment*:* $269,427
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $60,575	Year 3 Estimated Outcome Amount: $70,214	Year 4 Estimated Outcome Amount: $112,669	Year 5 Estimated Outcome Amount: $269,427
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $512,885			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-2 Potentially Preventable Admissions
Project Option: IT-2.1 Congestive Heart Failure Admission rate (CHF) Standalone Measure
Project Title: Increase Training of Primary Care Workforce-Outreach

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 139172412.3.2

RHP PERFORMING PROVIDER/TPI: Memorial Medical Center of East Texas-Lufkin/139172412

OUTCOME MEASURE DESCRIPTION:

- DY2
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-3 Develop and test data systems
- DY3
  - P-4 Conduct PDSA cycles to improve data collection and intervention activities
  - OD-2 Potentially Preventable Admissions
- DY4
  - IT-2.1 Congestive Heart Failure Admission rate (CHF) Standalone Measure - goal is to improve (reduce) CHF admission rates by 2% over baseline
- DY5
  - IT-2.1 Congestive Heart Failure Admission rate (CHF) Standalone Measure - goal is to improve (reduce) CHF admission rates by 4% over baseline

RATIONALE:
Managing CHF requires a multidisciplinary team including Nurse Educators, Dietitians, Pharmacists, Physical and Occupational Therapists and Social Workers working with the PCP. When any of these specialties are lacking the approach is fragmented and increased hospitalizations result. Of all the readmission measures, CHF is the most sensitive to availability of the inter-disciplinary team.

Outcome Measure Valuation
The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This

approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

IT-2.1 Congestive Heart Failure Admission rate reduction

A. Population Affected
    - Measure: All adults over 18 years with chronic diseases in primary and secondary markets.
    - Score: 3 points awarded for significant population affected, and 1 extra point for Medicaid/Uninsured population.
B. Severity
    - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.
C. Cost Effectiveness
    - Score: 4 points awarded for a low cost per person.
D. Community Benefit
    - Score: 5 points awarded; 1 for access; 1 for quality; 1 for cost; 1 for transformative; 1 for collaborative.

139172412.3.2	3.IT-2.1	Potentially Preventable Admissions, Congestive Heart Failure Admission rate (CHF) Standalone Measure	
Memorial Medical Center of East Texas			139172412
Related Category 1 or 2 Projects:	139172412.1.2		
Starting Point/Baseline:	The baseline congestive heart failure admission rate is 23.5%.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	***Year 4 (10/1/2014 – 9/30/2015)***	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: copies of planning documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $32,069 **Process Milestone 2**: P-3 Develop and test data systems Data Source: McKesson Internal data system Process Milestone 2 Estimated Incentive Payment: $32,069	**Process Milestone 3:** P-4 Conduct PDSA cycles to improve data collection and intervention activities Data Source: copies of PDSA documents, committee meetings Process Milestone 3 Estimated Incentive Payment: $74,345	**Outcome Improvement Target 1**: IT-2.1 Congestive Heart Failure Admission rate (CHF) Improvement Target: 2% reduction in CHF admission rate from baseline. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $119,297	**Outcome Improvement Target 2** : IT-2.1 Congestive Heart Failure Admission rate (CHF) Improvement Target: 4% reduction in CHF admission rate from baseline. Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $285,275
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $64,138	Year 3 Estimated Outcome Amount: $74,345	Year 4 Estimated Outcome Amount: $119,297	Year 5 Estimated Outcome Amount: $285,275
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $543,055			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1 Primary Care and Chronic Disease Management
Project Option: IT-1.7 Controlling High Blood Pressure
Project Title: Expand Primary Care Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.1

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital/131030203

OUTCOME MEASURE DESCRIPTION:
Addressing the issue of controlling high blood pressure will include a process of project planning, establishing baselines, implementing interventions and providing services to control blood pressure. The first process milestone will address project planning in Year 2. Project planning will engage stakeholders, identify current capacity and needed resources, determine timelines and create implementation plans. The second process milestone will occur in Year 3 and will focus on establishing the baseline rate of patients with controlled blood pressure. This baseline will derive from patient records (EHR and Registry data).

The outcome improvement target will be controlling high blood pressure. The numerator will be the number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. The denominator would be: the number of patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The data source for this information will be patient records (EHR and Registry data). In Year 4, the Outcome Improvement Target will be a 5% improvement in blood pressure control over the baseline established in Year 3. In Year 5, the Outcome Improvement Target will be a 10% improvement in blood pressure control over the baseline **RATIONALE:**
The above process milestones and outcome improvement targets were chosen because they are the most reasonable methods for program improvement. The health status measure of controlling hypertension is recognized as one of the best methods of disease prevention for heart disease, stroke and renal failure. Hypertension is known as a silent killer because an individual may have high blood pressure and not be aware of their condition. Hypertension is easily assessed at each patient appointment and the data is easily attainable from the patients' electronic health records. Interventions through patient education from providers and community health workers can be easily implemented.

Outcome Measure Valuation
The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). Based on 2005-2008 BRFSS data, those with hypertension make up 33.4% of the Nacogdoches County population. Using the rate of 33.4%, the uninsured population with hypertension will be approximately 9,335. This data shows us that a high

proportion of our population is affected by this issue, including the underserved and/or Medicaid patients. The severity of hypertension is not directly shown in our CNA; however the cerebrovascular mortality rate is 74.0, compared to a state rate of 49.4 and a U.S. rate of 38.9. Hypertension is the number one risk factor for cerebrovascular death.

The cost effectiveness of this project is calculated at approximately $3,775 per patient served, if at least 200 patients achieve blood pressure control. This is determined to be a very low cost when compared to the cost of hospitalizations avoided. The average cost for hospitalization of hypertension is $16,000 per visit. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, and will be a collaborative approach to transformative health care in Nacogdoches.

131030203.3.1	IT-1.7	Controlling High Blood Pressure	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	131030203.1.1		
Starting Point/Baseline:	**In Year 3 determine a baseline of the number of patients whose blood pressure is adequately controlled (BP less than 140/90 mm HG).**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of project planning timelines and plans. Process Milestone 1 Estimated Incentive Payment: $60,000	**Process Milestone 2 [P-2]** Establish baseline of the number of patients whose blood pressure is adequately controlled (BP <140/90 mm HG. Data Source: Documentation of baseline rates from EHR and Registry. Process Milestone 2 Estimated Incentive Payment: $120,000	**Outcome Improvement Target 1 [IT-1.7]:** Controlling high blood pressure. Improvement Target: Increase the number of patients with adequately controlled high blood pressure by 5% over baseline. Data Source: EHR and Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $175,000	**Outcome Improvement Target 2[IT-1.7]:** Controlling high blood pressure. Improvement Target: : Increase the number of patients with adequately controlled high blood pressure by 10 % over the baseline. Data Source: EHR, Registry Outcome Improvement Target 2 Estimated Incentive Payment*:* $400,000
Year 2 Estimated Outcome Amount: $60,000	Year 3 Estimated Outcome Amount: $120,000	Year 4 Estimated Outcome Amount: $175,000	Year 5 Estimated Outcome Amount: $400,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $755,000			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-8 Perinatal Outcomes
Project Option: IT-8.1 Timeliness of Prenatal/Postnatal Care
Project Title: Expand Primary Care Capacity-Perinatal Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.2

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital/131030203

OUTCOME MEASURE DESCRIPTION:
Measuring the outcome of timeliness of prenatal and postpartum care will include first (in Year 2) establishing the baseline of live births for which the mothers received the following facets of prenatal and postpartum care:

Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
Rate 2: Had a postpartum visit on or between 21 and 56 days after delivery.

Outcome Improvement Targets for each year:

- DY 3:
  - IT-8.1 Rate 1: Increase the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 10% above baseline.
  - IT-8.1 Rate 2: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 10% above baseline.
- DY 4:
  - IT-8.1 Rate 1: Increase the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 15% above baseline.
  - IT-8.1 Rate 2: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 15% above baseline.

- DY 5:
    - IT-8.1 Rate 1: Increase the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 20% above baseline.
    - IT-8.1 Rate 2: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 20% above baseline.

RATIONALE:
The above process milestones and outcome improvement targets were chosen because they are the most reasonable methods for perinatal outcomes in Nacogdoches. Providing prenatal and postpartum care to mothers would reduce premature births, increase live births and improve the health of the mother and child. The data to measure this outcome can be easily obtained from electronic health records and interventions (patient education from provider and clinic staff) can be easily documented.

Outcome Measure Valuation
According to the CNA in Nacogdoches, 2005-2009 birth statistics show that only 60.1% of live births are born to mothers who received prenatal care in the first trimester. The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.4%, approximately 28,000. This data shows us that a moderate portion of our population is affected by this issue, including the underserved and/or Medicaid patients.

The Nacogdoches Maternal/Child clinic has the capacity to see approximately 620 obstetric patients per year with two providers. If an additional provider enables them to see about 300 more patients, this calculates the project cost at $850 per patient for the project span.

The community will benefit from this project by improving access, quality of care, long-term cost savings, and will be a collaborative approach to transformative health care in Nacogdoches.

131030203.3.2	IT 8.1	Timeliness of Prenatal/Postnatal Care	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	131030203.1.2		
Starting Point/Baseline:	In Year 2, determine a baseline of the number of live births for which women receive prenatal/postnatal 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)**
Process Milestone 1 [P-2]: Establish baseline rates for prenatal and postnatal care. Data Source: Documentation of baseline rates from EHR. Process Milestone 1 Estimated Incentive Payment*:* $45,000	**Outcome Improvement Target 1 [IT-8.1 Rate 1]:** Timeliness of Prenatal Care Improvement Target: Increase the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 10% above baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $22,500 **Outcome Improvement Target 2 [IT-8.1 Rate 2]:** Timeliness of Postpartum Care Improvement Target: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 10% above baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $22,500	**Outcome Improvement Target 3 [IT-8.1 Rate 1]:** Timeliness of prenatal care Improvement Target: Increase the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 15% above baseline. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $26,250 **Outcome Improvement Target 4 [IT-8.1 Rate 2]:** Timeliness of Postpartum Care Improvement Target: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 15% above baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $26,250	**Outcome Improvement Target 5 [IT-8.1 Rate 1]:** Timeliness of prenatal care Improvement Target: Increase the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization by 20% above baseline. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $56,250 **Outcome Improvement Target 6 [IT-8.1 Rate 2]:** Timeliness of Postpartum Care Improvement Target: Increase the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by 20% above baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $56,250

131030203.3.2	IT 8.1	Timeliness of Prenatal/Postnatal Care	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	131030203.1.2		
Starting Point/Baseline:	In Year 2, determine a baseline of the number of live births for which women receive prenatal/postnatal care.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $45,000	Year 3 Estimated Outcome Amount: $45,000	Year 4 Estimated Outcome Amount: $52,500	Year 5 Estimated Outcome Amount: $112,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $255,000			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-8 Perinatal Outcomes
Project Option: IT-8.2 Percentage of Low Birth-weight Births
Project Title: Expand Primary Care Capacity-Perinatal Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.3

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital/131030203

OUTCOME MEASURE DESCRIPTION:
To measuring the outcome of low birth-weight births will include the process milestone of first (in Year 2) establishing the baseline of the percentage of babies born weighing <2,500 grams at birth. The baseline data would derive from patient records (EHR) for the deliveries for live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Outcome Improvement Targets for each year:

- DY 3:
  - IT-8.1- A decrease by 0.5% in the number of babies born weighing <2,500 grams at birth below baseline.
- DY 4:
  - IT-8.1- A decrease by 1.0% in the number of babies born weighing <2,500 grams at birth below baseline.
- DY 5:
  - IT-8.1- A decrease by 1.5% in the number of babies born weighing <2,500 grams at birth below baseline.

RATIONALE:
The above process milestone and outcome improvement targets were chosen due to being the most reasonable methods for perinatal outcomes in Nacogdoches. Improving access to obstetrics care for mothers in Nacogdoches would help reduce low birth-weight births thus preventing the cost associated with low birth-weight babies (transporting them to a neonatal ICU, NICU care, and treatment to improve lung capacity, weight gain and build immune system). The data to measure this outcome can be easily obtained from electronic health records, and interventions (patient education from provider and clinic staff) can be easily implemented.

Outcome Measure Valuation
According to the 2005-2009 birth statistics reported in the Nacogdoches CNA, only 7.6% of 100 live births are babies with low-birth weight and 11.9 of 1,000 births are preterm. Based on the

CNA, the population of Nacogdoches County is 64,524 and the uninsured population is 43.4% (approximately 28,000). This data shows us that a small portion of our population is affected by this issue, including the underserved and/or Medicaid patients.

The Nacogdoches Maternal/Child clinic can see approximately 620 obstetric patients per year with two providers. If an additional provider enables them to see about 300 patients, this calculates our project cost at $850 per patient for the project span. This is determined to be a very low cost when comparing the cost of the program to the cost of hospitalizations avoided.

The community will benefit from this project because it will improve access, quality of care, improve long-term cost savings, and will be a collaborative approach to transformative healthcare in Nacogdoches.

131030203.3.3	IT 8.2	Percentage of Low Birth-weight Births	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	131030203.1.2		
Starting Point/Baseline:	In Year 2, determine a baseline of the number of babies born weighing <2,500 grams.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates for low birth-weight births. Data Source: Documentation of baseline rates from EHR. Process Milestone 1 Estimated Incentive Payment*:* $45,000	**Outcome Improvement Target 1 [IT-8.2]:** Percentage of Low birth-weight births. Improvement Target: A 0.5% decrease in the number of babies born weighing <2,500 grams at birth below baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $45,000	**Outcome Improvement Target 2 [IT-8.2]:** Percentage of Low birth-weight births. Improvement Target: A 1% decrease in the number of babies born weighing <2,500 grams at birth below baseline. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $52,500	**Outcome Improvement Target 3 [IT-8.2]:** Percentage of Low birth-weight births. Improvement Target: A 1.5% decrease in the number of babies born weighing <2,500 grams at birth below baseline. Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $112,500
Year 2 Estimated Outcome Amount: $45,000	Year 3 Estimated Outcome Amount: $45,000	Year 4 Estimated Outcome Amount: $52,500	Year 5 Estimated Outcome Amount: $112,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $255,000			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1 Primary Care and Chronic Disease Management
Project Option: IT-1.10 Diabetes care: HbA1c poor control
Project Title: Implement a Chronic Disease Management Registry

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.4

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital/131030203

OUTCOME MEASURE DESCRIPTION:
Addressing the issue of HbA1c control among diabetics will first include a process of establishing baselines and then implementing interventions to improve HbA1c levels. In Year 2, MH will determine a baseline of the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. This baseline would derive from records (EHR and Registry data) on the patient population from MH primary care clinics.

Outcome improvement targets for each year:

- DY3:
    - IT-1.10: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0% by 5% over baseline.
- DY4:
    - IT-1.10: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0% by 10% over baseline.
- DY5:

- IT-1.10: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0% by 15% over baseline.

RATIONALE:

The above process milestones and outcome improvement targets were chosen because they are reasonable measures for determining the effectiveness of a chronic disease management registry. The health status measure of HbA1c control is recognized as one of the most effective methods of disease management for patients with diabetes (type 1 or type 2). HbA1c status is easily assessed with regular testing, the data is easily attainable from the patients' electronic health records, and interventions (patient education from provider and community health workers) can be easily implemented.

In Nacogdoches, death rates from diabetes are higher than Texas and US rates, with a mortality rate of 36.6 compared to the state rate of 26 and the US rate of 20.9. This rate has Nacogdoches in the lower 25% of counties in Texas. However, diabetes prevalence rates were similar to the Texas rates and slightly worse than US rates. This condition 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 approximately $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

The population of Nacogdoches County is 64,524. Based on the CNA, the uninsured population is 43.3% (approximately 28,000). Individuals with diabetes make up approximately 9.3% of the Nacogdoches County population. This data shows us that a moderate portion of our population is affected by this condition, including the underserved and/or Medicaid patients. The severity of diabetes is shown in our CNA with high death rates from diabetes and the rates of other related diseases such as cerebrovascular, cardiovascular and hypertensive renal disease.

To determine the cost effectiveness of the project, MH compared the total amount of patient visits provided by the clinic and the rate of diabetes in the community. The clinic will provide approximately 60,060 patient visits over the four year period, if 9.3% are patients with diabetes, an estimation of 5,585 patient visits can be assumed. The cost of this project is calculated at $110 per patient visit. This is determined to be a very low cost when comparing the cost of the program to the cost of hospitalizations avoided. According to information from the Department of State Health Services Preventable Hospitalization program, the average cost for hospitalization of short-term diabetes complications is $21,900 and the average cost of long-term complications is $27,839 per visit. The community will benefit from this project

because it will improve access, quality of care, have a long-term cost savings, and will be a collaborative approach to transformative health care in Nacogdoches.

131030203.3.4	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	131030203.1.3		
Starting Point/Baseline:	**In Year 2, determine a baseline of percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0%.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 2] Establish baseline rates Data Source: Documentation of baseline rates from Chronic Care Registry. Process Milestone 2 Estimated Incentive Payment : $61,000	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care:HbA1c control Improvement Target: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0% by 5% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $100,000	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care:HbA1c control Improvement Target: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0% by 10% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $125,000	**Outcome Improvement Target 3**[IT-1.10]: Diabetes care:HbA1c control Improvement Target: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control < 9.0% by 15% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $325,000
Year 2 Estimated Outcome Amount: $61,000	Year 3 Estimated Outcome Amount: $100,000	Year 4 Estimated Outcome Amount: $125,000	Year 5 Estimated Outcome Amount: $325,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $611,000.00			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Improve Access to Specialty Care
OD-3 Potentially Preventable Re-Admissions -30 Day Re-Admission Rates (PPRs)
IT-3.5 Acute Myocardial Infarction (AMI) 30 Day readmission rate

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.7 – PASS 3

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital/131030203

OUTCOME MEASURE DESCRIPTION:
Addressing the issue of reducing the 30-day readmission rate for AMI will include a process of project planning, establishing baselines, implementing interventions and providing services to ensure medication compliance. The first process milestone will address project planning in Year 2. Project planning will engage stakeholders, identify current capacity and needed resources, determine timelines and create implementation plans. The second process milestone will occur in Year 3 and will focus on establishing the baseline rate of the number of readmissions (for patients 18 years and older), for any cause within 30 days of discharge from the index AMI admission. This baseline will derive from hospital patient records (EHR and Registry data).

The outcome improvement target will be reducing the 30-day readmission rate for AMI. The numerator will be the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index AMI admission. If an index admission has more than one readmission, only first is counted as a readmission. The Denominator will be the number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of AMI and with a complete claims history for the 12 months prior to admission. The data source for this information will be patient records (EHR and Registry data). In Year 4, the Outcome Improvement Target will be a 5% reduction in the baseline of the 30-day readmission rate for AMI Year 3. In Year 5, the Outcome Improvement Target will be a 8% reduction in the baseline of the 30-day readmission rate for AMI Year 3.

RATIONALE:
The above process milestones and outcome improvement targets were chosen because they are the most reasonable methods for program improvement. This outcome measure was chosen because of the relationship between hospital readmissions and quality of care being well documented. If AMI patients are discharged from the hospital after their index admission to the appropriate specialist and care management plan, their risk of hospital readmission is reduced.

Outcome Measure Valuation
The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). Based on the CNA, the rate of preventable hospital stays (an indicator of lack of access to appropriate care) for the county is much higher than the Texas

rate. Also, high rates of visits to the emergency department (ED) can indicate lack of access to appropriate care, or inappropriate utilization. The rate of ED visits for Nacogdoches County is in the bottom 10% of all counties in Texas. This data shows us that a high proportion of our population is affected by this issue, including the underserved and/or Medicaid patients. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, and will be a collaborative approach to transformative health care in Nacogdoches.

131030203.3.7	IT-3.5	Acute Myocardial Infarction (AMI) 30 Day readmission rate	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	**131030203.1.4**		
Starting Point/Baseline:	**In Year 3, determine a baseline of the number readmissions (for patients 18 years and older), for any cause, within 30 days from the index AMI admission.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of project planning timeline and plans. Process Milestone 1 Estimated Incentive Payment : $89,983	**Process Milestone 2 [P- 2]** Establish baseline rates Data Source: Documentation of baseline rates from Electronic Health Records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $93,477	**Outcome Improvement Target 1** [IT-3.5]: Acute Myocardial Infarction (AMI) 30 day readmission rate. Improvement Target: Reduce the number of 30-day readmissions for AMI patients for any cause by 5% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $99,605	**Outcome Improvement Target 2**[IT-3.5]: Acute Myocardial Infarction (AMI) 30 day readmission rate. Improvement Target: Reduce the number of 30-day readmissions for AMI patients for any cause by 8% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $290,418
Year 2 Estimated Outcome Amount: $89,983	Year 3 Estimated Outcome Amount: $93,477	Year 4 Estimated Outcome Amount: $99,605	Year 5 Estimated Outcome Amount: $290,418
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $573,483			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Expand Existing primary Care Capacity
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 261955689.3.1 - PASS 2

RHP PERFORMING PROVIDER/TPI: Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital/261955689

OUTCOME MEASURE DESCRIPTION:

- IT-6.1 Percent improvement over baseline of patient satisfaction scores has been selected as the outcome measure for this DSRIP project with the focus on how our patients are getting timely care, appointments, and information.

  Process milestones:
  P-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans and
  P-2. Establish baseline rates

  RATIONALE:
  Patient Satisfaction:
  We have a very high utilization of our ED with approximately 72% non-emergent visits in our ED on an annual basis. This is a priority project for our organization to alleviate the high cost of non-urgent visits yet provide our patients with better preventive and primary care utilization resources. In order to accomplish this outcome measure, we must first have the capacity to expand access for patients to these services. We purchased an additional clinic space in January 2012 as our existing RHC was at maximum capacity and as a result, we will be able to provide an alternative care setting and avoid more costly ER and inpatient care. Engaging patients in preventive and primary care will also provide care management which yields more healthy outcomes and reduces the cost burden on public payers.

  Patient Satisfaction of the newly established clinic operations, its providers and the healthcare services rendered is critical or patients will resort to once again utilizing the ED for non-emergent healthcare needs or even worse, failing to obtain necessary medical care at all. With measured patient satisfaction scores, we will be able to ascertain and insure that the utilization and expansion of this primary care clinic's operations will meet patients' needs which should result in less ED visits, better preventive care and care management ultimately resulting in more healthy outcomes and reduction of costly hospital admissions, as well as reducing mortality risks.

- **Outcome Measure Valuation:**
    - Using the proportional relationship set forth in the PFM, we allocated Category 3 incentive funds.

261955689.3.1	3.IT-6.1	OD-6 Patient Satisfaction	
Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital			**261955689-2**
Related Category 1 or 2 Projects:	**261955689.1.1**		
Starting Point/Baseline:	**We will establish the baseline in DY 3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment*:* $136,589	**Process Milestone 2 P-2.** Establish baseline rates Data Source: EHR records indicating ACSC diagnoses. Process Milestone 2 Estimated Incentive Payment: $158,590	**Outcome Improvement Target 1** IT-6.1(1). Percent improvement over baseline of patient satisfaction scores- Patients . are getting timely care, appointments, and information Improvement Target: 10% improvement over baseline rates Data Source: Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $253,139	**Outcome Improvement Target 2** IT-6.1(1). Percent improvement over baseline of patient satisfaction scores- Patients . are getting timely care, appointments, and information Improvement Target: 15% improvement over baseline rates Data Source: Survey Outcome Improvement Target 3 Estimated Incentive Payment*:* *$609,553*
Year 2 Estimated Outcome Amount: $136,589	Year 3 Estimated Outcome Amount: $158,590	Year 4 Estimated Outcome Amount: $253,139	Year 5 Estimated Outcome Amount: $609,553
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,157,871			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Expand Specialty Care-Specialty Psychiatric Clinic
OD-6 Patient Satisfaction
IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.1

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION
For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 2.

RATIONALE:
Since the goal of this project is to provide expanded behavioral health care for an underserved population, measuring the availability and timeliness of behavioral health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access the care that will lead to improved behavioral health. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.1.1		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Survey document; survey results Process Milestone 1 Estimated Incentive Payment*:* $23,605	**Outcome Improvement Target 1** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $54,722	**Outcome Improvement Target 2** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $58,538	**Outcome Improvement Target 3** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 3 Estimated Incentive Payment*:* $127,262
Year 2 Estimated Outcome Amount: $23,605	Year 3 Estimated Outcome Amount: $54,722	Year 4 Estimated Outcome Amount: $58,538	Year 5 Estimated Outcome Amount: $127,262
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $264,127			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):

Project Outcome Measure: OD-9, Right Care, Right Setting

Project Option: IT-9.2 ED appropriate utilization, reduce Emergency Department visits for Behavioral Health

Project Title: Extended Crisis Stabilization

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.15 – Pass 3b

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION

For demonstration years 3-5, Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.2 for this project. The measure will be the reduction in days in Emergency Department visits for Behavioral Health as evidenced by an increase in referrals of patients to the Extended Crisis unit instead of having treatment in the ED. Outcome improvement targets will be determined in DY 2 for implementation in DY 3.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. Data will be accumulated regarding behavioral health visits to the Emergency Department.

RATIONALE:

We chose IT-9.2, the reduction in Emergency Department visits for Behavioral Health, for this project because the ultimate outcome of this project is to treat behavioral health crisis clients in a more appropriate setting than more costly Emergency Departments and to reduce hospital recidivism.

We chose process milestone P-2 to establish baselines for measuring the outcome improvement of the project.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. A health economic study that included these factors was also used to value the project.

096166602.3.15	OD-9 IT-9.2	Right Care, Right Setting-ED appropriate utilization, reduce Emergency Department visits for Behavioral Health.	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.1.6		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Hospital admissions records for Emergency Department visits for behavioral health crisis Process Milestone 1 Estimated Incentive Payment*:* $36,866	**Outcome Improvement Target 1** IT-9-2: ED Appropriate Utilization Metric: Reduction in ED behavioral health services as measured by increased referrals to extended crisis stabilization unit Improvement Target: TBD Data Source: Extended crisis stabilization unit referral records Outcome Improvement Target 1 Estimated Incentive Payment*:* $85,465	**Outcome Improvement Target 2** IT-9-2: ED Appropriate Utilization Metric: Reduction in ED behavioral health services as measured by increased referrals to extended crisis stabilization unit Improvement Target: TBD Data Source: Extended crisis stabilization unit referral records Outcome Improvement Target 2 Estimated Incentive Payment*:* $91,424	**Outcome Improvement Target 3** IT-9-2: ED Appropriate Utilization Metric: Reduction in ED behavioral health services as measured by increased referrals to extended crisis stabilization unit Improvement Target: TBD Data Source: Extended crisis stabilization unit referral records Outcome Improvement Target 3 Estimated Incentive Payment*:* $198,758
Year 2 Estimated Outcome Amount: $36,866	Year 3 Estimated Outcome Amount: $85,465	Year 4 Estimated Outcome Amount: $91,424	Year 5 Estimated Outcome Amount: $198,758
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $412,513			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9, Right Care, Right Setting
Project Option: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population
Project Title: Youth Respite/Residential Treatment

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.3

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION
For demonstration years 3-5, Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.1 for this project. The measure will be the decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population.
The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. The numerator is the number of individuals receiving the project intervention(s) who had a potentially preventable admission/readmission to a criminal justice within the measurement period, and the denominator is the number of individuals receiving the project intervention. Data will be accumulated regarding days in criminal justice facilities for youth in the target population.

RATIONALE:
The ultimate outcome of this project is to address youth behavioral health problems in an appropriate local setting that allows for treatment/training of the youth as well as training for the family. The measure will be the reduction in days in state behavioral health facilities, hospitals, and criminal justice facilities for youth in the target population. Providing youth respite services in an appropriate local setting is not only more beneficial for clients, it also will reduce overall costs of health care and criminal justice. Various studies, including a March 2010 study by Texas A&M University, found that crisis services programs offer direct and measurable reductions in cost of services associated with crisis that more than cover the cost of the programs.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration.

Another valuation factor used for this project is the monetary value for a behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.3	OD-9 IT-9.1	Right Care, Right Setting - Decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.1.3		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Criminal justice data for target population Process Milestone 1 Estimated Incentive Payment*:* $25,722	**Outcome Improvement Target 1** IT-9-4: Decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population. Numerator: # of youth in respite program with potentially preventable admission/readmission to criminal justice setting Denominator: # of youth in respite program. Improvement Target: TBD Data Source: Criminal justice data for target population Outcome Improvement Target 1 Estimated Incentive Payment*:* $59,630	**Outcome Improvement Target 2** IT-9-4: Decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population Numerator: # of youth in respite program with potentially preventable admission/readmission to criminal justice setting Denominator: # of youth in respite program. Improvement Target: TBD Data Source: Criminal justice data for target population Outcome Improvement Target 2 Estimated Incentive Payment*:* $63,788	**Outcome Improvement Target 3** IT-9-4: Decrease in mental health admissions and readmissions to criminal justice facilities for youth in the target population Numerator: # of youth in respite program with potentially preventable admission/readmission to criminal justice setting Denominator: # of youth in respite program. Improvement Target: TBD Data Source: Criminal justice data for target population Outcome Improvement Target 3 Estimated Incentive Payment*:* $138,676
Year 2 Estimated Outcome Amount: $25,722	Year 3 Estimated Outcome Amount: $59,630	Year 4 Estimated Outcome Amount: $63,788	Year 5 Estimated Outcome Amount: $138,676
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $287,816			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9, Right Care, Right Setting
Project Option: IT-9.2 ED appropriate utilization, reduction in Emergency Department visits for Substance Abuse
Project Title: Inpatient Detox Services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.16 096166602.3.4

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION
For demonstration years 4-5, Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.2 for this project. The measure will be the reduction in Emergency Department visits for Substance Abuse patients.

The process milestone selected for demonstration year 2 is P-1, project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. To achieve this, we will engage SETMA, the local substance abuse network authority, in developing a community network for patients after detox services are completed. For DY3, the process milestone is P-2, establish baseline rates. Data will be accumulated regarding current referrals from ED's for detox and the number of patients who receive detox services in the ED's.

RATIONALE:
We chose IT-9.2, reduction in Emergency Department visits for substance abuse, since the ultimate outcome of this project is to provide detox services in an appropriate setting and to develop continuity of care that will encourage patients to adhere to addiction treatment plans. This will reduce overall health care system costs by decreasing ED visits and hospital recidivism. It will also improve the health and quality of life for the patients. Justice system costs may be reduced as well.

Process Milestone P-1 to engage stakeholders was selected since SETMA, the local substance abuse network authority, is responsible for coordinating substance abuse services in our area. Process milestone 2 was selected for DY3 to establish baseline rates for measuring the outcome improvements in DY4-5.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for substance abuse, emergency room visits, and criminal justice incarceration. A health economic study that included these factors as well as quality of life was also used to value the project.

096166602.3.16 096166602.3.4	OD-9 IT-9.2	Right Care, Right Setting - ED appropriate utilization, reduce Emergency Department visits for Substance Abuse.	
Spindletop Center			**096166602**
Related Category 1 or 2 Projects:	**096166602.17 096166602.1.4**		
Starting Point/Baseline:	**To be established in Year 3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans: Engage SETMA (local substance abuse network authority) in developing community network for patients after detox services Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment*:* $89,532	**Process Milestone 2 P-2**: Establish baseline rates of detox referrals from ED Data Source: Hospital ED admissions records Process Milestone 2 Estimated Incentive Payment*:* $207,557	**Outcome Improvement Target 1** IT-9-2: Reduction in ED visits for substance Improvement Target: TBD Data SourceHospital ED admissions records Outcome Improvement Target 1 Estimated Incentive Payment*:* $222,030	**Outcome Improvement Target 2** IT-9-2: Reduction in ED visits for substance abuse Improvement Target: TBD Data Source: Hospital ED admissions records Outcome Improvement Target 2 Estimated Incentive Payment*:* $482,698
Year 2 Estimated Outcome Amount: $89,532	Year 3 Estimated Outcome Amount: $207,557	Year 4 Estimated Outcome Amount: $222,030	Year 5 Estimated Outcome Amount: $482,698
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,001,817			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information
Project Title: Client Health Information Access Portal

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.9 – PASS 2

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION
The process milestone selected for demonstration year 3 to prepare for the outcomes is P-1, project planning. The process milestone selected for demonstration year 3 is P-2, establish baseline rates. This will involve conducting a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 3.

For demonstration years 4-5, Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores-patients getting timely healthcare information.

RATIONALE:
Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, patients getting timely health information for DY4-5. One of the purposes of this project is for clients to have access to their healthcare information and learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment. For DY2, the process milestone is developing the plan; for DY3 the process milestone is establishing the baseline for the satisfaction survey scores.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to

the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

096166602.3.9	IT-6.1 (1)	Percent improvement over baseline of patient satisfaction scores- Patients getting timely healthcare information	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.1.5		
Starting Point/Baseline:	To be established in Year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Develop project plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment*:* $36,626	**Process Milestone 2 P-2**: Establish baseline rates Data Source: Survey document; survey results Process Milestone 2 Estimated Incentive Payment*:* $84,797	**Outcome Improvement Target 1** IT-6-1 (1): Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information Improvement Target: % improvement TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $90,646	**Outcome Improvement Target 2** IT-6-1 (1): Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information Improvement Target: % improvement TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $197,109
Year 2 Estimated Outcome Amount: $36,626	Year 3 Estimated Outcome Amount: $84,797	Year 4 Estimated Outcome Amount: $90,646	Year 5 Estimated Outcome Amount: $197,109
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $409,178			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-6 Patient Satisfaction
IT-6.1.1 Percent improvement over baseline satisfaction scores

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136367307.3.1

RHP PERFORMING PROVIDER/TPI: The Burke Center/136367307

OUTCOME MEASURE DESCRIPTION
Our primary outcome is OD-6 Patient Satisfaction. We have chosen IT6.1.1 to improve patients' satisfaction in receiving timely care, appointments, and information. The expansion of services will meet regional needs but must be done in a manner that meets the satisfaction of the individuals served. The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and continually improve the process. We plan to improve satisfaction as measured by a standardized survey by targeting areas identified as needing improvement. We will begin this milestone in Year 4.

The process outcomes we chose are P-2 Establish Baseline Rates. This process will require us to acquire a statistically valid patient satisfaction tool which includes a telemedicine component and conduct a sample survey to determine a baseline. This will begin in year 2. This process milestone will lead into the process milestone P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. We will utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined. We will begin in Year 3.

In addition, Burke Center 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 the 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:
Improvements can only be documented when baseline information regarding satisfaction is determined. Continuous improvements will be made as challenges and barriers are identified and successfully addressed.

Outcome Measure Valuation:
One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness and can be considered as population affected. In addition, the needs assessment morbidity data indicates there is a 76.8% gap in our area based on shortage of mental health providers. Expanding

services will reduce this gap. These statistics only emphasize the need to ensure satisfaction with our expansion.

136367307.3.1	OD-6, IT-6.1.1	Percent improvement over baseline satisfaction scores	
The Burke Center			136367307
Related Category 1 or 2 Projects:	**136367307.1.1**		
Starting Point/Baseline:	**Baseline will be the number of Providers current employed and the number of clinic hours in current operation**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: **P-2** Establish baseline rates Metric: Identify current experience of individuals seeking and receiving services regarding timely care, appointments and information. Data source: Appropriate satisfaction survey. Goal: To identify current percentage of rate of access and satisfaction. Rationale: Improvements can only be documented when baseline information regarding satisfaction is determined. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $97,773	**Process Milestone 2: P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Data is collected and analyzed on consumer satisfaction. Data source: Satisfaction surveys, client services in the EHR. Goal: Utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined. Rationale: Continuous improvements will be made as challenges and barriers are identified and successfully addressed. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 228,080	**Outcome Improvement Target 1:** IT-6.1 Improvement Target: Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: TBD% improvement over baseline satisfaction scores Data Source: Patient Survey Rationale: A patient survey captures perception which provides objective and meaningful data to determine factors important to the individual. Outcome Improvement Target 1 Estimated Incentive Payment*:* $242,271	**Outcome Improvement Target 2:** IT-6.1: Improvement Target: Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: TBD% improvement over baseline satisfaction scores Data Source: Patient Survey Rationale: A patient survey captures perception which provides objective and meaningful data to determine factors important to the individual. Outcome Improvement Target 2 Estimated Incentive Payment*:* $547,503
Year 2 Estimated Outcome Amount: $97,773	Year 3 Estimated Outcome Amount: $228,080	Year 4 Estimated Outcome Amount: $242,271	Year 5 Estimated Outcome Amount: $547,503
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,115,626			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):

OD-6 Patient Satisfaction
IT-6.1.1 Percent Improvement Over Baseline of Patient Satisfaction Scores. Timely Care, Appointments and Information

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136367307.3.2

RHP PERFORMING PROVIDER/TPI: The Burke Center/136367307

OUTCOME MEASURE DESCRIPTION
Our primary outcome is OD-6 Patient Satisfaction. We have chosen IT6.1.1 to improve patients' satisfaction in receiving timely care, appointments, and information. The expansion and enhance of telemedicine must go hand in hand with satisfaction. If we are unable to provide connectivity that will allow for a clear picture between patient and doctor, optimal service will not occur. In addition, telemedicine will allow our patients to receive timely care and appointments; alleviate the burden of travel expense and time; and increase our capacity. Telemedicine will also allow our HPSA to contract with psychiatrists in other areas to provide this service. The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and test and execute the plan. We plan to improve satisfaction as measured by survey by targeting areas identified as needing improvement. We will begin this milestone in Year 4.

The process outcomes we chose are P-2 Establish Baseline Rates. This process will require us to acquire a statistically valid measure tool with a telemedicine focus and conduct a sample survey to determine a baseline. This will begin in year 2. This process milestone will lead into the process milestone P-3 Develop and test data systems. We will conduct our survey with all patients who receive telemedicine services with a focus on satisfaction by site and by provider. We will begin in Year 3.

Our baseline is 325 which include all of those consumers in the expansion areas who receive Mental Health Services from our Center. We will conduct a satisfaction survey on every consumer who receives services in the time period of Year 3 to determine measures to be taken to increase satisfaction. By year 4, 70% of all satisfaction surveys in baseline area total will indicate a rating of at least satisfactory or higher. By year 5, 80% of all satisfaction surveys in baseline area total will indicate a rating of at least satisfactory or higher.

RATIONALE:
The intent of this outcome measure is to provide a standardized survey instrument and data collection methodology for measuring patients' satisfaction. By measuring satisfaction, we can determine needed areas of improvement by both location site and by provider.

Outcome Measure Valuation:

One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness and can be considered as population affected. In addition, the needs assessment morbidity data indicates there is a 76.8% gap in our area based on shortage of mental health providers. Expanding telemedicine will reduce this gap by allowing our Center to access psychiatrists from other regions. These statistics only emphasize the need to ensure satisfaction with our expansion and improvement to telemedicine.

136367307.3.2	OD-6, IT 6.1.1	Patient Improvement over baseline satisfaction scores	
The Burke Center			136367074
Related Category 1 or 2 Projects:	**136367307.1.2/1.7 Introduce, Expand or Enhance Telemedicine/Telehealth**		
Starting Point/Baseline:	**Establish in Year 2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2 Establish Baseline Rates: Metric: Acquire a statically valid survey tool with a telemedicine component and conduct a sample satisfaction survey to determine the current satisfaction rate of patients who are receiving telemedicine services. Data Source: Satisfaction surveys on telemedicine services. Process Milestone 1: Estimated Incentive Payment: $9,025	**Process Milestone 2** P-3 Develop and test data systems: Metric: A satisfaction survey will be given to 300 (baseline) consumers in the expansion areas who receive Mental Health services from our Center to determine measures to be taken to increase satisfaction. Data Source: Satisfaction scores. Process Milestone 2: Estimated Incentive Payment: $25,353	**Outcome Improvement Target 1** IT-6.1.1: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: 70% of all satisfaction surveys in baseline area total will indicate a rating of at least satisfactory or higher. Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,821	**Outcome Improvement Target 2** IT-6.1.1: Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: 80% of all satisfaction surveys in baseline area total will indicate a rating of at least satisfactory or higher. Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $51,160
Year 2 Estimated Outcome Amount: $9,025	Year 3 Estimated Outcome Amount: $25,353	Year 4 Estimated Outcome Amount: $30,821	Year 5 Estimated Outcome Amount: $51,160
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $116,359			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-10, Quality of Life/Functional Status
Project Option: IT-10.1 –Quality of Life: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool for the population served.
Project Title: Expanded Psychiatry Delivery Program

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 081844501.3.1

RHP PERFORMING PROVIDER/TPI: Tri-County Services/081844501

OUTCOME MEASURE DESCRIPTION:
For demonstration years 3-5, Tri-County has selected improvement outcome measure IT-10.1 Percent improvement over individual baseline quality of life scores for overall mental health functioning.

The process milestone selected for demonstration year 2 is to research and establish tool that will be used to measure quality of life/functioning improvement so that a baseline of functioning can be established in Demonstration Year 3. A likely tool for this effort would be the SF-12 mental health summary known as the Mental Component Score (MCS)-12. The MCS-12, if chosen, would be administered to persons receiving the service in the standard 4 week intervals or at each follow-up appointment.

Rationale:
Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status by direct patient survey. The importance of such patient-reported outcomes in evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on patient outcomes.

Tri-County has long been aware of the need to increase the capacity to provide psychiatric services so the individuals in our communities have increased access to these services. For individuals who are indigent, there are very few options for psychiatric care in Liberty County. Though medically indigent, these individuals may work or have other responsibilities which would make expanded service hours helpful. Due the unavailability of indigent psychiatric care in Liberty County, care for these disorders is typically provided in inappropriate care settings (including emergency departments and jails).

Tri-County proposes to improve the access to specialty psychiatric care for individuals who are in need of care, but who are otherwise unable to be served by the current service system. We will increase service availability with extended hours as needed, increase the number of

psychiatric clinic options for the medically indigent, will implement standardized referrals to appropriate services, and will conduct quality improvement for the project using rapid cycle improvement.

Tri-County has selected improvement outcome measure IT-10.1, Percent improvement over baseline of Quality of Life scores. Since the goal of this project is to provide expanded psychiatric care in our community, measuring the impact of this services on individuals' quality of life is important. If individuals believe that the service is contributing to their overall quality of life, they will be less likely to require interventions via local emergency departments, hospitals, psychiatric hospitals or criminal justice systems.

Outcome Measure Valuation:

Tri-County considered several factors in valuing this project including reductions in costs associated with emergency room visits, hospitalizations, psychiatric hospitalizations as well inappropriate law enforcement involvement for issues related to persons behavioral health.

Another valuation factor used for this project is the monetary value for behavioral health interventions as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

081844501.3.1	IT-10.1	Quality of Life	
Tri-County Services			081844501
Related Category 1 or 2 Projects:	081844501.1.1		
Starting Point/Baseline:	To be established in Demonstration Year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Research and establish tool that will be used to measure quality of life/functioning improvement Goal: Identify measurement tool Data Source: Peer reviewed research Process Milestone 1 Estimated Incentive Payment: $5,000	**Outcome Improvement Target 1** IT-10.1 Quality of Life/Functioning Improvement: Establish baseline functioning for population served by program using tool as determined in DY 2 Improvement Target: Establish baseline data for individuals served by the program. Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment: $20,550	**Outcome Improvement Target 2** IT-10.1 Quality of Life/Functioning Improvement: Percent improvement over baseline of quality of life scores for overall physical health Improvement Target: TBD Data Source: Survey results Outcome Improvement Target TBD Estimated Incentive Payment: $31,860	**Outcome Improvement Target 3** IT-10.1 Quality of Life/Functioning Improvement: Percent improvement over baseline of quality of life scores for overall physical health Improvement Target: TBD Data Source: Survey results Outcome Improvement Target TBD Outcome Improvement Target 3 Estimated Incentive Payment: $77,000
Year 2 Estimated Outcome Amount: $5,000	Year 3 Estimated Outcome Amount: $20,550	Year 4 Estimated Outcome Amount: $31,860	Year 5 Estimated Outcome Amount: $77,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$134,410**			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.10 – Diabetes Care: HbA1c Poor Control (>9.0%)
Project Title: Expand Primary Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136381405.3.1

RHP PERFORMING PROVIDER/TPI: Tyler County Hospital / 136381405

OUTCOME MEASURE DESCRIPTION:
We plan to engage stakeholders, identify current capacity and needed resources, determine timelines and implement a Chronic Disease Management Program. Our clinic has 15 patients out of 304 with HbA1c >9% and 4 more with HbA1c >8%. A normal HbA1c blood test is 6% or less. The community has a morbidity rate for Diabetes of 15.4%. We have an uninsured rate of 26% for 0-64 years of age. The county has 19.9% living at/below the poverty line. Also, 19.26% of patients with diabetes in Tyler County do not receive HbA1c screening.

Improvement Target: 1.10 Diabetic Care: HbA1c poor control (>9%). We currently have 15 out of 304 patients with diabetes diagnosis with HbA1c >9% over the last quarter. We anticipate an increase number of diabetes patients with expanded hours and additional providers. The rate of patients with HbA1c over 9% may be higher among these new patients because many will not have been under care. Our goal is to reduce the number with HbA1c >9% by DY5: specific reduction goal to be determined based on baseline information from DY3.

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 residents of Tyler County and save valuable health care dollars.

A Community Health Assessment was completed for Tyler County August 2012. This file posits that Tyler County has health needs in three major areas. They are the Health of the Community, Access to Health Care Services and Health Service Resources.

The Health of The Community's finding show that Tyler County has worse rates of diabetes and disability and more poor physical and mental health days than state, or national averages. Tyler

County's mortality rates for 4 of the 11 mortality indicators were among the worst compared to all other Texas Counties.

The Community's Access to Healthcare Services shows that Tyler County's rate of uninsured is almost double the United States rate for those 19 years of age, and more than 10 percentage points higher for the population under 65. Tyler County is federally designated as a medically underserved area. Also, a high rate of visits to the emergency department indicates lack of access to primary care or inappropriate utilization. The rate of ED visits for Tyler County was among the worst in Texas which is in the bottom 25% all counties.

The Community's Health Service Resources presents Tyler County as a federally designated Health Professional Shortage Area for primary care and mental health providers. The rates of providers per 100,000 population are also low for specialists, mid-level providers, dentists, and pharmacists. Also, there are no licensed psychiatric care beds and there are no facilities that provide substance abuse treatment, or detox. The 30 day readmission rate for medical discharges, a measure of quality of care, was higher than both the Texas and U.S. rates.

We chose the development of a Chronic Disease Management Program for Diabetes due to the overwhelming need in Tyler County. Tyler County has a Mortality Rate of 27.5 per 100,000 for Diabetes, which is higher than Texas at 26 per 100,000 and US at 20.9 per 100,000. Morbidity for Diabetes Mellitus is 11.4% in Tyler County, 9% in Texas, and 10.9% in the US. This program will improve health outcomes and quality reduces unnecessary acute and emergency care utilization. Also, 19.26% of patients with diabetes in Tyler County do not receive HbA1c screening. This program will be able to give access to those that have not been screened and work with existing patients that need improved in their HbA1c.

We plan to improve chronic disease management by developing a specific program for providers to engage with patients. The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.1 Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients. Also, it has been shown that "planned care for all" can be more effective than "disease-silo" care. For example, the Cherokee Nation adopted a systems approach to diabetes care in 2002, which included many of the concepts in the Improving Patient Care (IPC) change package, such as patient and population management by registered nurse diabetes care managers; evidence-based guidelines; planned visits; care by a multidisciplinary team; diabetes self-management support and education; use of registries for

1 Source: IHI website. Please see http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/ for more information.

population management; and data-driven improvement, resulting in improved diabetes care and intermediate outcomes.

Outcome Measure Valuation

Table A Expand Primary Care in Tyler County by adding a Primary Care Physician and LVN.
Table B Development and Implementation of a Chronic Disease Management Program.

A. Population Affected-

- The community needs assessment identified a significant amount (11.4%) of the population who were affected by diabetes, 19.6% of the population that did not receive HbA1c screening and 19.9% living at or below the poverty line in Tyler County. Those living at or below the poverty line averages are above the state and national average. Tyler County Population is 21,766 so we estimate about 2,481 are affected by diabetes. Currently there are only 2 Physicians and 1 Nurse Practitioner in our Clinic accepting new patients. Adding a Primary Care Physician will greatly enhance access to care and allow for flexible hours.

- Score: 5 points awarded because population is affected and there is a high percentage of uninsured population.

B. Severity-

- There is a need in Tyler County to reduce the Diabetes mortality of 27.5% per 100,000 which is significantly higher than 20.9% per 100,000 for the United States. Diabetes is one of the most costly of chronic diseases which leads to many complications if untreated. There is also a need to add a Primary Care Physician because we are a Health Professional Shortage Area and a Medically Underserved Area.
- Score: 5 points awarded for severity because it is higher than State and US average.

C. Cost effectiveness –

- Measure: The estimated cost of the project is $181,015 over 4 years. The expected number of people reached is to be determined by DY3. There will be a reduction in long term care needs for chronic patients as well as more patients receiving services in the Rural Health Clinic instead of the Emergency Department.
- Score: 5 points awarded

D. Community Benefit-

- Adding a Physician will benefit the entire community since we are a Medically Underserved Area. It will improve access, quality, and reduce cost for diabetes as well as other chronic diseases. We are at the bottom 10% of all Texas Counties for Varicella, Respiratory and Lung Morbidity. We are at the bottom 25% of all Texas Counties for Prostate, Skin and Pertussis Morbidity. Tyler County is at the bottom 25% of all Texas Counties for Chronic Lower Respiratory Disease and Diseases of the Heart.

- The US benchmark of PCP's is 10/1,000. Tyler County only has 4 physicians full-time, (2 Emergency Department full-time), 1 physician in private clinic and 5 nurse practitioners to cover a population of 21,766. Tyler County only has enough PCP's to cover 1,000 people and the population affected is 20,000.
  - Score: 5 points

Total Score: 20 points

136381405.3.1	IT 1.10	Diabetes Care: HbA1c Poor Control (>9.0%)	
Tyler County Hospital			136381405
Related Category 1 or 2 Projects:	**136381405.1.1**		
Starting Point/Baseline:	**Patients 18-75 years of age with diabetes Type 1 or 2 who have hemoglobin A1C (HbA1c) control >9.0%**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for Chronic Disease Management Program for Diabetes. Metric 1: Documentation of Development of a Chronic Disease Management Program for Diabetes, including people, process and technologies. Data Source: Written diabetic management plan goals. Development of Chronic Disease Management Program to be completed in DY 2. Goal: To develop and implement chronic disease management program that is geared toward effective management of chronic conditions and ultimately improving health outcomes and quality, and reducing unnecessary acute and emergency care utilization.	**Process Milestone 2** P-2 Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high quality clinical and chronic disease care. Numerator: Number of relevant staff trained in the Chronic Care Model Denominator: Total number of relevant staff Goal: 75% of staff to be trained Data Source: HR, training program materials	**Outcome Improvement Target 1:** IT-1.10 Diabetic Care: HbA1c poor control (>9%) 233 – NQF 0059 Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Goal TBD based on baseline rates established in DY3. Data Source: EHR, Registry, claims, administrative clinical data	**Outcome Improvement Target 2:** IT-1.10 Diabetic Care: HbA1c poor control (>9%) the number of clinic patients with HbA1c Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or 2) who have hemoglobin A1C (HbA1c) control >9% Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Goal TBD based on baseline rates established in DY3. Data Source: EHR, Registry, claims, administrative clinical data

136381405.3.1	IT 1.10	Diabetes Care: HbA1c Poor Control (>9.0%)	
Tyler County Hospital			136381405
Related Category 1 or 2 Projects:	**136381405.1.1**		
Starting Point/Baseline:	**Patients 18-75 years of age with diabetes Type 1 or 2 who have hemoglobin A1C (HbA1c) control >9.0%**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Estimated Incentive Payment $24,954	Process Milestone 2 Estimated Incentive Payment $28,925	Outcome Improvement Target 1 Estimated Incentive Payment: $ 46,415	Outcome Improvement Target 2 Estimated Incentive Payment: $ 110,992
Year 2 Estimated Outcome Amount: $24,954	Year 3 Estimated Outcome Amount: $28,925	Year 4 Estimated Outcome Amount: $46,415	Year 5 Estimated Outcome Amount: $110,992
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 211,286			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)[228]
Project Title: Expand Primary Care Access in Galveston and Brazoria Counties

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.1

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)[228.] (Stand-Alone Measure)

Process Milestones:

- DY2:
  - P-1 Project planning
  - P-2 Establish baseline rates
- DY3:
  - P-3 Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.7 Controlling high blood pressure – improvement target TBD based upon baseline established in DY2 and DY3.
- DY5:
  - IT-1.7 Controlling high blood pressure – improvement target TBD based upon baseline established in DY2 and DY3.

RATIONALE:
Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive patients, which are more likely to have heart failure. Yearly goals will be established according to local review of national **BENCHMARK** goals.

We are focusing on Controlling High Blood Pressure in order to impact a large part of our population seeking primary care services. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the U. S. Preventive Services Task Force (USPSTF) and the Joint National Committee.

The mortality rates for Brazoria and Galveston County concerning Hypertension are in the bottom 25% of all Texas counties, 6.9 (Brazoria) and 8.5 (Galveston) per 100,000 respectively

OUTCOME MEASURE VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.1	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects::	094092602.1.1		
Starting Point/Baseline:	To be determined in DY 2 and DY3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Completed comprehensive implementation plan to address controlling high blood pressure. Data Source: EMR Goal: Complete comprehensive implementation plan on how to address controlling high blood pressure in DY2. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 98,902 **Process Milestone 2 [**P-2]: Establish baseline rates. Metric: Gather baseline rates for blood pressure in patient population. Data Source: EMR	**Process Milestone 3 [**P-3]: Develop and test data systems. Metric: Test ability to pull blood pressure measure from EMR. Data source: EMR Goal: Successfully track ability to track patient blood pressure changes for reporting. Process Milestone 3 Estimated Incentive Payment: $372,419	**Outcome Improvement Target 1** [IT-1.7]: Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Improvement Target: TBD based upon baseline established in DY2 and DY3. Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $873,043	**Outcome Improvement Target 2** [IT-1.7]: Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Improvement Target: TBD based upon baseline established in DY2 and DY3. Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,687,508

094092602.3.1	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects::	**094092602.1.1**		
Starting Point/Baseline:	**To be determined in DY 2 and DY3.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Goal: Gather baseline rates for blood pressure in patient population in DY 2. Process Milestone 2 Estimated Incentive Payment: $98,902			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $197,804	Year 3 Estimated Outcome Amount: $372,419	Year 4 Estimated Outcome Amount: $873,043	Year 5 Estimated Outcome Amount: $2,687,508
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $4,130,775			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6, Patient Satisfaction
Project Option: IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction
Project Title: Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
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 first improvement target (IT) is to improve patient satisfaction related to timely care, appointments, and information. The data source will measure the percent improvement in scores of the survey areas of timely care, appointments, and information for the patients who are given the survey. By year 4, the scores will improve by 1% over baseline set and by 2% over baseline by DY5 .

The second improvement target (IT) is to improve patient satisfaction in how well the doctors communicate. The data source will measure the percent improvement in how well the doctors communicate for the patients given the survey. By year 4, the scores will improve by 1% over baseline set and by 2% over baseline by DY5.

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

Each of the improvement targets selected are key to the success of this project. The improvement in patient satisfaction scores is a tool to validate that our goals in this project are being met. Patient satisfaction with primary care services is largely related to utilization of primary care services. Understanding strengths, needs and receiving patient feedback allows for providers and staff to better understand how to tailor care delivery to meet their patients' needs. By selecting outcome improvement measures related to patient satisfaction , the project will have solid data to justify success in increasing timely care and improving communication between doctors and patients and help in identifying target areas for future improvements.

OUTCOME MEASURE VALUATION:

It is well known that the current national supply of primary care providers does not meet the demand for primary care services. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHPs must expand primary care capacity in order to implement the health care delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

094092602.3.2	IT-6.1 (1),(2)	Percent Improvement over baseline of patient satisfaction scores.	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.2		
Starting Point/Baseline:	Establish baseline patient satisfaction scores in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: [P-1 Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1: [P-1]: measure meeting the project plan and budget. Data Source: Communication documents, meeting notes, progress reports, timelines, clinic expansion and move plans. Goal: complete project plans including timelines and budgets. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $11,453.50 **Milestone 2: [P-2]** Establish base line rates of current pediatric patient satisfaction scores for patients seen in the urgent care setting at 61st location. Metric 1: clinic visits Data Source: envision software (current), EPIC software (future). Goal: establish base line patient satisfaction scores to project from in future years.	**Milestone 3: [P-2]** Establish base line rates of current pediatric patient satisfaction scores for patients seen in the urgent care setting at 61st location. Metric 1: clinic visits Data Source: envision software (current), EPIC software (future). Goal: establish base line patient satisfaction scores to project from in future years. Milestone 2 estimated incentive payment: $40,841	**Outcome Improvement Target 1 IT-6.1(1)** Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores. Improvement Target: Improve 2% over baseline of patient satisfaction set in DY3 in satisfaction domain of patients getting timely care, appointments, and information. Data Source: Patient Survey Metric = Percent improvement in (1) getting timely care, appointments, and information/Number of patients who were given survey. Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,825 **Outcome Improvement Target 2 IT-6.1(1):** Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores. Improvement Target: Improve 1% over baseline set in DY3 in satisfaction domain of how well doctors communicate. Data Source: Patient Survey Metric = Percent improvement in (2) how well	**Outcome Improvement Target 3 IT-6.1(2):** Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores. Improvement Target: Improve 4% benchmark established in DY3 over national average benchmark in satisfaction domain of how well doctors communicate Data Source: Patient Survey Metric = Percent improvement in (2) how well doctors communicate/Number of patients who were given survey. Outcome Improvement Target 3 Estimated Incentive Payment*:* $101,792 **Outcome Improvement Target 4 IT-6.1(1):** Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores. Improvement Target: Improve 2% over baseline set in DY3 in satisfaction domain of patients getting timely care, appointments, and information Data Source: Patient Survey Metric = Percent improvement in (1) are

094092602.3.2	IT-6.1 (1),(2)	Percent Improvement over baseline of patient satisfaction scores.	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.2		
Starting Point/Baseline:	Establish baseline patient satisfaction scores in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$11,453.50		doctors communicate/Number of patients who were given survey. Outcome Improvement Target 2 Estimated Incentive Payment*:* $50,825	getting timely care, appointments, and information/Number of patients who were given survey. Outcome Improvement Target 3 Estimated Incentive Payment*:* $101,792
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $22,907	Year 3 Estimated Outcome Amount: $40,841	Year 4 Estimated Outcome Amount: $101,650	Year 5 Estimated Outcome Amount: $203,584
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $368,981			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6, Patient Satisfaction
Project Option: IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction
Project Title: Expansion of Alvin Primary Care Clinic to Include Adult Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.3

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
Outcome targets for this project are selected from two domains. First, we would like to demonstrate that clinic expansion is meeting the goal of increased capacity in a way that brings convenience to the clients.

IT-1.1 Third next available appointment[1,2]: *(Non- standalone measure)*
Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

a Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.

b Denominator: This measure applies to providers within a reported clinic and/or department
Inclusions: This measure applies to providers* within a reported clinic and/or department**
*Providers:

A. All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week.
   1. Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice).
   2. When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA).
   3. If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing.
   4. For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time.
   5. New providers who started seeing patients during the reporting period and have an active schedule should be included.

[1] http://www.ihi.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx
[2] http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918

B. Locums are included in the measure only if they are assigned to a specific site for an extended period of time (greater than 4 weeks) and provide continuity care to a panel of patients.

C. Mid-Level providers are included in the measure (NP, PA, and CNM).
   1. Mid-Level providers should have continuity practice and their own schedule available to see patients.

D. Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization.

   Providers with closed practices should be included. They still have to schedule their current patients. In addition, it may not be clear when they start seeing new patients again.

   **Departments: Primary Care, General Internal Medicine

   a. Family Practice
   b. Pediatrics with the focus on generalists, not specialists' c. Med/Peds (physicians who see both adults and children)

      Exclusions:

      - Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave.
      - Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included.
      - Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.

c Data Source: Appointment management system d. Rationale/Evidence: Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the third next available appointment is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen.

Overarching Goals:

- Decrease number of days to third next available appointment to zero days (same day) for Primary Care.
- Decrease number of days to third next available appointment to two days for Specialty Care.

Data Collection: Sample all physicians on team the same day of the week, once a week. Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Report the average number of days for all physicians sampled.

OD-6 Patient Satisfaction

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

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool.
(2) how well their doctors communicate ***(Standalone measure)***

a Numerator: Percent improvement in targeted patient satisfaction domain

b Data Source: Patient survey

c Denominator: Number of patients who were administered the survey

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

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. 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.

Outcome Measure Valuation:

The patient satisfaction survey scores will focus on the question “how well their doctors communicate”. Currently the clinics use the Press Ganey survey tool, and data is available for the pediatric practice. CG-CAHPS will become the patient satisfaction tool, as its use is adopted, and results will be correlated between Press Ganey and CG-CAHPS.

094092602.3.3	OD 6 IT-6.1 (1),(2)	Percent Improvement over baseline of patient satisfaction scores.	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.3		
Starting Point/Baseline:	Starting point/baseline for first IT: Year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 **P-1:** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Data source: Business Plan Rationale: New project startup. Goal: Document implementation plan. Determine timeline. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $162,733 **Process Milestone 2** P-2: Establish baseline rates Data source: Epic Goal: Initiate registry Rationale: New project startup. Process Milestone 2 Estimated Incentive Payment: $162,733	**Process Milestone 3** **P-3:** Develop and test data systems Data source: Epic Reports/Patient Registries Goal: Implement new registry. Rationale: New project start up. Milestone 3 Estimated Incentive Payment: $127,394.50 **Outcome Improvement Target 1** IT 6.1 "Top Box" Standard Access patient Satisfaction scores are at or above 70. Data Source: patient satisfaction scores for certain supplemental modules for the adult CG-CAHPS and/or Press Ganey survey stored in Epic. Outcome Improvement Target 1 Estimated Incentive Payment*:* $127,394.50	**Outcome Improvement Target 2** IT 6.1 "Top Box" Standard Access patient Satisfaction scores are at or above 73. Data Source: patient satisfaction scores for certain supplemental modules for the adult CG-CAHPS and/or Press Ganey survey stored in Epic. Outcome Improvement Target 2 Estimated Incentive Payment*:* $277,118	**Outcome Improvement Target 3** IT 6.1 "Top Box" Standard Access patient Satisfaction scores are at or above 75. Data Source: patient satisfaction scores for certain supplemental modules for the adult CG-CAHPS and/or Press Ganey survey stored in Epic. Outcome Improvement Target 3 Estimated Incentive Payment*:* $656,005
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $325,466	Year 3 Estimated Outcome Amount: $254,789	Year 4 Estimated Outcome Amount: $277,118	Year 5 Estimated Outcome Amount: $656,005
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,513,378			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.1 Third Next Available Appointment
Project Title: Expansion of Alvin Primary Care Clinic to Include Adult Care
UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.4

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:

Third Next Available Appointment

Identifying Outcomes Measure and Provider Information

Outcome targets for this project are selected from two domains.

OD 1 Primary Care Expansion
IT1.1 Third Next Available Appointment (Non-Standard Measure)

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

OUTCOME MEASURE DESCRIPTION

Outcome targets for this project are selected from two domains. First, we would like to demonstrate that clinic expansion is meeting the goal of increased capacity in a way that brings convenience to the clients.

IT-1.1 Third next available appointment[1,2]: *(Non- standalone measure)*

Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

d Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.

e Denominator: This measure applies to providers within a reported clinic and/or department

Inclusions: This measure applies to providers* within a reported clinic and/or department**

*Providers:

E. All providers are included. Full-time and part-time providers are included

1. Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice).
2. When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA).

[1] http://www.ihi.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx
[2] http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918

3. If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing.
4. For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time.
5. New providers who started seeing patients during the reporting period and have an active schedule should be included.

F. Locums are included in the measure only if they are assigned to a specific site for an extended period of time (greater than 4 weeks) and provide continuity care to a panel of patients.

G. Mid-Level providers are included in the measure (NP, PA, and CNM).
   1. Mid-Level providers should have continuity practice and their own schedule available to see patients.

H. Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization.

Providers with closed practices should be included.

**Departments: Primary Care, General Internal Medicine

b. Family Practice b. Pediatrics with the focus on generalists, not specialists' c. Med/Peds (physicians who see both adults and children)

Exclusions:

o Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave.

o Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included.

o Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.

f Data Source: Appointment management system d. Rationale/Evidence: Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the third next available appointment is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen. Access to healthcare is important to the quality of healthcare outcomes.

Overarching Goals:

- Decrease number of days to third next available appointment to zero days (same day) for Primary Care.

- Decrease number of days to third next available appointment to two days for Specialty Care.

Data Collection: Sample all physicians on team the same day of the week, once a week. Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Report the average number of days for all physicians sampled.

OD-6 Patient Satisfaction

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

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(2) how well their doctors communicate ***(Standalone measure)***

e Numerator: Percent improvement in targeted patient satisfaction domain

f Data Source: Patient survey

g Denominator: Number of patients who were administered the survey

h Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers.

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. 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.

OUTCOME MEASURE VALUATION:

The patient satisfaction survey scores will focus on the question “how well their doctors communicate”. Currently the clinics use the Press Ganey survey tool, and data is available for the pediatric practice. CG-CAHPS will become the patient satisfaction tool, as its use is adopted, and results will be correlated between Press Ganey and CG-CAHPS.

094092602.3.4	OD 1 IT-.1.1	Third next available appointment	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.3		
Starting Point/Baseline:	TBD Starting point/baseline for first IT: Year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 **P-1:** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Data source: Business Plan Rationale: New project startup. Goal: Document implementation plan. Determine timeline. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $162,733 **Process Milestone 2** **P-2**: Establish baseline rates Data source: Epic Goal: Initiate registry Rationale: New project startup.	**Process Milestone 3** **P-3:** Develop and test data systems Data source: Epic Reports/Patient Registries Goal: Implement new registry. Rationale: New project start up. Milestone 3 Estimated Incentive Payment: $127,394 **Outcome Improvement Target 1** IT-1.1: Third next available appointment: (Non- standalone measure) Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Denominator: Denominator: This measure applies to providers within a reported clinic and/or department Data Source: Epic Rationale: Access is ability to seek and receive care. Third next available is industry standard. Goal: Decrease days to third available appointment to zero.	**Outcome Improvement Target 2** [IT-1.1]: Third next available appointment: (Non- standalone measure) Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Denominator: Denominator: This measure applies to providers within a reported clinic and/or department Data Source: Epic Rationale: Access is ability to seek and receive care. Third next available is industry standard. Goal: Decrease days to third available appointment to zero. Outcome Improvement Target 2 Estimated Incentive Payment*:* $277,118	**Outcome Improvement Target 3** [IT-1.1]: Third next available appointment , : (Non- standalone measure) Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Denominator: Denominator: This measure applies to providers within a reported clinic and/or department Data Source: Epic Rationale: Access is ability to seek and receive care. Third next available is industry standard. Goal: Decrease days to third available appointment to zero. Outcome Improvement Target 3 Estimated Incentive Payment*:* $656,005

094092602.3.4	OD 1 IT-.1.1	Third next available appointment	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.3		
Starting Point/Baseline:	TBD Starting point/baseline for first IT: Year 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment: $162,733	Outcome Improvement Target 1 Estimated Incentive Payment: $ 127,395		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $325,466	Year 3 Estimated Outcome Amount: $254,789	Year 4 Estimated Outcome Amount: $277,118	Year 5 Estimated Outcome Amount: $656,005
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,513,378			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3, Potentially Preventable Re-Admission- 30 day Readmission Rates (PPRs); IT 3.12 VAD
Additional non-standalone measures added: OD-1 Primary Care and Chronic Disease Management; IT-1.20(a) Monitoring of compliance with medical regimen, and IT-1.20(b) Decrease waitlist time for end-stage renal failure patients
Project Option: 1.3.1 Implement and Use Chronic Disease management Registry
Project Title: Transplantation Chronic Disease Management Registry

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.5

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:

P-3 Develop and Test Data Systems – to ensure accuracy and effectiveness of the system, we will periodically run monthly reports to verify status on enrollment of patients into the registry and accuracy of reminders. Through ongoing testing of the system, we can identify and address issues in a timely and efficient manner.

IT 3.12 Lower PPR for VAD) Decrease readmission rates in the Ventricular Assist Device population (VAD) as the registry allows for more effective patient tracking pre transplant/VAD implantation procedure to ensure that patients are compliant; post procedure which allows for early identification and treatment of factors that may influence readmission, such as non-compliance with the medical regimen. One goal is to decrease VAD readmission rates within 30 days of discharge from implantation by 3% initially and 5% over baseline by year 5 .Baseline readmission is 38% within 30 days of VAD procedure in FY12. A ventricular assist device (VAD) is a technological advance that artificially assists the heart thus controlling the signs and symptoms of heart failure. Through the utilization of this technology readmission rates are expected to decrease. This also provides a means for patients with end stage cardiovascular disease to survive until cardiac transplantation is a viable option. . I

IT-1.20 (a)) Other Improvement Targets – are monitoring of compliance with the medical regimen follow-up schedule for patients with end stage organ failure currently on the organ transplant waitlist. The baseline for this target is 0/200 currently waitlisted patients, as the current process for monitoring is manual and very labor intensive. This population will grow over time with program growth. Our goal is to effectively monitor 100/200 patients to be enrolled in the registry with progression to 200/200 of patients enrolled by year 5. IT 1-20 (b) Decrease time from referral to listing on the transplant waitlist. The registry allows for tracking of progress of patients toward listing. The goal would be to decrease from the baseline of 229 days by 3% and 5% respectively by year 5 which results in a decrease in dialysis days and potential for improved quality of life for patients currently suffering from end stage organ disease.

Overall effectiveness of the registry is measured by the ability to accurately track patient's due dates for follow-up visits and, testing and compliance with the health maintenance schedule throughout all phases of patient care for this high risk population. CMS Conditions of Participation (CMS CoP 482.94) for Transplant Centers and the United Network for Organ Sharing (UNOS) require evaluation testing for patients with end stage organ failure, as well as, continued testing and monitoring to treat the chronic condition through transplantation. The registry provides an effective tool to track patient data in one central location to improve communication with the primary/referring community physician throughout all phases of transplantation from referral to post-transplant. The registry allows for patient data to be maintained in a single repository. This registry allows for streamlining of shared information to primary care providers and referring physicians. As reported in "Ending the Document Game" one of every seven primary care visits is affected by missing medical information. A single repository for patient information minimizes this risk and allows for the opportunity to communicate and/or access a complete patient record electronically to promote collaboration with the over 50% of primary care physicians currently utilizing an electronic format for medical records (as published in Information Week HealthCare July 13, 2010). Additional benefits of this patient registry is that it provides a repository for patient data improving the ability to track patients and their progress toward listing which allows for a reduction in the time from referral

to listing and early identification and treatment of issues that may increase readmission rates, such as, non-compliance with follow-up. As continuous monitoring and collaboration with primary care providers is essential throughout all phases of transplantation from referral to post-transplant, this registry provides a means of effective management of this chronic and challenging patient population improving communication, and through patient tracking of due dates for testing; ensures early identification and treatment of infection and/or rejection to ensure optimal medical management and health status for the waitlisted patient as well as decreasing the risk of organ failure and return to end stage organ disease for the post transplant patient.

RATIONALE

The reason for selecting implementation of a chronic disease registry and specifically primary care and chronic disease management to ensure early identification and treatment of new or worsening co-morbidities, such as, hypertension, heart disease and diabetes, which are prevalent in our region and this patient population. The overreaching goal is to maximize medical management to maintain or improve current health status and suitability for continued listing to give this high risk patient population every opportunity to address their chronic conditions through transplantation. In addition, this provides documentation to share with referring providers, dialysis units and primary care physicians in the community to improve and promote collaboration, communication and continuity of care for this patient population.

From a quality standpoint, the registry provides a repository for data collection to actively promote analysis and real time trending of data and compliance with patient care protocols to ensure cost effective treatments and promote patient and graft survival in support of continuous quality improvement efforts.

OUTCOME MEASURE VALUATION

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.5	OD-1, IT-1.20	Other Outcome improvement target	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.4		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Create project scope. Identify multidisciplinary steering committee members. Develop timeline and project budget. Goal: Meet scope requirements and deadlines Data source: *project scope/implementation plan* Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $278,937	**Process Milestone 2 [P-4]** Develop and test data systems Goal: Ensure accurate assessment of the ability of the registry to monitor patients on the waitlist. Numerator/Denominator or other metric: # of patients accurately assessed/200 patients on waitlist Data source: registry reports/UNOS database compliance reports Goal: provide an accurate assessment of the ability of the registry to monitor patients Rationale: This registry is an improved attempt to identify patients with a variety of conditions in various stages of diseases and monitor real time suitability for wait -listing and promote early identification of new or worsening co-morbidities . By federal regulation patients on the transplant waitlist must be monitored for ongoing suitability for transplant which includes annual testing at a minimum. Process Milestone 2 Estimated	**Outcome Improvement 1** IT-3.12 PPR VAD Goal: Decrease VAD readmission rates by 3% over baseline.. Baseline – 5/13= 38% FY 12. Data Source: EMR/Registry Numerator# LVAD patients with a hospital readmit within 30 days of discharge Denominator: # of LVAD patients receiving a LVAD implant. Rationale: Data system allows for closer tracking of patients pre procedure to ensure they are compliant and post procedure to measure and promptly address factors that may influence readmission. Outcome Improvement Target 1 estimated incentive payment**:** $47,105.33 **Outcome Improvement Target 2:** IT-1.20 (a) Waitlist compliance Monitoring Goal: 50% of waitlist receiving compliance monitoring (100 patients receiving compliance monitoring) Numerator: Number of patients	**Outcome Improvement Target** 4 IT-3.12 PPR VAD Goal: Decrease VAD readmission rates by 6% over baseline.. Baseline – 5/13= 38% FY 12. Data Source: EMR/Registry Numerator# LVAD patients with a hospital readmit within 30 days of discharge Denominator: # of LVAD patients receiving a LVAD implant. Rationale: Data system allows for closer tracking of patients pre procedure to ensure they are compliant and post procedure to measure and promptly address factors that may influence readmission. Outcome Target 4 estimated incentive payments: $51,816 **Outcome Improvement Target 5** **IT-1.20 (a)** Waitlist compliance monitoring- Goal: 100% Waitlist compliance monitoring- Numerator: Number of patients receiving compliance monitoring Denominator 200 patients entered

094092602.3.5	OD-1, IT-1.20	Other Outcome improvement target	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.4		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Incentive Payment: $94,211	receiving compliance monitoring Denominator 200 patients entered into patient registry Data Source: EMR/Registry Rationale/Evidence: Improve effective management of chronic conditions to promote continued suitability to offer transplantation as a treatment option for patients with chronic disease to promote improved health outcomes. By federal regulation patients on the transplant waitlist must be monitored for ongoing suitability for transplant which includes annual testing at a minimum. Outcome Improvement Target 2 estimated incentive payment: $47,105.33 **Outcome Improvement Target 3** IT1.20 (b) Reduce time from referral to waitlist for patients with renal failure Goal: Decrease time from referral to listing of renal patients by 10%. .. Numerator: Number of median days from referral to waitlist for all renal failure patients	into patient registry Data Source: EMR/Registry Rationale/Evidence: Improve effective management of chronic conditions to promote continued suitability to offer transplantation as a treatment option for patients with chronic disease to promote improved health outcomes. By federal regulation patients on the transplant waitlist must be monitored for ongoing suitability for transplant which includes annual testing at a minimum. Outcome Improvement Target 5 estimated incentive payments: $51,816 **Outcome Improvement Target 6** IT1.20 (b) Reduce time from referral to waitlist for patients with renal failure Goal: Decrease time from referral to listing of renal patients by 20%. .. Numerator: Number of median days from referral to waitlist for all renal failure patients Denominator : Baseline FY11 – QTR 4

094092602.3.5	OD-1, IT-1.20	Other Outcome improvement target	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.1.4**		
Starting Point/Baseline:	**Baseline TBD in DY2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Denominator: Baseline FY11 – QTR 4 Median 229 days. Data Source: EMR/patient registry Rationale/Evidence: More efficient listing increases the size of the waitlist resulting in additional patients being eligible for transplantation in response to their chronic kidney disease. This leads to decrease costs as the patients spend less time on dialysis and improved quality of life. Outcome Improvement Target 3 Estimated Incentive Payment: $47,105.33	Median 229 days. Data Source: EMR/patient registry Rationale/Evidence: More efficient listing increases the size of the waitlist resulting in additional patients being eligible for transplantation in response to their chronic kidney disease. This leads to decrease costs as the patients spend less time on dialysis and improved quality of life. Improvement Target 6 estimated incentive payments: $51,816
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $278,937	Year 3 Estimated Outcome Amount: $94,211	Year 4 Estimated Outcome Amount: $141,316	Year 5 Estimated Outcome Amount: $155,448
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $669,912			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure
Project Title: Implement and Utilize Disease Management Registry

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.6

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION
The outcome measure selected for evaluation for *Implement and use chronic disease management registry* will be HbA1c poor control (>9.0%). HbA1c will be assessed for type 1 and type 2 diabetic patients included in the chronic disease registry. The denominator population will be diabetic patients between 18 to 75 years of age. The numerator will be the number of patients in the denominator where the most recent HbA1c recorded during the measurement period was greater than 9.0%. The EHR, from which the registry population is derived, contains all the necessary elements for evaluation, including lab values and documentation in the problem list.

Baseline scores for HbA1c will be determined based on performance observed during 2011 and reported to CMS through The Group Practice Reporting Option. Improvement targets will be set for years 3 through 5 as follows:

Baseline: 22.10% (GPRO 2011 performance)
Year 3 - 2 percentage points below the baseline or 20.1%
Year 4 - 5 percentage points below the baseline or 17.1%
Year 5 - 7 percentage points below the baseline or 15.1%
P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan
P-2 Establish baseline rates
P-3 Develop and test data systems
A chronic disease registry implementation requires participation principally from information technology, clinical staff, and EHR vendor involvement. Correct configuration will ensure accurate patient populations are created and promote confidence among users of the registries. Representatives from IT, clinical staff and EHR vendor will be identified. Project team duties will include identifying current capacity and needed resources, determine timelines and develop an implementation plan.

Close coordination between technical and clinical staff is critical in development of disease registries in the EHR. Analysis of necessary components often requires a translation of clinical

and technical terms between information technology and clinical staff. Individual indicators will be assigned to subgroups to investigate workflows and to pinpoint data elements in the EHR for designation in the configuration of the registries.

By year 2 Initial configuration for chronic disease registries should be complete and ready for testing. After initial runs to populate the registries, the project team will identify measures to ensure accuracy of individual indicators and recommend configuration changes to produce more accurate data.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

PDSA cycles will be incorporated to improve data collection and intervention activities. Methodical application of PDSA principles enable cross sectional improvement teams to effectively analyze and target improvement initiatives.

P-5 Disseminate findings, including lessons learned and best practices, to stakeholders.

The project team will disseminate findings, including lessons learned and best practices, to stakeholders. The goal is to raise awareness of project experience among leadership and clinical staff. Publication of successes and failures promotes a transparent atmosphere and support in the organization to undertake improvement initiatives.

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

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.

- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.6	IT-1.10	Diabetes Care: HbA1c Poor Control (>9.0%)	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.5		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Data Source: Meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $31,403.66 **Process Milestone 2** [P-2] Establish baseline rates Data Source: EHR, Meeting minutes Process Milestone 2 Estimated Incentive Payment: $31,403.66 **Process Milestone 3** [P-3] Develop and test data systems Data Source: EHR Process Milestone 3 Estimated Incentive Payment: $31,403.66	**Process Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Meeting minutes Process Milestone 4 Estimated Incentive Payment: $48,200 **Process Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Improvement team findings/reports Process Milestone 5 Estimated Incentive Payment: $ 48,200 **Outcome Improvement Target 1** [IT-1.10] Improvement Target: Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure). Decrease of at least 2 percentage points under the	**Outcome Improvement Target 2** [IT-1.10] Improvement Target: Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure). Decrease of at least 5 percentage points under the baseline. Data Source: EHR **Outcome Improvement Target 2** Estimated Incentive Payment*:* $70,658	**Outcome Improvement Target 3** [IT-1.10] Improvement Target: Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure). Decrease of at least 7 percentage points under the baseline. Data Source: EHR **Outcome Improvement Target 3** Estimated Incentive Payment*:* $538,137

094092602.3.6	IT-1.10	Diabetes Care: HbA1c Poor Control (>9.0%)	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.1.5**		
Starting Point/Baseline:	**Baseline TBD in DY2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $48,200		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $94,211	Year 3 Estimated Outcome Amount: $144,600	Year 4 Estimated Outcome Amount: $70,658	Year 5 Estimated Outcome Amount: $538,137
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $847,606			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9, Right Care, Right Setting
Project Option: IT-9.2 ED appropriate utilization (standalone measure) Reduce all ED visits (including ambulatory care sensitive conditions)
Project Title: Nurse Advice Line: Texas Regional Health Line (Region 2)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.7

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
The goal is to reduce inappropriate visits to the Emergency Department (right care, right setting) for target populations in the participating communities in the region by 15% over the next 5 years.

DY2 will identify target patient populations by community and emphasize active promotion of nurse advice line by informing patients on the availability of services and educating them on how to use the nurse line.

DY3 will establish baseline rates for nurse advice line use by target population and establish metrics for measuring the ED utilization. Additionally learning collaborative will be established to improve communication between participating communities and provide opportunities to share lessons learned and to engage in quality improvement initiatives.

DY4 will begin measuring increases in utilization of the nurse advice line and corresponding reduction in people seeking inappropriate care in the ED as reported by the callers of the nurse advice line and reports generated by Emergency Departments in the target population communities. Goal is to increase nurse advice line utilization baseline set in DY3 by 5%.

DY5 will continue measuring increases in utilization of the nurse advice line and corresponding reduction in people seeking inappropriate care in the ED as reported by the callers of the nurse advice and reports generated by Emergency Departments in the target population communities. Goal is to increase nurse advice line utilization from established baseline in DY 4, goal of 10%

Rationale
Rationale for these outcomes includes patients that use Nurse Triage services are less likely to

go to the ED, preventing unnecessary visits[1]. Targeted populations will come from communities where this service is not currently available and therefore there is no baseline data. Access to the nurse advice team will offer an after-hours alternative to the emergency department for patients who are concerned and not sure if they have an emergent condition or what the appropriate setting is for addressing their health concern.

Outcome Measure Valuation

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Provision of a nurse advice line is a low cost project that covers a large population. The severity of inappropriate emergency department utilization in our region is great as was documented in the community needs assessment. The cost savings of reducing inappropriate emergency department utilization are substantial. In addition to reducing the inappropriate emergency department visits there will be a positive increase in patient experience as well as increased provider satisfaction with right care provided in the right setting.

---

[1] Telephone Nurse Triage System Reduces Use of Emergency Department by Dent, Robert MBA, RN, FACHE: *Nonurgent Patients, Reducing Wait Times, Length of Stay, and Patient Walkouts 9/29/2010* Obtained from http://www.innovations.ahrq.gov/content.aspx?id=2860

Campbell R. Hospital telephone nurse triage system well used. MyWestTexas News. November 3, 2009. Available at: http://www.mywesttexas.com/articles/2009/11/03/news/top_stories/doc4aefc4c6bfa24616439722.txt

Billings J., Parikh N. Mijanovich T. Emergency Department use in New York City: A Substitute for Primary Care? The Commonwealth Fund: Issue Brief, November 2000

094092602.3.7	IT-9.2	ED appropriate utilization (Standalone measure)	
The University of Texas Medical Branch at Galveston			TPI 094092602
Related Category 1 or 2 Projects:	094092602.1.6		
Starting Point/Baseline:	**Baseline data: The actual baseline data is not known and will be determined in DY2** **Target populations will be defined in DY2.**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Establish nurse advice line for participating counties Data source: There is no current service in participating counties documentation of current capacity and needed resources, timelines, implementation plans and stakeholder engagement. service in participating counties Goal: To provide urgent medical advice to community and reduce ED visits as evidence by patients in participating communities in Region 2 accessing nurse advice line Rationale: Patients that use Nurse Triage services are less likely to go to ED, preventing unnecessary visits.	**Process Milestone 2** P-2 Establish baseline rates Goal: to determine baseline for nurse advise utilization from target population and to establish metrics for measuring corresponding • unnecessary ED utilization by target population. Numerator: number of calls to nurse advice line Denominator: 0 Metrics for determining unnecessary ED utilization by target population to be developed and baseline established. Process Milestone 2 Estimated Incentive Payment: $431,543	**Outcome Improvement Target 1:** IT-9.2 ED Appropriate Utilization Goal for this milestone/metric: 5% improvement from baseline in number of patient not utilizing ED by patients Data source: Call Center data on self-reported data from patient Improvement Target: 5% of patients calling the nurse advice line accept alternative setting for appropriate care and do not use the emergency department. Outcome Improvement Target 1: Estimated Incentive Payment $1,021,023	**Milestone 3 Outcome Improvement Target 2:** IT-9.2 ED Appropriate Utilization Goal for this milestone/metric:10% improvement from baseline in number of patients not utilizing ED utilization by patients calling the nurse advice line. . Data source: Call Center data on self-reported data from patient Improvement Target: 10% of patients calling the nurse advice line accept alternative setting for appropriate care and do not use the emergency department. Outcome Improvement Target 2: Estimated Incentive Payment $2,009,008

094092602.3.7	IT-9.2	ED appropriate utilization (Standalone measure)	
The University of Texas Medical Branch at Galveston			**TPI 094092602**
Related Category 1 or 2 Projects:	**094092602.1.6**		
Starting Point/Baseline:	**Baseline data: The actual baseline data is not known and will be determined in DY2** **Target populations will be defined in DY2.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $123,065			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $123,065	Year 3 Estimated Outcome Amount: $431,543	Year 4 Estimated Outcome Amount: $1,021,023	Year 5 Estimated Outcome Amount: $2,009,008
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,584,639			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):

Outcome Measure: OD-3, Potentially Preventable Re-Admissions-30 Day Re-Admission Rates
Project Option: IT-3.1 All Case 30 Day Readmission Rate
Project Title: Enhance Performance Improvement and Reporting Capacity

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.8

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:

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

IT-3.1 All cause 30 day readmission rate- NQF 1789 (Standalone measure)

Process Milestones 1 - 3 (DY2 and DY3):

P-1 Project planning - We will 1) track the establishment and use of regional infrastructure; 2) track member participation of teams in all efforts – including regional readmission improvement collaborative learning sessions (incl. improvement training), collaborative teleconference calls and webinars, and local improvement project team meetings; and 3) evaluate the effectiveness of our approach to skill-building with each session and at the close of the collaborative.

P-2 Establish baseline rates - Metric: 30 Day readmission rate for participating member facility. There is regional agreement on a priority focus on reducing readmissions. Texas HHSC has supplied Potentially Preventable Readmission Reports to member hospitals for the last two years. The results for CMS Hospital Compare performance data in Figure 1 illustrates that while rates of readmission in RHP 2 hospitals are not any different than those of US hospitals generally, there remains ample opportunity for reduction.

Hospital Name	ANGLETON-DANBURY MEDICAL CENTER	BRAZOSPORT REGIONAL HEALTH SYSTEM	CHRISTUS HOSPITAL	CHRISTUS JASPER MEMORIAL HOSPITAL	CLEVELAND REGIONAL MEDICAL CTR	MEMORIAL HERMANN BAPTIST BEAUMONT HOSPITAL	MEMORIAL HERMANN BAPTIST ORANGE HOSPITAL	MEMORIAL MEDICAL CENTER LIVINGSTON	NACOGDOCHES MEDICAL CENTER	THE MEDICAL CENTER OF SOUTHEAST TEXAS	TYLER COUNTY HOSPITAL	UNIVERSITY OF TEXAS MEDICAL BRANCH GAL	WOODLAND HEIGHTS MEDICAL CENTER
Hospital 30-Day Readmission Rates from Heart Attack	**Not Available**	**19.5**	**19.8**	**Not Available**	**Not Available**	**18.4**	**19.1**	**Not Available**	**19.7**	**18.2**	**Not Available**	**19.6**	**19.4**
Comparison to U.S. Rate - Hospital 30-Day Readmission Rates from Heart Attack	Number of Cases Too Small	No Different than U.S. National Rate	No Different than U.S. National Rate	Number of Cases Too Small	Number of Cases Too Small	No Different than U.S. National Rate	No Different than U.S. National Rate	Number of Cases Too Small	No Different than U.S. National Rate	No Different than U.S. National Rate	Number of Cases Too Small	No Different than U.S. National Rate	No Different than U.S. National Rate
Number of Patients - Hospital 30-Day Readmission Rates from Heart Attack	17	110	404	8	17	281	29	18	94	95	13	106	110
Hospital 30-Day Readmission Rates from Heart Failure	**23.2**	**24.7**	**24.7**	**22.9**	**26.1**	**25.8**	**25.4**	**25.8**	**26.3**	**23.5**	**25.4**	**24.4**	**21.3**
Comparison to U.S. Rate - Hospital 30-Day Readmission Rates from Heart Failure	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Number of Patients - Hospital 30-Day Readmission Rates from Heart Failure	142	251	1049	85	148	585	124	247	213	324	70	263	283
Hospital 30-Day Readmission Rates from Pneumonia	**17.2**	**17.4**	**16.6**	**17**	**20.8**	**18.2**	**16.4**	**17**	**18.1**	**18**	**19.3**	**19.1**	**20.5**
Comparison to U.S. Rate - Hospital 30-Day Readmission Rates from Pneumonia	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Lower Readmission Estimate - Hospital 30-Day Readmission Rates from Pneumonia	13.9	14.6	14.3	13.9	16.9	15.8	12.9	14	14.8	14.7	15.4	15.6	17

Figure 3. Readmissions data Region 2 Hospitals, recent Hospital Compare website

P-3 Develop and test data systems - Metric: Periodic reporting of 30 day readmission. We will use simple, intermittent, real-time assessments of readmissions during the course of the collaborative to assess impact of tests of change.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric: Number of PDSA cycles successfully completed. We will regularly track the iterative tests of change that members conduct at each participating site – both via groupware for common access and via one-page story boards that will be the basis for bi-weekly teleconference calls.

Outcome Improvement Targets 1 and 2 (DY4 and DY5):

DY4 IT-3.1 All cause 30 day readmission rate- NQF 1789 (Standalone measure). Baseline: TBD in Year 2; [Texas Region 2 - 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)]; Improvement Target: 16% average for Region 2

DY5 IT-3.1 All cause 30 day readmission rate- NQF 1789 (Standalone measure). Baseline: TBD in Year 2; [Texas Region 2 - 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)]; Improvement Target: 15% average for Region 2

RATIONALE:

The ultimate measure of impact of this Improvement Collaborative will be the outcomes of publicly reported measures of hospital readmission by comparing baseline rates of hospital readmission established in DY 2 against resulting rates in DY 4 and DY 5. The All cause 30 day readmission rate estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[1]

Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. For all individual conditions, admissions for patients that meet any of the following criteria are excluded. These exclusions were originally listed as part of the Heart Failure readmission metric,[2] obtained from the National Quality Forum, and are applied to all other individual-condition metrics for consistency.

- With an in-hospital death;
- Without at least 30 days post-discharge enrollment in Medicare FFS;
- Transferred to another acute care facility;
- Discharged against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge);
- Admitted with heart failure within 30 days of discharge from an index admission.

[1] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75-91.

[2] Quality Positioning System (QPS) Measure Description Display Information: Heart Failure. http://www.qualityforum.org/QPS/. Accessed June 5, 2012.

Addressing the issue of potentially avoidable readmissions requires a community approach with input from various actors across the continuum of care. Better health care outcomes are not only dependent on receiving better care in the hospital, but increasingly, on receiving better care at home.[3]

Several programs to reduce hospital readmissions have proven efficacious and even cost-effective in randomized controlled trials,[4] and this collaborative intervention aims to deploy resources needed to implement them among Region 2 hospitals.

OUTCOME MEASURE VALUATION

The average cost per readmission in the US is $14,500.[5] Using UTMB as an example, in FY 2010 there were 88 Potentially Preventable Readmissions attributable to only Medicaid patients ("Potentially Preventable Readmissions in the Texas Medicaid Population, SFY 2010" www.hhsc.state.tx.us and at www.tmhp.com). Extrapolating the aforementioned cost estimate to the UTMB Medicaid readmissions alone, a modest 2% reduction in potentially preventable readmissions would net savings of $ 25,000. The potential savings across all payers and all Region 2 settings will be calculated during DY 2 when baseline data for all participants is confirmed.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

[3] Osei-Anto A, Joshi M, Audet AM, Berman A, Jencks S, *Health Care Leader Action Guide to Reduce Avoidable Readmissions.* Health Research & Educational Trust, Chicago, IL. January 2010.

[4] Coleman EA, Parry C, Chalmers S, Min S-J. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006;166(17):1822-1828.

[5] Sommers, A and Cunningham, PJ. Physician visits after hospital discharge: Implications for reducing readmissions. Research Brief: National Institute for Health Care Reform. Number 6, December, 2011.

094092602.3.8	IT-3.1	All cause 30 day readmission rate- NQF 1789 (Standalone measure)	
The University of Texas Medical Branch Hospital at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.1.7**		
Starting Point/Baseline:	**Texas Region 2 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)**		
Year 2 (10/1/2012 – 9/30/2013)	**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 plan Metric: Member participation in a local readmission improvement training, learning, or project Data source: readmission improvement training attendance log or project meeting minutes Goal: 50% of collaborative members participate in training, learning or execute a readmission improvement project Rationale: Participating in training, learning or running a local readmission improvement project is the first step to improving readmission outcomes Milestone 1 Estimated Incentive Payment *(maximum amount):* $72,003 **Process Milestone 2 [**P-2]: Establish baseline rates	**Process Milestone 3 [P-3]:** Develop and test data systems Metric: Periodic reporting of 30 day readmission Data source: EHR, Claims Goal: 50% of members report 30 day readmission on a periodic basis (monthly, quarterly) Rationale: Periodic reporting is a necessary step to improvement and maintenance of goals Milestone 3 Estimated Incentive Payment *(maximum amount): $* $48,002 **Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Number of PDSA cycles successfully completed. Data source: PDSA documentation Goal: Each active participant	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate- NQF 1789 *(Standalone measure)* a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: Admissions to acute care facilities for patients aged 18 years or older. c. Data Source: EHR or Medical Record, Claims d. Baseline: TBD in Year 2 [Texas Region 2 - 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)] Improvement Target: 16% average for Region 2	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate- NQF 1789 (Standalone measure) a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: Admissions to acute care facilities for patients aged 18 years or older. c. Data Source: EHR or Medical Record, Claims d. Baseline: TBD in Year 2 [Texas Region 2 - 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)]

094092602.3.8	IT-3.1	All cause 30 day readmission rate- NQF 1789 (Standalone measure)	
The University of Texas Medical Branch Hospital at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.1.7		
Starting Point/Baseline:	Texas Region 2 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric: 30 Day readmission rate for participating member facility Data source: EHR or Medical Record, Claims Goal: Collect and track readmission data for 50% of Region 2 members Rationale: Measurement is a vital first step to improvement Milestone 2 Estimated Incentive Payment *(maximum amount):* $72,003	complete at least 1 PDSA cycle Rationale: Improvement goes beyond measurement into intervention activities. The success, failure, and lessons learned from PDSA cycles are critical to learning. Milestone 4 Estimated Incentive Payment *(maximum amount): $* $48,002 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Metric: # members attending of PDSA lesson learned sessions Data source: Each PDSA cycle will conclude with a lessons learned session available to the entire Region 2 membership. Goal: 50% of Region 2 members participate in a lesion learned session.	Outcome Improvement Target 1 Estimated Incentive Payment: $216,009	Improvement Target: 15% average for Region 2 Outcome Improvement Target 2 Estimated Incentive Payment: $475,220

094092602.3.8	IT-3.1	All cause 30 day readmission rate- NQF 1789 (Standalone measure)	
The University of Texas Medical Branch Hospital at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.1.7**		
Starting Point/Baseline:	**Texas Region 2 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Rationale: Sharing the direct results of a PDSA with the region will promote learning and invite collaboration to improve on future cycles. Milestone 4 Estimated Incentive Payment *(maximum amount):* $48,002		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $144,006	Year 3 Estimated Outcome Amount: $144,006	Year 4 Estimated Outcome Amount: $216,009	Year 5 Estimated Outcome Amount: $475,220
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $979,241			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD 3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
Project Option: IT-3.1 All cause 30 day readmission rate – NQF 1789
Project Title: Enhance Interpretation Services and Culturally Competent Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.17 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
IT 3.1 All Cause 30 day readmission rate – NQF1789 for the target population of LEP patients. In DY2, we selected P-1, Project Planning, including engaging stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan, because this is a major expansion that will require planning and coordination. This will allow us to properly plan ahead for the next four years.
The project plan will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. The metric used will be participation in Language Services infrastructure and staff planning. The data source for the project planning will be meeting agendas/minutes and project plan documents. The goal is for stakeholders to complete data-driven language services project plans that meet enterprise demands via direct service. The rationale is that stakeholder participation and needs-driven plans are the first step to improving language services

In DY3, we selected P-2, to establish baseline rates in order to provide a baseline for30 day all cause readmission rates in our target population (LEP and deaf patients) in subsequent years.

The metric will we use to establish the baseline rates for 30 day all cause re-admission rates for the targeted population which will be collected from internal data sources. Our goal for DY3 is to establish the baseline results in order to calculate the program's success. Measurement is a vital first step to improvement.

In DY4 and DY5, we selected outcome improvement targets. Outcome Improvement
IT-3.1 All cause 30 day readmission rate – NQF1789
The numerator is the difference between DY4 data on readmission rates for LEP patients and baseline results. Our goal for % decreased readmission rates will be based on baseline DY3 results. The data source is internal data collection systems.

Rationale/Evidence:

IT-3.1 All cause 30 day readmission rates is the best measure that reflects the overall regional improvement area identified.

In an article published by the Department of Family Medicine and Community Health, University of Massachusetts Medical School entitled, "Professional language interpretation and inpatient length of stay and readmission rates", the study conducted by Lindholm, Hargraves, Ferguson and Reed, indicates that LEP patients who did receive qualified interpretation services at admission and /or discharge were less likely to be readmitted within 30 days, than those who did not receive interpretation services. The Galveston County Needs Assessment also indicates the need for improving the health of Medicaid clients. Qualified interpreters and community education programs which meet the needs of LEP patients would have a significant impact on improving the health care for all LEP patients, including Medicaid and uninsured populations in Galveston County.

Outcome Measure Valuation

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.17	IT- 3.1	Percent reduction in 30 day all cause readmission rates for LEP patients (Standalone measure)	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.1.8**		
Starting Point/Baseline:	**Texas Region 2 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)**		
Year 2 (10/1/2012 – 9/30/2013)	**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 plan Metric: Participation in Language Services infrastructure and staff planning Data source: Project planning meeting agendas/minutes and project plan documents Goal: Stakeholders complete data-driven language services project plans that meet enterprise demands via direct service Rationale: Stakeholder participation and needs-driven plans are the first step to improving language services Milestone 1 Estimated Incentive Payment (maximum amount): $32,700	**Process Milestone 2 [**P-2]: Establish baseline rates Metric: All cause 30 day readmission rates for LEP and deaf patients Data source: Internal data source. Goal: Establish baseline Rationale: Measurement is a vital first step to improvement Milestone 2 Estimated Incentive Payment (maximum amount): $161,283	**Outcome Improvement Target 1** IT-3.1 Reduction in 30 day all cause readmission rates for target patient population Improvement Target: Reduce the percentage of all cause 30 day readmissions with target patient population by X% below baseline The numerator is the difference between DY4 data on readmission rates for LEP patients and baseline results. Our goal for % decreased readmission rates will be based on baseline DY3 results. The data source is internal data collection systems. Outcome Improvement Target 1 Estimated Incentive Payment: $294,068	**Outcome Improvement Target 2** IT 3.1 Reduction in 30 day all cause readmission rates for target patient population Improvement Target: Reduce the percentage of all cause 30 day readmissions with target patient population by X% below baseline The numerator is the difference between DY5 data on readmission rates for LEP patients and baseline results. Our goal for % decreased readmission rates will be based on baseline DY3 results. The data source is internal data collection systems. Outcome Improvement Target 2 Estimated Incentive Payment: $821,584

094092602.3.17	IT- 3.1	Percent reduction in 30 day all cause readmission rates for LEP patients (Standalone measure)	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.1.8**		
Starting Point/Baseline:	**Texas Region 2 30 Day Readmission Rates: 16.0%-18.3% (Dartmouth Atlas)**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,700	Year 3 Estimated Outcome Amount: $161,283	Year 4 Estimated Outcome Amount: $294,068	Year 5 Estimated Outcome Amount: $821,584
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,309,635			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-11, Addressing Health Disparities in Minority Populations
Project Option: IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group (HbA1C poor control among African Americans)
Project Title: Strengthening the UTMB health information system to Reduce Health Disparities

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.18 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
In DY2 we selected P-3 Develop and Test Data Systems (data source: reports from the electronic medical record).
In DY3 we selected P-2: Establish Baseline Rates (data source: electronic medical record).
In DY 4 and DY5 we selected IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group.

Rationale:
In DY2 we selected P-3 Develop and Test Data Systems. **Metric**: Ability of EMR to generate REAL data useful for monitoring health disparities and planning interventions to reduce disparities **Data source**: reports from the electronic medical record. **Goal**: To create a system that provides meaningful data for monitoring health disparities and planning interventions to reduce disparities. **Rationale**: We selected this Process Milestone because we need to ensure that our data system is set up to record outcomes for a range of clinical indicators that we may select based on the health disparity analysis that is part of this project.
In DY3 we selected P-2: Establish Baseline Rates. **Metric:** Calculation of baseline data on health disparities according to a variety of health outcomes and disparity stratifiers. **Data Source:** EMR reports. **Goal:** Creation of baseline rates of disparities for 3 clinical indicators showing significant disparities within the patient population

RATIONALE:
We selected this Process Milestone because we do not have a baseline for disparities data in relation to patient health experiences, access, and outcomes. Establishing baseline rates is necessary if we are to monitor and measure our progress toward improving a clinical indicator in a disparity group. By establishing the baseline rates after we have developed and tested the system, we can ensure that the baseline is more accurate. In order to confirm HbA1c poor control among African Americans as an appropriate Improvement Target in DY4 and DY5, baseline rates on this issue and group will be compared with other priority issues identified through the broad assessment of baseline rates of disparities more generally.

In DY 4 and DY5 we selected IT-11.1 Improvement in Clinical Indicator (HbA1c poor control) in Identified Disparity Group (OD- 11 Addressing Health Disparities in Minority Populations). **Metric**: Our Improvement Target will be: % improvement over baseline (TBD in DY3) of disparity . HbA1c poor control among African Americans. Because we have never before had the capacity to analyze and identify disparities in clinical indicators, the decision regarding which clinical indicator to improve is based on research describing common disparities. However, if the baseline data (to be collected in DY3) suggests that this is not a priority clinical indicator to address, we hope to able to redefine our outcome measure in consultation with HHSC and/or CMS. **Numerator**: # of disparity population patients with HbA1c poor control divided by # of total disparity population patients with diabetes. **Denominator**: # of total patients with HbA1c poor control divided by # of total patients with diabetes (E.g. African American patients with uncontrolled diabetes/African American patients with diabetes, divided by Total patients with uncontrolled diabetes/Total patients with diabetes). **Data source**: electronic medical record. **Goal**: In DY4 and DY5, our goal is to see an improvement over the baseline in DY3 The % improvement will be determined in DY3, based on reasonable impact expectations of the interventions proposed, as indicated in the research literature.

Rationale: We selected this Improvement Target because it best lent itself to disparities related work, provided a clear path for making sustainable evidence based change, and could be accomplished in the time frame allowed. The clinical indicator to be improved will be HbA1C poor control and disparity group addressed will be African Americans, unless data collected for baseline rates in DY3 indicate that this disparity issue and group is not a priority.

This category 1 project intends to collect and analyze REAL data from the merging of various health information systems at UTMB. This information will be used to prioritize clinical indicators and health outcomes with the greatest disparities based on REAL stratifiers. Next, clinical practices and health information system HIS controls will be implemented targeting these clinical indicators, leading to decreases in the targeted disparities. Thus, outcomeIT-11.1 is an appropriate outcome for this project.

Outcome Measure Valuation.

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.

- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.18	3.IT-11.1	Improvement in Clinical Indicator in Identified Disparity Group	
University of Texas Medical Branch			094092602
Related Category 1 or 2 Projects:	094092602.1.9		
Starting Point/Baseline:	Baseline TBD in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-3: Develop and Test Data Systems Metric: Ability of EMR to generate REAL data useful for monitoring health disparities and planning interventions to reduce disparitie Data Source: EMR reports Goal: To create a system that provides meaningful data for monitoring health disparities and planning interventions to reduce disparities Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $322,264	**Process Milestone 2** P-2: Establish Baseline Rates Metric: Calculation of baseline data on health disparities according to a variety of health outcomes and disparity stratifiers Data Source: EMR reports Goal: Creation of baseline rates of disparities for 3 clinical indicators showing significant disparities within the patient population Process Milestone 2 Estimated Incentive Payment: $74,356	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group(HbA1c poor control) Improvement Target: % improvement over baseline of HbA1c (improvement level TBD in DY3) Numerator: # of disparity population patients with HbA1c poor control divided by # of total disparity population Denominator: # of total patients with HbA1c poor control divided by # of total patients Goal: improve HbA1C control, rate TBD in DY3 based on reasonable impact expectations of the interventions proposed, as indicated in the research literature Data Source: electronic medical record Outcome Improvement Target 2 Estimated Incentive Payment*:* $104,633	**Outcome Improvement Target 2** IT-11.1: Improvement in Clinical Indicator in identified disparity group (HbA1c poor control) Improvement Target: % improvement over baseline of HbA1c (improvement level TBD in DY3) Numerator: # of disparity population patients with HbA1c poor control divided by # of total disparity population patients with diabetes Denominator: # of total patients with HbA1c poor control divided by # of total patients with diabetes Goal: improve HbA1C control, rate TBD in DY3 based on reasonable impact expectations of the interventions proposed, as indicated in the research literature Data Source: electronic medical record Outcome Improvement Target 3 Estimated Incentive Payment*:* $259,324
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome 322,264	Year 3 Estimated Outcome Amount: $74,356	Year 4 Estimated Outcome Amount: $104,633	Year 5 Estimated Outcome Amount: $259,324
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $760,577			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-4, Potentially Preventable Complications and Health Care Acquired Conditions
Project Option: IT-4.1: Improvement in Risk-Adjusted Potentially Preventable Complications Rate(s)
Project Title: Expand High Impact Specialty Care Capacity in most impacted Medical Specialties: Through Training for Burn and Trauma Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.19 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
IT-4.1: Percent improvement over baseline rate for patients with burns or traumatic injuries transferred to UTMB and Shriners:

1) Renal Failure
2) Length of Stay
3) Ventilator Days
4) Compartment Syndrome
5) Risk Adjusted Mortality

Process Milestones:

- DY2:
  - P- 1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P- 2: Establish baseline rates
- DY3:
  - P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome Improvement Targets for each year:

- DY4: IT-4.1: 5% Percent improvement over baseline rates for:
  1) Decrease Renal Failure
  2) Decrease Length of Stay
  3) Decrease Ventilator Days
  4) Decrease Compartment Syndrome
  5) Decrease Risk Adjusted Mortality
- DY5: IT-4.1: 10% Percent improvement over baseline rates for:
  1) Decrease Renal Failure

2) Decrease Length of Stay
3) Decrease Ventilator Days
4) Decrease Compartment Syndrome
5) Decrease Risk Adjusted Mortality

RATIONALE:

The process milestones were selected to establish a plan to collect data and to establish a baseline of average number of patients with burn and trauma injuries admitted to UTMB or Shriners Hospital that develop complications due to increased time to definite treatment and/or delay in transfer to UTMB or Shriners Hospital.

Outcome Measure Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.19	IT-4.1	Improvement in risk adjusted Potentially Preventable Complications rate(s) (Standalone measure)	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.2.1.10		
Starting Point/Baseline:	**We will gather baseline data regarding incidence, mortality, and time to definitive treatment for burn and trauma patients in Region 2. We may be only to obtain data from those patients that were transferred to UTMB and Shriners hospitals in DY2.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1)-Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Metric:** Documentation of assessment identifying complication rates and time to definitive care. **Goal**: Completion assessment and plan for implementation by 9/30/2013. **Process Milestone 1 Estimated** Incentive Payment $8,071.50 **Process Milestone 2** (P-2): Establish baseline rates of current complications providing increased risk to patient morbidity and mortality (Renal Failure, Respiratory Failure, Injury adjusted risk for mortality, Length of Stay, Compartment Syndromes). **Metric:** Baselines rates documented. **Goal:** Documentation completed.	**Process Milestone 3** (P-4)-Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Metric:** Documentation of PDSA cycle program specific to determine the needs to reduce complications previously listed. **Goal:** Develop and provide quality improvement activities based upon PDSA findings. **Data Source:** Program records. **Process Milestone 3 Estimated** Incentive Payment: $159,516	**Outcome Improvement Target 1** [IT-4.1]: Percent improvement over baseline rate of complications which increase risk to patient morbidity and mortality (Renal Failure, Respiratory Failure, Injury adjusted risk for mortality, Length of Stay, Compartment Syndromes) for burn and trauma patients transferred to UTMB and Shriners Hospital. **Numerator:** Percent change in risk adjusted complication rates. **Denominator:** Number of patients. **Improvement Target:** 5% decrease in complication rates over DY2. **Data Source:** Burn/Trauma databases. **Outcome Improvement Target 1** Estimated Incentive Payment: $228,896	**Outcome Improvement Target 1** [IT-4.1]: Percent improvement over baseline rate of complications which increase risk to patient morbidity and mortality (Renal Failure, Respiratory Failure, Injury adjusted risk for mortality, Length of Stay, Compartment Syndromes) for burn and trauma patients transferred to UTMB and Shriners Hospital. **Numerator:** Percent change in risk adjusted complications rates. Denominator: Number of patients. **Improvement Target:** 10% decrease in complication rates over DY2. **Data Source:** data collection log. **Outcome Improvement Target 1** Estimated Incentive Payment: $579,796

094092602.3.19	IT-4.1	Improvement in risk adjusted Potentially Preventable Complications rate(s) (Standalone measure)	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.2.1.10**		
Starting Point/Baseline:	**We will gather baseline data regarding incidence, mortality, and time to definitive treatment for burn and trauma patients in Region 2. We may be only to obtain data from those patients that were transferred to UTMB and Shriners hospitals in DY2.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Burn/Trauma databases and Transfer Center records and documentation. **Process Milestone 2 Estimated** Incentive Payment: $8,071.50			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $16,143	Year 3 Estimated Outcome Amount: $159,516	Year 4 Estimated Outcome Amount: $228,896	Year 5 Estimated Outcome Amount: $579,796
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $984,350			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.11 – Diabetes care: BP control (<140/80mm Hg)
Project Title: Expand Specialty Care Access in Galveston and Brazoria Counties

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.1

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/109372601

OUTCOME MEASURE DESCRIPTION:
IT-1.11 – Diabetes care: BP control (<140/80mm Hg)[234] – NQF 0061 (standalone measure)
The numerator is the use of automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg. The denominator is patients 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2). The data source for this will be the EHR, registry, claims, and administrative clinical data.

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. Galveston County has a Diabetes Mellitus Morbidity rate of 10% as compared to 9% and 10.9% for Texas and the US, respectively. Galveston County has an Obesity Morbidity rate of 29.6 as compared to 29% and 30% in Texas and the US, respectively. Brazoria County has a Diabetes Mellitus Morbidity rate of 9.8% as compared to 9% and 10.9% for Texas and the US, respectively. Brazoria County has an Obesity Morbidity rate of 27.3 as compared to 29% and 30% in Texas and the US, respectively. Both counties are in the bottom 25% of all Texas counties for the Hypertension & Hypertension Renal. 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
Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of

health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol

109372601.3.1	IT-1.11	Diabetes Care: Blood Pressure (BP) Control	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects:	109372601.1.1		
Starting Point/Baseline:	Baseline to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Conduct a specialty care gap analysis based on community need. Data source: Assessment including consultants' reports, service line plans, and third available appointment data. Goal: To identify gaps in high-demand specialty areas Rationale: A validated assessment tool will be necessary to identify needs and make improvements. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2 [P-2]:** Establish baseline rates Metric: Documentation of gap assessment Data source: Needs assessment Goal: To identify gaps in high-demand specialty areas Rationale: Foundation for DY3-5 Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $232,721 **Process Milestone 3 [P-4]:** Develop and test data systems Metric: Training of staff and providers on referral guidelines, process and technology. Data source: Log of specialty care personnel trained and Curriculum for training. Goal: Develop Standard Reports Rationale: Standard reports are necessary to measure the providers	**Outcome Improvement Target 1** [IT-1.11]: Diabetes care: BP control (<140/80mm Hg) Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: Epic, Claims, Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $497,914	**Outcome Improvement Target 2** [IT-1.11]: Diabetes care: BP control (<140/80mm Hg) Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) Data Source: Epic, Claims, Administrative clinical data Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $1,082,423

109372601.3.1	IT-1.11	Diabetes Care: Blood Pressure (BP) Control	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects:	109372601.1.1		
Starting Point/Baseline:	Baseline to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	and staff who have been trained on the general/operational referral guidelines, process and technology. Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $232,721		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $465,442	Year 4 Estimated Outcome Amount: $497,914	Year 5 Estimated Outcome Amount: $1,082,423
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,045,780			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6, Patient Satisfaction
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Project Title: Providing Psychiatry Telemedicine Clinics to RHP 2 and the State of Texas

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.3

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/109372601

OUTCOME MEASURE DESCRIPTION:
The expected outcome/goal is to show percentage improvement over the baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. In DY2 we will review and finalize the specific supplemental modules for the adult and/or child CG-CAHPS surveys we will be implementing in DY 4 and DY5 based on the populations we will serve with our Psychiatry telemedicine clinics. Some of the possible supplemental modules include the following:

(1) [Patients] are getting timely care, appointments, and information; (Standalone measure)
(2) how well their doctors communicate; (Standalone measure)
(3) patient's rating of doctor access to specialist; (Standalone measure)
(4) patient's involvement in shared decision making, and (Standalone measure)
(5) patient's overall health status/functional status. (Standalone measure)

A baseline will be established for the selected patient satisfaction domains. We will engage all stakeholders, identify current capacity and needed resources, determine timelines and document an implementation plan.

RATIONALE:
The intent of the CAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on care. Our project will use the CG-CAHPS surveys that are part of the overall CAHPS initiative. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions and providers on domains that are important to consumers. 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. Improvement targets will be specified for DY4 and DY5 once a baseline is established.

OUTCOME MEASURE VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.3.3	IT – 6.1	Percent improvement over baseline of patient satisfaction scores	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects::	109372601.1.2		
Starting Point/Baseline:	Baseline to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
8. Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Review the supplemental modules for CG-CAHPS surveys. Data Source: CAHPS Goal: Finalize the supplemental modules of CG-CAHPS surveys to establish baseline in DY3. Rationale: To determine appropriate patient satisfaction surveys. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**9. Process Milestone 2** P-2 Establish baseline rates Metric: Complete initial patient surveys. Data Source: CAHPS and patient surveys. Goal: Complete in DY3 Rationale: Foundation for DY4 and DY5 Process Milestone 2 Estimated Incentive Payment: $395,124	**10. Outcome Improvement Target 1** IT-6.1 Percent improvement over baseline of patient satisfaction scores (Standalone measure) Metric: Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey Improvement Target: TBD in DY2 and DY3 Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $422,691	**11Outcome Improvement Target 2** IT-6.1 Percent improvement over baseline of patient satisfaction scores (Standalone measure) Metric: Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey Improvement Target: TBD in DY4 Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $918,893
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $395,124	Year 4 Estimated Outcome Amount: $422,691	Year 5 Estimated Outcome Amount: $918,893
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,736,707			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT- IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)
Project Title: Update Primary Care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.7 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/109372601

OUTCOME MEASURE DESCRIPTION:
Process Milestone 1 in DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Data Source: Documentation of program. Goal: Develop and document training plan. Rationale: Training programs in primary care should reflect the evolving primary care delivery models.

Process Milestone 2 in DY3: P-2 Establish baseline rates. Metric: Rate of LDL-C screening and LDL-C level < 100 mg/dl. Data Source: EHR and Registry. Goal: Complete in DY3. Rationale: Foundation for DY4 and DY5.

Improvement Target 1 in DY4 and DY5: IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure). Metric: Numerator: Number of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year. LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL. Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year. The population to be monitored includes patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year. Goal: The goal is to manage a number of patients who had both an

LDL-C screenings and LDL-C Level that is less than 100 mg/dL during the reporting period. Specific goal measures are TBD in DY3. Data Source: EHR, Registry.

RATIONALE:

Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Outcome Measure Valuation

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.3.7	IT – 1.6	Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)	
University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects::	109372601.1.3		
Starting Point/Baseline:	Goal to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Data Source: Documentation of program Goal: Develop and document training plan. Rationale: Training programs in primary care should reflect the evolving primary care delivery models. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** P-2 Establish baseline rates Metric: Rate of LDL-C screening and LDL-C level < 100 mg/dl Data Source: EHR and Registry Goal: Complete in DY3 Rationale: Foundation for DY4 and DY5 Process Milestone 2 Estimated Incentive Payment: $255,317	**Outcome Improvement Target 1** IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure) Metric: Numerator: Number of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year. LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL. Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and	**Outcome Improvement Target 2** IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure) Metric: Numerator: Number of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year. LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL. Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and

109372601.3.7	IT – 1.6	Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012)	
University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects::	109372601.1.3		
Starting Point/Baseline:	Goal to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		the year prior to the measurement year. Goal: TBD in DY3 Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $273,364	the year prior to the measurement year. Goal: TBD in DY3 Data Source: EHR, Registry Outcome Improvement Target 2 Estimated Incentive Payment*:* $531,969
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $255,317	Year 4 Estimated Outcome Amount: $273,364	Year 5 Estimated Outcome Amount: $531,969
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $1,060,650			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3, Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
Project Option: IT: 3. 1: All cause 30 Day Readmission Rate-NQF 1789(Standalone); 121805903 (Standalone)
Project Title: Establish/Expand a Patient Care Navigation Program

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 121805903.3.3

RHP PERFORMING PROVIDER/TPI: Angleton Danbury Hospital District/121805903

OUTCOME MEASURE DESCRIPTION:
Outcome Domain 3 All cause 30 Day Readmission Rate was selected in conjunction with the chosen Category 2.9 Project of establishing a patient care navigation program because

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.
According to the Centers for Disease Control, Stroke is the 3rd leading cause of death in the United States with 140,000 people dying each year from a stroke and stroke is a leading cause of disability in the U.S. Each year, approximately 795,000 people suffer a stroke, about 600,000 of these are first attacks, and 185,000 are recurrent attacks. On average, someone in the United States has a stroke every 40 seconds. High blood pressure is the most important risk factor for a stroke which directly coordinates with obesity, smokers and COPD.
Chronic Obstructive Pulmonary Disease (COPD) is one of the most common lung diseases. It makes it difficult to breathe. The American Lung Association (2006 State of Air Report) reports that Brazoria County received an ozone grade of "F" for air quality. One of the greatest risk factors for COPD is exposure to certain gases or fumes in the workplace. Brazoria County has 12% of its population identified with some type of lung disease according to the Centers for Disease Control. The majority of business and industry in Brazoria County is made up of the petro chemical, oil and gas companies which factor into the growing statistic we see. There is a high incidence rate of adult asthma, chronic bronchitis, emphysema, COPD and lung cancer.

According to the American Heart Association, Cardiovascular Disease takes the lives of more than 2,150 Americans each day, an average of 1 death every 40 seconds. As documented in the community needs assessment, Brazoria County has 223 deaths per 100,000 related to Heart Disease which is higher than both the State and National average.

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

The Data Source will be the Electronic Health Record:

The starting point/baseline for first Improvement Target will be to Establish number of readmissions (for patients 18 years and older), for patients discharged from the hospital with a complete claims history for the 12 months prior to admission The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

The Metric used will be a ratio consisting of the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge The electronic health record will be used to gather this information. The community needs assessments shows a demonstrated need for Chronic Disease Management Support. This navigational system will benefit the targeted population navigate through the health care system in order to receive the most appropriate care in the right setting.

Through the establishment of an effective navigation program (P-4 & P-5), we strive to decrease the percentage of all cause 30 day readmissions for our targeted population. This information will be gathered by the hospital electronic health record and the navigation system. As the program grows we will continue to disseminate findings, lessons learned, and best practices to our stakeholders to improve our internal processes and to make the most impact.

With the high incidence of Chronic Diseases in the community (according to the CNA), preventable readmissions can be achieved by taking appropriate pro-active steps to avoid conditions that can lead to expensive care in the ED and inpatient settings. With the help of the mobile bus and navigational services to the targeted population who are at high risk, we will be able to connect patients to primary and preventative care services – leading to the right care in the right setting. The baseline population for this measure will be gathered though the electronic medical record found within the hospital. The overall goal of this measure is to reduce the all cause 30-day readmissions from 9.1% baseline (DY2) to 3% by the end of the waiver period.

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.

According to the Centers for Disease Control, Stroke is the 3rd leading cause of death in the United States with 140,000 people dying each year from a stroke and stroke is a leading cause of disability in the U.S. Each year, approximately 795,000 people suffer a stroke, about 600,000 of these are first attacks, and 185,000 are recurrent attacks. On average, someone in the United States has a stroke every 40 seconds. High blood pressure is the most important risk factor for a stroke which directly coordinates with obesity, smokers and COPD.

Chronic Obstructive Pulmonary Disease (COPD) is one of the most common lung diseases. It makes it difficult to breathe. The American Lung Association (2006 State of Air Report) reports that Brazoria County received an ozone grade of "F" for air quality. One of the greatest risk factors for COPD is exposure to certain gases or fumes in the workplace. Brazoria County has 12% of its population identified with some type of lung disease according to the Centers for Disease Control. The majority of business and industry in Brazoria County is made up of the petro chemical, oil and gas companies which factor into the growing statistic we see. There is a high incidence rate of adult asthma, chronic bronchitis, emphysema, COPD and lung cancer.

According to the American Heart Association, Cardiovascular Disease takes the lives of more than 2,150 Americans each day, an average of 1 death every 40 seconds. As documented in the community needs assessment, Brazoria County has 223 deaths per 100,000 related to Heart Disease which is higher than both the State and National average.

Outcome Measure Valuation (All cause 30 Day readmission rate-NQF 1789)

The patient navigation system and mobile health bus would add much value to the community – especially to our chronic disease population with multiple comorbidities. The project will navigate the targeted population through the healthcare system so that they receive timely services in the right setting. This project will also promote education and 1-1 chronic disease management; so that individuals will be less likely to suffer added complications due to chronic disease process while supporting improved compliance and quality.

Brazoria County is the 5th fastest growing county in Texas and is among the largest counties in Texas. A mobile health bus will cover a huge service area while addressing the transportation barriers in the community. We will serve both the Medicaid and uninsured population through various outreach strategies while targeting high risk individuals. The community needs assessment supports the demand for this project. Access barriers (lack of personal resources

and lack of insurance), Primary Care Physician Shortage, and High Chronic disease are proven factors within the community. According to the Community Needs Assessment, we have a high identified diabetic population and many that may currently be undiagnosed and unmanaged.

Providing the targeted population with proactive care early on in their disease process will result in savings if the patient condition is managed and does not require expensive ED visits, inpatient hospitalization, or other extensive treatments. With proactive education, monitoring, and screening, ADHD anticipates a reduction in our all cause 30 Day Readmission Rates to the Hospital.

Currently Angleton Danbury Hospital District is not receiving any additional federal funding to support chronic disease management.

121805903.3.3	IT-3.3	All cause 30 Day Readmission Rate-NQF 1789	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects::	121805903.2.1		
Starting Point/Baseline:	Baseline to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Implementation plan which includes a review and selection of a validated assessment tool for use in achieving the improvement milestones documented in this project. Data source: Implementation plan and patient records (verify implementation of assessment tool). Goal: Draft an implementation plan and select an assessment tool. Rationale: A validated assessment tool will be necessary to document improvements. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $29,368	**Outcome Improvement Target 1:** (IT-3.1) All cause 30 day readmission rate- NQF 1789 (Standalone measure) a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EMR **Outcome Improvement Target 1:** **Goal:** Decrease % of readmissions from baseline 9.1% to 7.0% Estimated Incentive Payment: $90,779	**Outcome Improvement Target 2**: (IT-3.1) All cause 30 day readmission rate- NQF 1789 (Standalone measure) a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EMR Outcome Improvement Target 2 Goal: Decrease % of readmissions from baseline 9.1% to 5% Estimated Incentive Payment*:* $121,390	**Outcome Improvement Target 3** : (IT-3.1) All cause 30 day readmission rate- NQF 1789 (Standalone measure) a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EMR Outcome Improvement Target 3 Goal: Decrease % of readmissions from baseline 9.1% to 3% Estimated Incentive Payment*:* $226,947

121805903.3.3	IT-3.3	All cause 30 Day Readmission Rate-NQF 1789	
Angleton Danbury Hospital District			121805903
Related Category 1 or 2 Projects::	121805903.2.1		
Starting Point/Baseline:	Baseline to be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 P-2 Establish baseline rates for all cause 30-day readmissions Metric Determine a baseline rate for all cause 30-day readmissions Data Source: EMR database Goal: Develop a baseline rate for all cause 30-day readmissions Rationale: A baseline rate will be necessary to determine improvements Baseline: 132 all cause 30 day readmissions based on 1436 admissions excluding deliveries, births, & deaths. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $29,368			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $44,379	Year 3 Estimated Outcome Amount: $45,389	Year 4 Estimated Outcome Amount: $82,917	Year 5 Estimated Outcome Amount: $197,391
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $390,076			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3, Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
Project Option: IT-3.2: Congestive Heart Failure Admission Rate
Project Title: Expand Chronic Care Management Models

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094148602.3.1

RHP PERFORMING PROVIDER/TPI: Baptist Hospitals of Southeast Texas ("Baptist")/094148602

OUTCOME MEASURE DESCRIPTION:
We plan to expand the management of congestive heart failure ("CHF") for our inpatient population during their stay and after discharge. In particular, we want to concentrate our effort on patients with congestive heart failure who are insured through Medicare or Medicaid or are uninsured. Baptist's plan is to better ensure successful patient outcomes by engaging in patient activation through a program called "teach back" and through implementing a Patient Navigation program. The "teach back" program is designed to help patients better understand how to manage their conditions after discharge, setting them up for success and hopefully decreasing the risk of readmission. We hope to have 80% of those patients admitted with CHF-enrolled in a self-management program by the end of the waiver. The expected outcome of this project is a 15% reduction in the 30 day readmissions for patients with a primary diagnosis of CHF. Achieving this outcome will improve patient quality of life and decrease the institutional cost of providing care to the chronically ill.

RATIONALE:
CHF presents a health risk dilemma for Jefferson County residents, as it is hard to manage, requires expensive medications, and demands daily maintenance care. The cost of annual hospitalization of CHF in our facility exceeds $2,000,000.00. Thus, the cost of teaching self-management skills while are admitted to the hospital can be invaluable to reducing the future cost of treating these patients while improving the quality of care for these individuals.

Outcome Measure Valuation
The valuation of each Baptist outcome measure takes into account the degree to which the project accomplishes the triple-aims of the Waiver, 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 is valued based on the importance, from both a cost perspective and quality of life perspective, of reducing the number of hospital readmissions for patients with CHF. Baptist intends to transform its delivery of healthcare in a manner to improve patient outcomes and reduce the cost of providing care per patient so more patients can benefit from medical care, and this outcome directly comports with that goal.

094148602.3.1		3.3.1 – Potentially Preventable Readmissions: 30 day CHF admissions	
Baptist Hospitals of Southeast Texas - Beaumont			**094148602**
Related Category 1 or 2 Projects:	**094148602.2.1**		
Starting Point/Baseline:	**For the year September 2011 – August 2012, there were a total of 422 patients who were discharged with a primary diagnosis of heart failure and met the criteria for the numerator. There are 252,273 individuals in Jefferson County with approximately 625 having a diagnosis of heart disease.**		
Year 2 (10/1/2012 – 9/30/2013)	**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 [P-1] Project planning – Baptist will create a plan to use the self-management program and telehealth capabilities to reduce the number of readmissions – this plan will include provisions for provider education, patient education, tracking, and setting goals **Data Source**: documentation of the plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $140,953	**Process Milestone [P-2]** Establish a baseline – determine the number of CHF admissions during DY2 and cross reference with patients who were engaged in Baptist's self-management program and/or telehealth Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $163,383	**Outcome Improvement Target 2** [IT-3.2]: Reduce CHF 30-day readmissions by 10% Data source: hospital EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $262,173	**Outcome Improvement Target 3** [IT-3.2]: Reduce CHF 30-day readmissions by 20% Data source: hospital EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $626,936
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $140,953	Year 3 Estimated Outcome Amount: $163,383	Year 4 Estimated Outcome Amount: $262,173	Year 5 Estimated Outcome Amount: $626,936
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,193,445			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-2, Potentially Preventable Admissions
Project Option: IT-2.1 Congestive Heart Failure Admission rate (CHF)
Project Title: Expand Care Transition Program

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094148602.3.2

RHP PERFORMING PROVIDER/TPI: Baptist Hospitals of Southeast Texas ("Baptist")/094148602

OUTCOME MEASURE DESCRIPTION:
During the first year, BHSET will develop trust with the targeted population and to ensure mechanisms are in place that successfully identify and serve the needs of the population. The following years will be used to develop the community network and ensure a community wide support system for this population

An excellent tool, Crimson Data Base, is already in place and has over 10 years of documented and verified success. In addition to that, we will set up a system managed by the Patient Navigators to track and document care and support for the target population. As more community health care providers join the network, the data sharing will be refined and available to everyone.

We will start with a Registered Nurse (Patient Navigator) in the ED with access to pharmacists and case managers assisting this people, working to prevent admission to the hospital and improving their quality of life. The eventual goal is to have this triad of professionals available 24 hours a day 7 days a week working in a community partnership with other community health care providers. This network will be responsible for serving people in the community with a diagnosis of heart failure with special emphasis on individuals who are uninsured or unable to care for themselves.

RATIONALE:
Congestive heart failure is a chronic disease that, if not managed well, decreases the quality of life and even shortens the lives of those afflicted. Over 600 individuals in Jefferson County have a diagnosis of heart failure. Though that number sounds insignificant, each of these people has the potential of being admitted to the hospital at least once during the year. The cost of these admissions is currently valued at $9,500 with a total annual hospital cost of $5,700,000.00.

In addition, these people, if not managed well, will return at least once for additional hospitalization within the year. Our current readmission rate is 16.11%. It is our goal to reduce the rate to below 10% and to set up a network of care in the community supporting these individuals in their effort to manage this disease.

Heart failure is a complex and dynamic disease that is difficult to manage. Many of the people who have been diagnosed with heart failure have barriers (language, age, thinking, economic, etc) standing in the way of their learning to self-manage their disease. Dedicating staff to meet their needs can not only improve their quality of life but also decrease the cost of healthcare by approximately $9,500 per avoided hospital admission. Cost for the staff to follow along and assist these people with their care will more than pay for itself

Outcome Measure Valuation

The valuation of each Baptist outcome measure takes into account the degree to which the project accomplishes the triple-aims of the Waiver, 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 is valued based on the importance, from both a cost perspective and quality of life perspective, of reducing the number of hospital readmissions for patients with CHF. Baptist intends to transform its delivery of healthcare in a manner to improve patient outcomes and reduce the cost of providing care per patient so more patients can benefit from medical care, and this outcome directly comports with that goal.

094148602.3.2	IT-2.1	IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8	
Baptist Hospitals of Southeast Texas – Beaumont			094148602
Related Category 1 or 2 Projects:	094148602.2		
Starting Point/Baseline:	**Starting Point/Baseline for this IT: 68 of the designated patients return to the hospital within 30 days of discharge. Approximately 80% of these patients are admitted through the ED – 54 patients.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 (P-3) Develop and test data systems—BSHET will up a system managed by the Patient Navigators to track and document care and support for the target population. Data Source: Crimson, ED Records, Patient Navigator Records **Process Milestone 2** (P-4) Plan Do Study Act— The Plan Do Study Act protocol will be used for continuous improvement of the care provided this patient population. All stakeholders, to include by not limited to, the hospital, the ED, and patients receiving services, will be included in the process to ensure those being served receive timely and effective care and support. Process Milestone 1 Estimated Incentive Payment: $140,953	**Process Milestone 2 (P-5) –** Disseminate Findings, Including Lessons Learned and Best Practices, to Stakeholders— BHSET will develop and distribute a comprehensive plan for reducing CHF admissions (in conjunction with the Care Transitions program) to other provider cooperating with in the Region. Data Source: Written integration plan Process Milestone 2 Estimated Incentive Payment: $163,383	**OD-2- Potentially Preventable Admissions** **IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8** Improvement target: 6% reduction in CHF admission rate Data Source: EHR, ED Records, Crimson, Patient Navigator Records, Region 2 Community Health Needs Assessment for Jefferson County Outcome Improvement Target 2 Estimated Incentive Payment: $262,173	**OD-2- Potentially Preventable Admissions** **IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8** Improvement target: 8% reduction in CHF admission rate Data Source: EHR, ED Records, Crimson, Patient Navigator Records, Region 2 Community Health Needs Assessment for Jefferson County Outcome Improvement Target 3 Estimated Incentive Payment: $626,936
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $140,953	Year 3 Estimated Outcome Amount: $163,383	Year 4 Estimated Outcome Amount: $262,173	Year 5 Estimated Outcome Amount: $626,936

094148602.3.2	IT-2.1	IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8	
Baptist Hospitals of Southeast Texas – Beaumont			094148602
Related Category 1 or 2 Projects:	094148602.2		
Starting Point/Baseline:	Starting Point/Baseline for this IT: 68 of the designated patients return to the hospital within 30 days of discharge. Approximately 80% of these patients are admitted through the ED – 54 patients.		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,193,445			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1, Primary Care and Chronic Disease Management
Project Option: IT-1.10 Diabetes Care: HbA1c poor control (>9.0%)
Project Title: Expanding Chronic Care Management Model for Diabetes

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112671602.3.2

RHP PERFORMING PROVIDER/TPI: Brazosport Regional Health System – Lake Jackson Family Medicine Center/112671602

OUTCOME MEASURE DESCRIPTION:
The outcome domain chosen for the project is OD-1, Primary Care and Chronic Disease Management. The improvement target chosen to supplement the outcome domain is IT 1.10, Diabetes care: HbA1c poor control (>9.0%). The project proposes initiating a chronic care self-management model to be implemented with patients from the existing primary care clinic, LJFMC. The measurement taken will be the number of patients with a hemoglobin A1c level that is not adequately controlled (> 9.0%) during the measurement year compared to the total number of diabetes self-management program participants 18-85 years of age of the measurement year. The data will be collected from the LJFMC EMR as well as the patient list of those who agree to diabetes self-management instruction by a primary care provider.

The outcome improvement target aims to decrease the percentage of patients with a poorly controlled hemoglobin A1c level compared to the total number of diabetes self-management program participants 18-85 years of age of the measurement year. The percent of patients with poorly controlled HbA1c levels is TBD; we will need to develop a method to collect the HbA1c information on all of the participants and gather the data to establish a baseline.

The process milestone for year 2 will be to simply use data to establish baseline rates for the proposed project (P-2). The metric is number of diabetes patients with HbA1c levels greater than 9.0% (poor control). . The data will be obtained from the Lake Jackson Family Medicine Center EMR, with the ability to disseminate the results of the entire groups compared to the self-management group. The project will use current patient data, without identifiers, to determine the baseline number of patients and baseline hemoglobin A1c level and use the information to generate future goals.

The second process milestone chosen for year 3 is to conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities (P-4). The achievement metric is to conduct the PDSA cycles to monitor data quality and the effects of the diabetes self-management program. The data will also be obtained from the Lake Jackson Family Medicine Center EMR. The goal of this process milestone is to conduct a PDSA cycle once per quarter and have the information reported to the BRHS Performance Improvement Committee.

RATIONALE:
The outcome domain, Primary Care and Chronic Disease Management, was very appropriate for the project, as the proposal includes monitoring patients experiencing diabetes (a chronic condition) in the primary care setting, monitoring their hemoglobin A1c rates and the rates of participation. The prevalence of diabetes is significantly high in the primary service area of Lake Jackson Family Medicine Center and is an influential factor in many other health conditions.

The process milestone to establish baseline rates for the project (P-2) is important because the baseline data must be correct in order for the goals to be attainable. Without accurate baseline data, the project cannot hope to create realistic goals.

The process milestone on conducting PDSA cycles is important because the validity of the data collection process should be monitored and checked periodically to evaluate process effectiveness. The effectiveness of a new process can be evaluated by periodically evaluating the process and amending as necessary, continuously monitoring the effects of each change.

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
The valuation criteria used to determine the value of the project, and the value for each project year, was based on data obtained from the BRHS EMR. The team chose the DRGs for both inpatient and outpatient services that could result from uncontrolled diabetes and estimated that the Brazosport Regional Health System could save an estimated 25% of the total costs for these services if proper self-management programs were implemented in a primary care and/or outpatient setting. This approached allowed BHRS to look at the population it currently serves in Southern Brazoria County, eliminating other county-wide data that would generate an unrealistic view of the BRHS market share. This approach also allowed the team to examine the utilization and payment trends already occurring in the hospital to better predict the financial impact and cost avoidance created by the self-management diabetes programs.

112671602.3.2	IT-1.10	Diabetes Care: HbA1c poor control (>9.0%) NQF 0059	
Brazosport Regional Health System (BRHS) – Lake Jackson Family Medicine Center (LJFMC)			112671602
Related Category 1 or 2 Projects:	**112671602.2.1**		
Starting Point/Baseline:	**The baseline patient population in the diabetes self-management program is 20 patients, but the percent of patients with poorly controlled HbA1c levels cannot be determined because of the lack of a defined method to collect the HbA1c information on all of the participants. Baseline will be identified in Year 2.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 **P-2:** Establish baseline rates **Metric**: number of diabetes patients with HbA1c levels greater than 9.0% (poor control). **Data Source**: LJFMC Electronic Medical Record (EMR), Patient Registry **Goal**: to determine the baseline percentage of patients in the program with HbA1c levels greater than 9.0% in order to use the information to generate future goals. **Rationale**: the baseline data must be correct in order for the goals to be attainable **Process Milestone 1 Estimated Incentive Payment***(maximum amount):* $100,000	**Milestone 2** **P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric**: Conduct PDSA cycles to monitor data quality and the effects of diabetes self-management program activities **Data Source**: LJFMC Electronic Medical Record (EMR), Patient Registry **Goal**: Conduct a PDSA cycle once per quarter and report to the BRHS Performance Improvement Committee **Rationale:** the validity of the data collection process should be monitored and checked periodically to evaluate process effectiveness, amending as necessary, and monitoring the effects of each change. **Process Milestone 2 Estimated Incentive Payment:**$120,000	**IT 1.10**: Diabetes Care: HbA1c poor control (>9.0%) **Numerator**: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. **Denominator**: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Data Source**: LJFMC EMR, Patient Registry **Outcome Improvement Target 2 Estimated Incentive Payment**: $180,000	**IT 1.10**: Diabetes Care: HbA1c poor control (>9.0%) **Numerator**: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2 who had hemoglobin A1c (HbA1c) control > 9.0%. **Denominator**: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Data Source**: LJFMC EMR, Patient Registry **Outcome Improvement Target 3 Estimated Incentive Payment**: $396,000

112671602.3.2	IT-1.10	Diabetes Care: HbA1c poor control (>9.0%) NQF 0059	
Brazosport Regional Health System (BRHS) – Lake Jackson Family Medicine Center (LJFMC)			**112671602**
Related Category 1 or 2 Projects:	**112671602.2.1**		
Starting Point/Baseline:	**The baseline patient population in the diabetes self-management program is 20 patients, but the percent of patients with poorly controlled HbA1c levels cannot be determined because of the lack of a defined method to collect the HbA1c information on all of the participants. Baseline will be identified in Year 2.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $100,000	Year 3 Estimated Outcome Amount: $120,000	Year 4 Estimated Outcome Amount: $180,000	Year 5 Estimated Outcome Amount: $396,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*:$796,000			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3, Potentially Preventable Re-Admissions
Project Option: IT-3.1 – All Cause 30-Day Readmission Rate
Project Title: Apply evidence-based care management model to patients identified as having high-risk health care needs

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112706003.3.1

RHP PERFORMING PROVIDER/TPI: CHRISTUS Jasper Memorial Hospital/112706003

OUTCOME MEASURE DESCRIPTION:
To achieve improvement under this metric, CHRISTUS will engage in project planning during DY 2. In DY 3, CHRISTUS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, CHRISTUS intends to improve its all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, CHRISTUS intends to improve its all-cause 30-day readmission rate by at least 2.5% over the DY 4 measurement.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.1: All-cause 30-day readmission rate—2.5% improvement over DY3
- DY5:
  - IT-3.1: All-cause 30-day readmission rate—2.5% improvement over DY4

RATIONALE:
According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving care coordination through the use of electronic medical records and computerized provider order entry systems. A measurable reduction in CHRISTUS' all-cause 30-day readmission rate will indicate that

CHRISTUS has made progress towards these goals. In order to record this reduction, CHRISTUS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:
The valuation of the outcome measure takes into account the transformational impact of the outcome, the population served by the related project 2.2.2 (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree collaboration involved in the project, and the sustainability of the project. By reducing re-admissions in patients with chronic illnesses, this outcome will demonstrate an improvement in the patients' quality of life and reduction in healthcare costs. This particular project also directly addresses the aims of the Waiver, in that it is transformational, patient-centered, and will result in a reduced systemic cost of providing care.

112706003.3.1	IT-3.1	All-Cause 30-Day Readmission Rate	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects:	112706003.2.1		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning Process Milestone 1 Estimated Incentive Payment: $94,737	**Process Milestone 2**: P-2 Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $94,737	**Outcome Improvement Target 1**: IT-3.1 All cause 30 day readmission rate. Improvement Target: 2.5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $153,947	**Outcome Improvement Target 2**: IT-3. 1 All cause 30 day readmission rate. Improvement Target: 2.5% improvement over DY4. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $338,684
Year 2 Estimated Outcome Amount: $94,737	Year 3 Estimated Outcome Amount: $94,737	Year 4 Estimated Outcome Amount: $153,947	Year 5 Estimated Outcome Amount: $338,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $682,105			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-13: Palliative Care
Project Option: IT-13.3: Proportion with more than one emergency room visit in the last days of life
Project Title: Comprehensive Palliative Care Program

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112706003.3.2

RHP PERFORMING PROVIDER/TPI: CHRISTUS Jasper Memorial Hospital/112706003

OUTCOME MEASURE DESCRIPTION:
This outcome measure will measure the increase of patient family satisfaction using the FAMCARE scale from the Center for Advanced Palliative Care (CPAC).

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

DY4: Metric 1: I-10.1 Percent of total in-hospital deaths who had a palliative care consult.
Goal: 15% improvement over baseline.

DY5: Metric 1: I-10.1 Percent of total in-hospital deaths who had a palliative care consult.
Goal: 20% improvement over baseline.

RATIONALE

This outcome measure was selected for DY4 and DY5 because the successful implementation of this palliative care project will result in both an increase in patient family satisfaction and greater use of consults for palliative care by physicians.

For DY2 and DY3, process milestones P-1 and P-2 were chosen due to the significant investment of resources and planning that will be necessary in order to begin measuring this outcome in later years.

Outcome Measure Valuation: The valuation of the outcome measure takes into account the transformational impact of the outcome, the population served by the related Category 2 project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

112706003.3.2	IT-13.3	Proportion with more than one emergency room visit in the last days of life	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects:	**112706003.2.2**		
Starting Point/Baseline:	**Baseline TBD in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: Planning documentation. Baseline/Goal: Submit planning documentation. Data Source: Planning documents. Process Milestone 1 Estimated Incentive Payment*:* $86,842	**Process Milestone 3:** P-2 – Establish baseline rates. Metric: Documentation of baseline rates. Baseline/Goal: Establish baseline. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $86,842	**Outcome Improvement Target 1**: IT-13.3: Proportion with more than one emergency room visit in the last days of life. Goal: ___% improvement over DY3 baseline. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $141,118	**Outcome Improvement Target 2:** IT-13.3: Proportion with more than one emergency room visit in the last days of life. Goal: ___% improvement over DY3 baseline. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $310,461
Year 2 Estimated Outcome Amount: $86,842	Year 3 Estimated Outcome Amount: $86,842	Year 4 Estimated Outcome Amount: $141,118	Year 5 Estimated Outcome Amount: $310,461
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $625,263			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: : OD 6: Patient Satisfaction
Project Option: IT-6.1: Percent improvement over baseline of patient satisfaction scores
Project Title: Provide Navigation Services to Targeted patients Who are at High Risk of Disconnect from Institutionalized Health Care

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112706003.3.3

RHP PERFORMING PROVIDER/TPI: CHRISTUS Jasper Memorial Hospital/112706003

OUTCOME MEASURE DESCRIPTION:
Outcome Improvement Target 2 CHRISTUS believes that by working with patients to use primary and preventative care in the community on an expanded basis, of uninsured and indigent patients . will have higher satisfaction with their care.

Process Milestones 1-4

The process milestones CHRISTUS chose are meant to enable CHRISTUS to create a plan of action, establish a baseline for measuring success, test its systems for collecting and analyzing data, and putting an action plan into effect to cause a successful increase in patient satisfaction.

Improvement Targets:
- Increase average patient satisfaction by 5% by the end of DY4
- Increase average patient satisfaction by 10% by the end of DY5

CHRISTUS chose these improvement targets because we believe patients' satisfaction and health outcomes will improve when they seek and receive care in the appropriate setting for their conditions.

RATIONALE:
CHRISTUS selected this Category 3 Outcome for its project to establish a Care Navigation Program because CHRISTUS expects a direct correlation between improved education of patients and their satisfaction with care.
Outcome Measure Valuation:
The valuation of each CHRISTUS Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. CHRISTUS determined the value of this outcome by assessing the potential impact on individual patients and the community related to increased patient satisfaction which leads to increased quality of life, functionality, morale, - Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage

and support patients' conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.

112706003.3.3	IT 6.1	Right Care Right Setting – ED appropriate utilization-all ((non-urgent/non-emergent) ED visits	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects::	112706003.2.3		
Starting Point/Baseline:	Baseline to be determined in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – **Data Source**: Project plan documentation **Baseline/Goal:** Submit planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $59,210.50 **Process Milestone 2** [P-2]: Establish baseline rates – **Metric:** Documentation of baseline rates **Baseline/Goal:** Submit documentation of baseline rates. **Data Source**: Internal Documents and Patient Satisfaction Surveys Process Milestone 2 Estimated	**Process Milestone 3 [P-3]** Develop and test data systems – **Metric:** Planning and testing documentation **Baseline/Goal:** Submit planning and testing documentation **Data Source**: Planning and testing documents Process Milestone 3 Estimated Incentive Payment: $59,210.50 **Process Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities – specifically, CHRISTUS will create and implement a plan to disseminate information to the community about the benefits using the clinics for primary care and the appropriate use of the ED **Data Source:** Performance improvement plans (PIP)	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores**Improvement Target**: Increase average patient satisfaction by 5%**Data Source:** CG-CAHPS survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $192,434	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores**Improvement Target**: : Increase average patient satisfaction by 5% **Data Source:** CG-CAHPS survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $423,355

112706003.3.3	IT 6.1	Right Care Right Setting – ED appropriate utilization-all ((non-urgent/non-emergent) ED visits	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects::	112706003.2.3		
Starting Point/Baseline:	Baseline to be determined in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Incentive Payment: $59,210.50	Process Milestone 4 Estimated Incentive Payment: $59,210.50		
Year 2 Estimated Outcome Amount:$118,421	Year 3 Estimated Outcome Amount: $118,421	Year 4 Estimated Outcome Amount: $192,434	Year 5 Estimated Outcome Amount: $423,355
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $852,631			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD 6: Patient Satisfaction
Project Option: IT-6.1 Percent Improvement over baseline of patient satisfaction scores
Project Title: Establish/Expand a patient Care Navigation Program

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112706003.3.5 – PASS 2

RHP PERFORMING PROVIDER/TPI: CHRISTUS Jasper Memorial Hospital/112706003

OUTCOME MEASURE DESCRIPTION:
Outcome Measure is IT-6.1 uses patient satisfaction surveys to report the percent improvement over baseline of patient satisfaction scores measuring whether patients are getting timely specialty care, appointments, and information.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. To be 10% over baseline.
- DY5:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores related to whether patients are receiving timely care, appointments, and information. To be 15% over baseline.

RATIONALE:
This outcome measure for DY4-DY5 was selected because CHRISTUS considers enhanced patient satisfaction/experience to be one of its highest priorities. This outcome measure will provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on care provided by CHRISTUS' new clinics. The surveys will be designed to produce comparable data on the patient's perspective on care provided at the clinics that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care funded in part by public investment.

For DY2-DY3, Process milestones P-1 through P-3 were chosen due to the current lack of a survey instrument and other resources needed to measure and monitor patient satisfaction. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3, we will establish baseline numbers for patient satisfaction.

Outcome Measure Valuation

The valuation of the outcome measure takes into account the transformational impact of the outcome, the population served by the related project 1.1.1 (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree collaboration involved in the project, and the sustainability of the project. This outcome is related to a large project involving the opening of two clinics in underserved areas of the community. It is anticipated these clinics will have a large indigent volume with many patients suffering from chronic illnesses such as diabetes. Providing a medical home for these patients will improve their quality of life and reduce health care costs.

112706003.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
	CHRISTUS Jasper Memorial Hospital		112706003
Related Category 1 or 2 Projects:	112706003.2.4		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric: Planning documentation Baseline/Goal: Submit planning documentation Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment: $26,511.50 **Process Milestone 2**: P-3 – Develop and test data systems Metric: Planning and testing documentation Baseline/Goal: Submit planning and testing documentation Data Source: Planning and testing documents Process Milestone 1 Estimated Incentive Payment: $26,511.50	**Process Milestone 3:** P-2 – Establish baseline rates Metric: Documentation of baseline rates Baseline/Goal: Submit documentation of baseline rates. Data Source: Internal Documents and Patient Satisfaction Surveys	**Outcome Improvement Target 1**: IT-6.1 - Percent improvement over baseline of patient satisfaction scores. Improvement Target: 10% improvement Data Source: Patient Satisfaction Surveys	**Outcome Improvement Target:**: IT-6.1 - Percent improvement over baseline of patient satisfaction scores. Improvement 15% improvement. Data Source: Patient Satisfaction Surveys

112706003.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects:	**112706003.2.4**		
Starting Point/Baseline:	**Baseline patient satisfaction numbers will be determined in DY 3.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $53,023	Year 3 Estimated Outcome Amount: $61,562	Year 4 Estimated Outcome Amount: $98,396	Year 5 Estimated Outcome Amount: $236,688
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $449,669			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-3: Potentially Preventable Re-Admissions
IT-3.1 All cause 30 day readmission rate
Apply evidence-based care management model to patients identified as having high-risk health care needs

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 112706003.3.6-Pass 2

RHP PERFORMING PROVIDER/TPI: CHRISTUS Jasper Memorial Hospital/112706003

OUTCOME MEASURE DESCRIPTION:
To achieve improvement under this metric, CHRISTUS will engage in project planning during DY 2. In DY 3, CHRISTUS will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, CHRISTUS intends to improve its all-cause 30-day readmission rate by at least 2.5% over the baseline recorded in DY 3. In DY 5, CHRISTUS intends to improve its all-cause 30-day readmission rate by at least 2.5% over the DY 4 measurement.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.1: All-cause 30-day readmission rate—2.5% improvement over DY3
- DY5:
  - IT-3.1: All-cause 30-day readmission rate—2.5% improvement over DY4

RATIONALE:

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Other populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving care coordination through the use of electronic medical records and computerized provider order entry systems. A measurable reduction in CHRISTUS' all-cause 30-day readmission rate will indicate that

CHRISTUS has made progress towards these goals. In order to record this reduction, CHRISTUS must first engage in planning and baseline measurement in DYs 2 and 3, respectively.

Outcome Measure Valuation:

The valuation of the outcome measure takes into account the transformational impact of the outcome, the population served by the related project 2.2.2 (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree collaboration involved in the project, and the sustainability of the project. By reducing re-admissions in patients with chronic illnesses, this outcome will demonstrate an improvement in the patients' quality of life and reduction in healthcare costs. This particular project also directly addresses the aims of the Waiver, in that it is transformational, patient-centered, and will result in a reduced systemic cost of providing care.

112706003.3.6	IT-3.1	All-Cause 30-Day Readmission Rate	
CHRISTUS Jasper Memorial Hospital			112706003
Related Category 1 or 2 Projects:	**112706003.2.5**		
Starting Point/Baseline:	**Baseline patient satisfaction numbers will be determined in DY 3.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning	**Process Milestone 2**: P-2 Establish baseline rates. (estimated 4284 diabetes related admissions annually) Data Source: EHR; claims.	**Outcome Improvement Target 1**: IT-2.7 Diabetes Short Term Complication Admission Rate- PQI 1 Improvement Target Estimated 4070 diabetes related admissions annually (decrease of 5% baseline) Data Source: EHR; claims.	**Outcome Improvement Target 2**: IT-2.7 Diabetes Short Term Complication Admission Rate- PQI 1 Improvement Target: . Estimated 3856 diabetes related admissions annually (decrease of 10% baseline) Data Source: EHR; claims.
Year 2 Estimated Outcome Amount: $65,259	Year 3 Estimated Outcome Amount: $75,769	Year 4 Estimated Outcome Amount: $121,103	Year 5 Estimated Outcome Amount: $291,308
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $553,439			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-3: Potentially Preventable Re-Admissions
IT-3.2: Congestive Heart Failure 30 Day Readmission Rate
Project Title: CHRISTUS CHRONIC DISEASE MANAGEMENT CLINICS IN SETX

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 138296208.3.2

RHP PERFORMING PROVIDER/TPI: CHRISTUS Hospital – St. Elizabeth/138296208)

OUTCOME MEASURE DESCRIPTION:
In conjunction with its chronic care management project, CHRISTUS expects a reduction in the number of patients who are discharged from the inpatient setting with a diagnosis of CHF who are readmitted within 30 days. The multi-disciplinary care management teams located at clinics within the community will provide necessary support, training, and interventions necessary for patients to manage their chronic conditions, including CHF. This will improve patient outcomes, quality of life, and satisfaction with the healthcare delivery system. In addition, this will reduce the systemic cost of providing healthcare to this population of patients as a result.

Process Milestones:

- DY 2:
  - P-1 – Establish a baseline
    - CHRISTUS will measure the current number of potentially preventable readmissions (PPRs) for patients discharged with CHF during DY2, in order to measure the scope of the problem and to measure progress going forward. Additionally, CHRISTUS will attempt to determine how many of those patients are already engaged in care management models (if any), to determine how many patients need to be targeted with the care management project.
- DY 3:
  - P-2 – Disseminate findings with stakeholders
    - CHRISTUS will work with the formalized multi-disciplinary teams placed in the local clinics to explain and examine the baseline rate of PPRs for CHF patients, and cooperatively develop an approach to specifically reducing the rate of PPRs for CHF patients over the next two years by sharing best practices and identifying key challenges.

Outcome Improvement Targets for each year:

- DY 4:

    - Reduce CHF 30-day potentially preventable readmissions by 5% under the baseline set in DY2.
- DY 5:
    - Reduce CHF 30-day potentially preventable readmissions by 5% under the baseline set in DY2.

RATIONALE:
CHRISTUS believes that creating multi-disciplinary, formalized care management teams at clinics in the community will reduce the number of CHF 30 day readmissions, which will improve patient outcomes, quality of life, and satisfaction. Additionally, the healthcare community will experience cost savings in treating these patients in the long-term that can be redirected to improving health care delivery in other areas. This outcome is important for Jefferson County, which has a higher rate of 30 day readmissions after medical discharges than the statewide average, and a higher rate of potentially preventable hospital stays than the statewide average (information available in the RHP 2 Jefferson County Profile, August 2012). Addressing this problem for even one isolated population of chronically ill patients is expected to have a meaningful impact on the healthcare delivery system in the community.

CHRISTUS decided to approach this problem in an organized and systematic fashion, which is why it will engage in process oriented milestones during DYs 2-3. CHRISTUS chose to establish a baseline because it is necessary to know the scope of the current problem in order to create meaningful targets for improvement and to measure that improvement. CHRISTUS chose to disseminate its findings to community stakeholders in order to communicate the scope of the problem with the providers engaging in the care management interventions, and to discuss best practices and address key challenges.

CHRISTUS chose improvement targets for DYs 4-5 targeting CHF 30-day readmissions because CHF is a condition that can be managed by regular access to primary care, including medication management and advice regarding diet, exercise, and lifestyle changes. Because patients at high risk for readmission will be identified upon discharge from the inpatient setting and assigned to the clinical care management teams, CHRISTUS Hospital believes it is reasonable to expect a reduction in the readmission rate for this population.

Outcome Measure Valuation:
The valuation of each CHRISTUS project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. CHRISTUS considers this outcome to be of the utmost importance, as potentially preventable readmissions result in fewer resources being available to address other pressing healthcare needs, is exponentially more expensive to provide than care management, and does not result in the best possible health outcomes for patients. Thus, to reduce CHF 30 day PPRs will create benefit for the entire community.

138296208.3.2	IT-3.2	3.3.2	Potentially Preventable Readmissions: CHF 30 Day Readmission Rate
CHRISTUS Hospital – St. Elizabeth			138296208
Related Category 1 or 2 Projects:	138296208.2.1	Expand Chronic Care Management Models	
Starting Point/Baseline:	Baseline to be determined in DY2		

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-2]: Establish baseline rates – CHRISTUS will determine the number of CHF with PPRs within 30 days of discharge; CHRISTUS will also determine the number of those patients who were engaged in chronic care management programs **Data source**: hospital records, patient EHR, clinic data Milestone 1 Estimated Incentive Payment: $140,953	**Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders CHRISTUS will work with the formalized multi-disciplinary teams placed in the local clinics to explain and examine the baseline rate of PPRs, and cooperatively develop an approach to specifically reducing the rate of PPRs for CHF patients over the next two years by sharing best practices and identifying key challenges **Data source**: meeting minutes, meeting materials Milestone 2 Estimated Incentive Payment: $163,383	**Improvement Target 1** : A reduction in PPRs (all-cause) for CHF patients of 5% under the baseline set in DY2 **Data source**: hospital admission records, patient EHR Milestone 3 Estimated Incentive Payment: $262,173	**Improvement Target 2:** A reduction in PPRs (all-cause) for CHF patients of 10% under the baseline set in DY2 **Date source:** hospital admission records, patient EHR Milestone 4 Estimated Incentive Payment: $626,936
Year 2 Estimated Milestone Bundle Amount: $140,953	Year 3 Estimated Milestone Bundle Amount: $163,383	Year 4 Estimated Milestone Bundle Amount: $262,173	Year 5 Estimated Milestone Bundle Amount: $626,936
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,193,447			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-10: Quality of Life/Functional Status
IT-10.1: Quality of Life (standalone measure)
Project Title: Integrate Primary and Behavioral Health Care: Integrate Primary and Behavioral Health Care in Brazoria and Galveston County

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.6

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:
Outcome Domain OD-10 Quality of Life/Functional Status

IT-10-1 Quality of Life [1, 2, 3] (standalone measure) The outcome will be determined by Quality of Life assessment scores as measured by an evidence based and validated tool.

The frequency of administration of the tool is to be determined. As a baseline is established scores will be compared and the expectation is that there will be improvement in physical and behavioral health outcomes, resulting in better quality of life, fewer visits to the local emergency department and fewer hospitalizations for chronic healthcare issues.

Rationale
Presently there is no Integrated Primary and Behavioral Health Care service offered within our current service delivery system. Outcome targets will be determined in DY2 for implementation in DY3. It is anticipated that we will serve approximately 75 individual clients by the end of DY2, 150 individuals by the end of DY3. There will be significant increases as additional clinic locations are added, up to our goal of 40% and 50% respectively for DY4 and DY5 in the established locations.

Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes. The Center will also participate in at least twice annual meetings within the RHP to address 'lessons learned' and collaborative implementation of improvements.

_____

http://www.qualitymeasures.ahrq.gov/expert/expert-commentary.aspx?id=16466&search=quality+of+life
[2] http://www.ncbi.nlm.nih.gov/pubmed/10472152
[3] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3349491/

Outcome Measure Valuation

Population Affected: Upon completion of the proposed project, the planned services will be available in both Galveston and Brazoria county Center adult clinics; and almost all will be either uninsured or on Medicaid. Within the Center's MH Adult services, over 75% are reported to have serious physical health issues (such as diabetes, high blood pressure, and heart problems) in addition to their serious mental health diagnosis. Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment. Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.[1]

Score: Total of 4 points for relatively large population affected (3) and the number of uninsured/Medicaid population to be served (1).

Severity: Within the Region 2 CNA, the average number of poor mental health days and poor physical health days both averaged 3 days in both the Galveston and Brazoria counties. Additionally it was reported in the CNA, a total average of over 35% of survey respondents in both the Galveston (31%) and Brazoria (42%) counties did not consider themselves healthy. Compounding that was the identified lack of community resources including specific identification of the lack of preventive services and mental health care. The proposed project will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and access the physical health care not currently available.

Score: Total of 5 points for strong support on Community Needs Assessment (2) and will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and access the physical health care not currently available (3).

Cost-Effectiveness: It is projected that over the four year period, the total cost of the proposed project is estimated to be approximately $2.6 million; with projections of affecting over 2,000 individuals over the period of time for an approximate costs of $1,300/person...considered to be very cost effect considering the services provided, the persons served, and the expected positive impact on their overall physical and mental health.

Score: Total of 5 points for a very low cost per person.

Community Benefit: The proposed project will improve access to the physical health services sooner; improve overall quality of the service received and more importantly improvement to the quality of life; improve long term costs by reducing un-necessary hospital admissions or extensive medical care resulting from untreated medical issues; is a transformative initiative for behavioral health services in the Galveston and Brazoria county areas by integrating mental and physical health care to those who otherwise would have limited access; and will work in collaboration with other community resources specifically local community health care and FQHC's.

---

1 Bazelon Center for Mental Health Law (2004), GET IT TOGETHER How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves long term costs (1), transformative (1), and collaboration (1)

135222109.3.6	IT-10.1	Quality of Life/Functional Status	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.2.1		
Starting Point/Baseline:	No Integration of Primary/Behavioral Health Services and Related Quality of Life Data		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Estimated service to 75 individuals by end of DY2. Data source: Attendance records P-2 Establish baseline rates Data source: Utilize established spreadsheets and other encounter data. Establish evidenced-based assessment tool P-3 Develop and test data systems Data source: Compare internal data repository with primary care provider data P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data source: Conduct joint meetings with BH/Primary Care providers. Meeting agenda records as well as sign-in/attendance records P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Data source: Meeting agenda records as well as sign-in/attendance	**Process Milestone 2** **OD- 10 Quality of Life/Functional Status** **IT-10.1. Quality of Life*(Standalone measure)*** Data Source: Compare internal data utilizing results from identified evidenced-based assessment tool with encounter data from BH/Primary Care providers P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Data source: Attendance records P-2 Establish baseline rates Data source: Established spreadsheets and other encounter data P-3 Develop and test data systems Data source: Compare internal data repository with primary care provider data P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data source: Conduct joint meetings with BH/Primary Care providers. Meeting agenda records as well as sign-in/attendance records	**Outcome Improvement Target 1** **OD- 10 Quality of Life/Functional Status** **IT-10.1. Quality of Life*(Standalone measure)*** Data Source: Compare internal data utilizing results from identified evidence-based assessment tool with encounter data from BH/Primary Care providers Goal: Increase quality of life as measured by evidence-based assessment tool. Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 196,063	**Outcome Improvement Target 2** **OD- 10 Quality of Life/Functional Status** **IT-10.1. Quality of Life*(Standalone measure)*** Data Source: Compare internal data utilizing results from identified evidence-based assessment tool with encounter data from BH/Primary Care providers Goal: Increase quality of life as measured by evidence-based assessment tool. Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 366,553

135222109.3.6	IT-10.1	Quality of Life/Functional Status	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.2.1		
Starting Point/Baseline:	No Integration of Primary/Behavioral Health Services and Related Quality of Life Data		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
records **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $ 31,623	P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Data source: Meeting agenda records as well as sign-in/attendance records **Process Milestone 2** Estimated Incentive Payment: $ 146,621		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each Milestone/outcome improvement target): $ 31,623	Year 3 Estimated Outcome Amount: $ 146,621	Year 4 Estimated Outcome Amount: $ 196,063	Year 5 Estimated Outcome Amount: $ 366,553
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 740,860			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-10: Quality of Life/Functional Status
IT-10.1: Quality of Life (standalone measure)
Project Title: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 135222109.3.7 – PASS 2

RHP PERFORMING PROVIDER/TPI: The Gulf Coast Center/135222109

OUTCOME MEASURE DESCRIPTION:
Outcome Domain OD-10 Quality of Life/Functional Status

IT-10-1 Quality of Life [1, 2, 3] (standalone measure) The outcome will be determined by Quality of Life assessment scores as measured by an evidence based and validated tool.

The frequency of administration of the tool is to be determined. As a baseline is established scores will be compared and the expectation is that there will be improvement in physical and behavioral health outcomes, resulting in better quality of life, fewer visits to the local emergency department and fewer hospitalizations for chronic healthcare issues.

RATIONALE:
Presently there are no innovative interventions for a targeted behavioral health population to prevent unnecessary use of services within our current service delivery system. Outcome targets will be determined in DY2 for implementation in DY3.

Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes. The Center will also participate in at least twice annual meetings within the RHP to address 'lessons learned' and collaborative implementation of improvements.

---

http://www.qualitymeasures.ahrq.gov/expert/expert-commentary.aspx?id=16466&search=quality+of+life
[2] http://www.ncbi.nlm.nih.gov/pubmed/10472152
[3] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3349491/

Outcome Measure Valuation

Population Affected:

Score: Total of 4 points for relatively large population affected (3) and the number of uninsured/Medicaid population to be served (1).

Severity: Within the Region 2 CNA, the average number of poor mental health days and poor physical health days both averaged 3 days in both the Galveston and Brazoria counties. Additionally it was reported in the CNA, a total average of over 35% of survey respondents in both the Galveston (31%) and Brazoria (42%) counties did not consider themselves healthy. Compounding that was the identified lack of community resources including specific identification of the lack of preventive services and mental health care. The proposed project will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and access the physical health care not currently available.

Score: Total of 5 points for strong support on Community Needs Assessment (2) and will have a significant and lasting impact on both the mental and physical health of those to be served within the proposed project; improving the quality of service and access the physical health care not currently available (3).

Cost-Effectiveness: It is projected that over the four year period, the total cost of the proposed project is estimated to be approximately $2.6 million; with projections of affecting over 2,000 individuals over the period of time for an approximate costs of $1,300/person...considered to be very cost effect considering the services provided, the persons served, and the expected positive impact on their overall physical and mental health.

Score: Total of 5 points for a very low cost per person.

Community Benefit: The proposed project will improve access to the physical health services sooner; improve overall quality of the service received and more importantly improvement to the quality of life; improve long term costs by reducing un-necessary hospital admissions or extensive medical care resulting from untreated medical issues; is a transformative initiative for behavioral health services in the Galveston and Brazoria county areas by integrating mental and physical health care to those who otherwise would have limited access; and will work in collaboration with other community resources specifically local community health care and FQHC's.

Score: Total of 5 points for its improvement of access (1), improvement of quality (1), improves long term costs (1), transformative (1), and collaboration (1).

135222109.3.7	IT-10.1	Quality of Life/Functional Status	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.2.2		
Starting Point/Baseline:	No innovative intervention services and related quality of life data		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Data source: Attendance records Process Milestone 1 Estimated Incentive Payment: $ 3,028 **Process Milestone 2** P-2 Establish baseline rates Data source: Utilize established spreadsheets and other encounter data. Establish evidenced-based assessment tool. It is anticipated that 50 individuals will be served by the end of DY2. Process Milestone 2 Estimated Incentive Payment: $ 3,028 **Process Milestone 3** P-3 Develop and test data systems Data source: Compare internal data repository with intervention data Process Milestone 3 Estimated Incentive Payment: $ 3,028	**Outcome Improvement Target 1** **OD- 10 Quality of Life/Functional Status** **IT-10.1. Quality of Life*(Standalone measure)*** a. Demonstrate improvement in QOL scores as measured by evidence based tool b. Data Source: selected validated tool c. Rationale: One of the best ways to measure symptoms and functional status is by direct patient survey. Goal: Increase quality of life as measured by evidence-based assessment tool. Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 14,735 **Process Milestone 6** P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Data source: Attendance records Process Milestone 6 Estimated Incentive Payment*:* $ 14,735 **Process Milestone 7**	**Outcome Improvement Target 2** **OD- 10 Quality of Life/Functional Status** **IT-10.1. Quality of Life*(Standalone measure)*** a. Demonstrate improvement in QOL scores as measured by evidence based tool b. Data Source: selected validated tool c. Rationale: One of the best ways to measure symptoms and functional status is by direct patient survey. Goal: 30% Increase quality of life as measured by evidence-based assessment tool Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 95,816	**Outcome Improvement Target 3** **OD- 10 Quality of Life/Functional Status** **IT-10.1. Quality of Life*(Standalone measure)*** a. Demonstrate improvement in QOL scores as measured by evidence based tool b. Data Source: selected validated tool c. Rationale: One of the best ways to measure symptoms and functional status is by direct patient survey. Goal:50% Increase quality of life as measured by evidence-based assessment tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 164,803

135222109.3.7	IT-10.1	Quality of Life/Functional Status	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.2.2		
Starting Point/Baseline:	No innovative intervention services and related quality of life data		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 4 P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data source: documentation of PDSA cycles and identified improvement needs. Process Milestone 4 Estimated Incentive Payment: $ 3,028 **Process Milestone 5** P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Data source: Meeting agenda records as well as sign-in/attendance records Process Milestone 5 Estimated Incentive Payment: $ 3,029	P-2 Expand services based on DY2 baselines rates It is anticipated that we will serve 60 individuals by the end of DY3. Data source: Established spreadsheets and other encounter data Process Milestone 7 Estimated Incentive Payment: $ 14,736 **Process Milestone 8** P-3 Develop and test data systems Data source: Compare internal data repository with intervention data Process Milestone 8 Estimated Incentive Payment: $ 14,736 **Process Milestone 9** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data source: documentation of PDSA cycles and identified improvement needs Process Milestone 9 Estimated Incentive Payment: $ 14,736 **Process Milestone 10**		

135222109.3.7	IT-10.1	Quality of Life/Functional Status	
The Gulf Coast Center			135222109
Related Category 1 or 2 Projects:	135222109.2.2		
Starting Point/Baseline:	No innovative intervention services and related quality of life data		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Data source: Meeting agenda records as well as sign-in/attendance records Process Milestone 10 Estimated Incentive Payment: $ 14,736		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each Milestone/outcome improvement target): $15,141	Year 3 Estimated Outcome Amount: $88,414	Year 4 Estimated Outcome Amount: $95,816	Year 5 Estimated Outcome Amount: $164,803
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):*$364,174			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-3 Potentially Preventable Re-Admissions
IT 3.1 All Cause 30 Day Readmission Rate-NQF 1789 (Standalone Measure)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 139172412.3.3

RHP PERFORMING PROVIDER/TPI: Memorial Medical Center of East Texas-Lufkin/139172412

OUTCOME MEASURE DESCRIPTION:

- DY2
  - P-1 Project Planning- Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- DY3
  - P-3 Develop and test systems
- DY4
  - IT-3.1 All cause readmission rate will be reduced to 18%.
- DY5
  - IT-3.1 All cause readmission rate will be reduced to 16%.

RATIONALE:
When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home- and community-based services, etc. Patients with limited resources have a difficult time adhering to discharge prescription and other provisions due to limited resources. By concentrating on a coordinated approach by health care providers and providing tools to enable successful adoption of desired compliance, patients will have a greater chance of succeeding in adhering to the discharge plan and thus avoiding readmission. According to the Texas Region 2 Health Partnership, Angelina, Polk and San Augustine Counties have higher than State average rates for adult smoking, obesity, physical inactivity and preventable hospitalizations.

Outcome Measure Valuation
The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a)

enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

IT-3.1 All cause readmission rate will be reduced

A. Population Affected
   - Measure: All adults over 18 years with multiple chronic medical conditions.
   - Score: 3 points awarded for significant population affected, and 1 extra point for Medicaid/Uninsured population.

B. Severity
   - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.

C. Cost Effectiveness
   - Score: 4 points awarded for a low cost per person.

D. Community Benefit
   - Score: 4 points awarded; 1 for quality; 1 for cost; 1 for transformative; 1 for collaborative.

139172412.3.3	IT-3.1	All Cause 30 day readmission rate-NQF 1789 (Standalone measure)	
Memorial Medical Center of East Texas-Lufkin			**139172412**
Related Category 1 or 2 Projects:	**139172412.2.1**		
Starting Point/Baseline:	**The baseline starting point for the 30 day re-hospitalization rate is 20%.**		
Year 2 (10/1/2012 – 9/30/2013)	**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: Submission of planning documents and meeting minutes. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $60,575	**Process Milestone 2:** P-3 Develop and test systems Data Source: Submission of a Data Systems implementation plan. Process Milestone2 Estimated Incentive Payment: $70,214	**Outcome Improvement Target 1**: IT-3.1 All Cause 30 day readmission rate (standalone measure). Improvement Target: All cause readmission rate will be reduced to 18%. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $112,669	**Outcome Improvement Target 2**: IT-3.1 All Cause 30 day readmission rate (standalone measure) Improvement Target: All cause readmission rate will be reduced to 16%. Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $269,427
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $60,575	Year 3 Estimated Outcome Amount: $70,214	Year 4 Estimated Outcome Amount: $112,669	Year 5 Estimated Outcome Amount: $269,427
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $512,885			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-3 Potentially Preventable Re-Admissions
IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 139172412.3.4

RHP PERFORMING PROVIDER/TPI: Memorial Medical Center of East Texas-Lufkin/139172412

OUTCOME MEASURE DESCRIPTION:
IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure)
The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[1] Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates. For calendar year 2011, 2.4% of all acute care admissions to Memorial Health System of East Texas, Lufkin had a diagnosis of DRG 190 Acute Myocardial Infarction. The primary service area rates of obesity, smoking, diabetes and low rates of physical activity all have negative variances to the state rate. The long term cost of management of these patients post discharge is high. Readmission within 30 days signals a failure of the system to manage these patients effectively.

- DY2
  - Process Milestone 1: P-1 Project Planning: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- DY3
  - Process Milestone 2: P-3 Develop and test systems.
- DY4
  - Outcome Improvement Target 1: IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure) will be reduced to 17%
- DY5
  - Outcome Improvement Target 2: IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure) will be reduced to 15%

[1] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp. 75-91.

RATIONALE:
When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home- and community-based services, etc. Patients with limited resources have a difficult time adhering to discharge prescription and other provisions due to limited resources. By concentrating on a coordinated approach by health care providers and providing tools to enable successful adoption of desired compliance, patients will have a greater chance of succeeding in adhering to the discharge plan and thus avoiding readmission.

According to the Texas Region 2 Health Partnership, Angelina, Polk and San Augustine Counties have higher than State average rates for adult smoking, obesity, physical inactivity and preventable hospitalizations. According to the County Health Rankings and Roadmaps, Polk and San Augustine Counties, two of the 2 primary service area counties have worse than State Average rates of Children in Poverty and unemployed. Lack of resources contributes to high readmissions rates.

Outcome Measure Valuation
The project is valued using a method which ranks the importance of each projects based on five factors: (1) the amount of local funding government funding available to support the project; (2) the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c)improve the cost-effectiveness of care provided in the community; (3) the degree of need for the project in the community; (4) the cost of the time, effort, and clinical resources involved in implementing the project, and (5) the size and scope of the patient population served by the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community.

IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate reduction

A. Population Affected
   - Score: 1 point awarded for relatively small population affected, and 1 extra point for Medicaid/Uninsured population.

B. Severity
   - Score: 2 points awarded for strong support of identified community need; 3 points awarded for higher rate than State average.

C. Cost Effectiveness
   - Score: 4 points awarded for a low cost per person.

D. Community Benefit
   - Score: 4 points awarded; 1 for quality; 1 for cost; 1 for transformative; 1 for collaborative.

139172412.3.4	**IT-3.5**	**Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure)**	
Memorial Medical Center of East Texas-Lufkin			**139172412**
Related Category 1 or 2 Projects:	**139172412.2.2**		
Starting Point/Baseline:	**For the period 2011Q2 through 2012Q1 AMI 30 day readmission rate for Memorial Health System of East Texas, Lufkin was 9.09%, 14.29%, 14.29%, 30% and 22.73% respectively, for a cumulative readmission rate of 19% for the 6 month period.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project Planning - Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project planning documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $53,448	**Process Milestone 2:** P-3 Develop and test systems Data Source: Development, planning and testing documents Process Milestone 3 Estimated Incentive Payment: $ Outcome Improvement Target 1 Estimated Incentive Payment*:* $61,954	**Outcome Improvement Target 1**: IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure) Improvement Target: Reduce acute myocardial infarction (AMI) 30 day readmission rate to 17% Data Source: Internal IT system (Minepoint) Outcome Improvement Target 2 Estimated Incentive Payment*:* $99,414	**Outcome Improvement Target 2**: IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure) Improvement Target: Reduce acute myocardial infarction (AMI) 30 day readmission rate to 15% Data Source: Internal IT system (Minepoint) Outcome Improvement Target 3 Estimated Incentive Payment*:* $237,730
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $53,448	Year 3 Estimated Outcome Amount: $61,954	Year 4 Estimated Outcome Amount: $99,414	Year 5 Estimated Outcome Amount: $237,730
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $452,546			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-1 - Primary Care and Chronic Disease Management
IT-1.11 - Diabetes care: Blood Pressure control

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.5

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital (MH)/TPI: 131030203

OUTCOME MEASURE DESCRIPTION:
Addressing the issue of BP control among diabetics will first include a process of establishing baseline rates and then implementing interventions to improve blood pressure levels.
Process Milestones:

- DY2:
  - P-2-Establish baselines of the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure control (<140/80 mm Hg).

Outcome Improvement Targets:

- DY3:
  - IT-1.11- Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 5% over baseline.
- DY4:
  - IT-1.11- Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 10% over baseline.
- DY5:
  - IT-1.11- Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 15% over baseline.

Rationale
The above process milestones and outcome improvement targets were chosen because they are reasonable measures for determining the effectiveness of a self-management program for health promotion. The health status measure of blood pressure control is recognized as an accurate method of disease management for patients with diabetes (type 1 or type 2). Blood pressure control is easily assessed with regular testing, the data is easily attainable from the patients' electronic health records, and interventions (patient education from community health workers) can be implemented effectively.

In Nacogdoches, mortality from diabetes are higher than Texas and US rates, with a death rate of 36.6 compared to the state rate of 26 and the US rate of 20.9. This rate has Nacogdoches in the lower 25% of counties in Texas. However, diabetes prevalence is similar to the Texas rates and slightly worse than US rates. This condition 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. If detected and addressed in the early stages many complications, such as amputation, blindness, and kidney failure, can be prevented. 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

The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). Individuals with diabetes make up approximately 9.3% of the Nacogdoches County population. This data shows us that a moderate portion of our population is affected by this issue, including the underserved and/or Medicaid patients. The severity of diabetes is shown in our CNA with high death rates from diabetes and other related diseases such as cerebrovascular, cardiovascular and hypertensive renal disease.

To determine the cost effectiveness of the project, MH compared the total amount of patient visits provided by the clinic and the rate of diabetes in the community. The clinic will provide approximately 60,060 over the four year period, if 9.3% are diabetes patients, an estimation of 5,585 patient visits can be assumed. The target population for this project will be selected from the clinics patient population. The goal of the project is to educate at least 150 individuals with diabetes in self management to control their disease. The cost of this project is calculated at $3,800 per patient enrolled in the self-management program. This is determined to be a very low cost when comparing the cost of the program to the cost of hospitalizations avoided. According to information for the Department of State Health Services Preventable Hospitalization program, the average cost for hospitalization of short-term diabetes complications is $21,900 and the average cost of long-term complications is $27,839 per visit. The community will benefit from this project because it will improve access, quality of care, have a long-term cost savings, and will be a collaborative approach to transformative health care in Nacogdoches.

131030203.3.5	IT-1.11	Diabetes care: Blood Pressure control	
Nacogdoches Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	**131030203.2.1**		
Starting Point/Baseline:	**In Year 2, determine a baseline of percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure control (<140/80 mm Hg).**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 2] Establish baseline rates Data Source: Documentation of baseline rates from Chronic Care Registry. Process Milestone 2 Estimated Incentive Payment : $70,000	**Outcome Improvement Target 1** [IT-1.11]: Diabetes care: BP control Improvement Target: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 5% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $80,000	**Outcome Improvement Target 2** [IT-1.11]: Diabetes care: BP control Improvement Target: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 10% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $120,000	**Outcome Improvement Target 3**[IT-1.11]: Diabetes care: BP control Improvement Target: Increase the percentage of MH patients 18-75 years of age with diabetes (type 1 or type 2) who had BP control (<140/80mm Hg) by 15% over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment*:* $300,000
Year 2 Estimated Outcome Amount: $70,000	Year 3 Estimated Outcome Amount: $80,000	Year 4 Estimated Outcome Amount: $120,000	Year 5 Estimated Outcome Amount: $300,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $570,000			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-4 – Potentially preventable complications in Health Care Acquired conditions
IT-4.5 – Patient Fall Rate NQF0141

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 131030203.3.6 – PASS 2

RHP PERFORMING PROVIDER/TPI: Nacogdoches Memorial Hospital/131030203

OUTCOME MEASURE DESCRIPTION:
Addressing the issue of reducing the patient fall rate will include a process of project planning, establishing baselines, and implementing interventions. The first process milestone will address project planning in Year 2. Project planning will engage stakeholders, identify current capacity and needed resources, determine timelines and create implementation plans. The second process milestone will occur in Year 3 and will focus on establishing the baseline for the patient fall rate. This baseline will derive from electronic health records, claims or administrative records.

Outcome improvement targets for each year:

- DY4:
  - IT-4.5: Reduce the number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by 5% over baseline.

    The data collection method utilized will be Method 2-Midnight Census + Patient Days from Actual Hours for Short Stay Patient.

- DY5:
  - IT-4.5: Reduce the number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by 10% over baseline.

    The data collection method utilized will be Method 2-Midnight Census + Patient Days from Actual Hours for Short Stay Patient.

RATIONALE:
The above process milestones and outcome improvement targets were chosen because they are the most reasonable methods for program improvement. This outcome measure was chosen because of the relationship between the care provided by the floor nurse, patient fall rates and the patient experience. If patient needs are quickly responded to by the nurse, the patient fall rate should decrease due to the improved nurse response.

Outcome Measure Valuation

The population of Nacogdoches County is 64,524. Based on the CNA the uninsured population is 43.3% (approximately 28,000). The project is expected to cost approximately $600,000 over the four years. The community will benefit from this project because it will improve access, quality of care, long-term cost savings, and will be a collaborative approach to transformative health care in Nacogdoches.

131030203.3.6	IT-4.5	Patient Fall Rate	
Memorial Hospital (MH)			131030203
Related Category 1 or 2 Projects:	131030203.2.2		
Starting Point/Baseline:	In Year 3, determine a baseline of the patient fall rate.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of project planning timeline and plans. Process Milestone 1 Estimated Incentive Payment : $89,983	**Process Milestone 2 [P- 2]** Establish baseline rates of patient falls (with or without injury to the patient and whether or not assisted by a staff member). Data Source: Documentation of baseline rates from Electronic Health Records, claims or administrative records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $93,477	**Outcome Improvement Target 1** [IT-4.5]: Patient fall rate. Improvement Target: Reduce the number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by 5% over baseline. Data Source: EHR, claims or administrative records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $132,806	**Outcome Improvement Target 2**[IT-4.5]: Patient fall rate. Improvement Target: Reduce the number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by 10% over baseline. Data Source: EHR, claims or administrative records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $290,418
Year 2 Estimated Outcome Amount: $89,983	Year 3 Estimated Outcome Amount: $93,477	Year 4 Estimated Outcome Amount: $132,806	Year 5 Estimated Outcome Amount: $290,418
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $606,684			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-6 – Patient Satisfaction
IT-6.1(1) – Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information
Integrating Primary and Behavioral Health Care Service

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.5

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1 (1), percent improvement over baseline of patient satisfaction scores, patients are getting timely care, appointments, and information.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 2.

Rationale:
Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Outcome Measure Valuation:
Spindletop 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.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.5	***IT-6.1(1)***	***Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information***	
Spindletop Center			***096166602***
Related Category 1 or 2 Projects:	***096166602.2.1***		
Starting Point/Baseline:	***To be established in Year 2***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Survey document; survey results Process Milestone 1 Estimated Incentive Payment*:* $42,607	**Outcome Improvement Target 1** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $98,773	**Outcome Improvement Target 2** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $105,660	**Outcome Improvement Target 3** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 3 Estimated Incentive Payment*:* $229,708
Year 2 Estimated Outcome Amount: $42,607	Year 3 Estimated Outcome Amount: $98,773	Year 4 Estimated Outcome Amount: $105,660	Year 5 Estimated Outcome Amount: $229,708
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $476,748			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-9, Right Care, Right Setting
IT-9.4 Reduction in days in state behavioral health facilities, supported living centers, hospitals, and criminal justice facilities IDD individuals in behavioral crisis
Community Behavioral Crisis Services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.6

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
For demonstration years 3-5, Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting and measure IT-9.4 for this project. The measure will be the reduction in days in state behavioral health facilities, supported living centers, hospitals, and criminal justice facilities for individuals in the target population.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. Data will be accumulated regarding days in state behavioral health facilities, hospitals, and criminal justice facilities for in the target population.

RATIONALE:
The ultimate outcome of this project is to treat IDD individuals in behavioral crises in a more appropriate setting than more costly hospitals, state-supported living centers, or criminal justice system. Various studies, including a March 2010 study by Texas A&M University, found that crisis services programs offer direct and measurable reductions in cost of services associated with crisis that more than cover the cost of the programs.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, state-supported living centers, and criminal justice incarceration.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.6	OD-9 IT-9.4	Right Care, Right Setting-Reduction in days in state behavioral health facilities, supported living centers, hospitals, and criminal justice facilities IDD individuals in behavioral crisis	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.2.2		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Hospital admissions, state behavioral health admissions, state-supported living admissions, criminal justice data for target population Process Milestone 1 Estimated Incentive Payment*:* $8.732	**Outcome Improvement Target 1** IT-9-4: Reduction in days in state behavioral health facilities, supported living centers, hospitals, and criminal justice facilities IDD individuals in behavioral crisis Improvement Target: TBD Data Source: Hospital admissions, state behavioral health admissions, state-supported living admissions, criminal justice data for target population Outcome Improvement Target 1 Estimated Incentive Payment*:* $20,243	**Outcome Improvement Target 2** IT-9-4: Reduction in days in state behavioral health facilities, supported living centers, hospitals, and criminal justice facilities IDD individuals in behavioral crisis Improvement Target: TBD Data Source: Hospital admissions, state behavioral health admissions, state-supported living admissions, criminal justice data for target population Outcome Improvement Target 2 Estimated Incentive Payment*:* $21,655	**Outcome Improvement Target 3** IT-9-4 Reduction in days in state behavioral health facilities, supported living centers, hospitals, and criminal justice facilities IDD individuals in behavioral crisis Improvement Target: TBD Data Source: Hospital admissions, state behavioral health admissions, state-supported living admissions, criminal justice data for target population Outcome Improvement Target 3 Estimated Incentive Payment*:* $47,077
Year 2 Estimated Outcome Amount: $8,732	Year 3 Estimated Outcome Amount: $20,243	Year 4 Estimated Outcome Amount: $21,655	Year 5 Estimated Outcome Amount: $47,077
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $97,707			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-6 Patient Satisfaction
IT-6.1 (4) Percent improvement over baseline of patient satisfaction scores- Patients involvement in shared decision making
Behavioral Health Training

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.7

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1 (4), percent improvement over baseline of patient satisfaction scores, patients' involvement in shared decision making.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 2.

RATIONALE:
Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (4) patient's involvement in shared decision making. One of the purposes of this project is for clients to learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Outcome Measure Valuation:
Spindletop 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.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.7	IT-6.1(4)	Percent improvement over baseline of patient satisfaction scores-Patients involvement in shared decision making	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.2.3		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Survey document; survey results Process Milestone 1 Estimated Incentive Payment*:* $16,160	**Outcome Improvement Target 1** IT-6-1(4): Percent improvement over baseline of patient satisfaction scores- Patients involvement in shared decision making Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $37,465	**Outcome Improvement Target 2** IT-6-1(4): Percent improvement over baseline of patient satisfaction scores- Patients involvement in shared decision making Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $40,079	**Outcome Improvement Target 3** IT-6-1(4): Percent improvement over baseline of patient satisfaction scores- Patients involvement in shared decision making Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 3 Estimated Incentive Payment*:* $87,133
Year 2 Estimated Outcome Amount: $16,160	Year 3 Estimated Outcome Amount: $37,465	Year 4 Estimated Outcome Amount: $40,079	Year 5 Estimated Outcome Amount: $87,133
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $180,837			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-10, Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target
Affordable Housing for People with Mental Illness

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: -096166602.3.17 **– Pass 3b**

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
The process milestone selected for demonstration year 2 is P-1, project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. To do this, we plan to complete the project plan with timelines for the various phases of the project. For DY3, the process milestone is P-2, establish baseline rates for the outcome measures: reduced homelessness, increased employment, and improved compliance with behavioral health treatment plans.

For demonstration years 4-5 Spindletop has selected improvement outcome measure OD-10, Quality of Life/Functional Status, IT-10.7 Other Outcome Improvement Target. The measures will be reduced homelessness, increased employment, and improved compliance with behavioral health treatment plans for clients in the apartments. These statistics have been compiled for previous Spindletop housing projects to demonstrate the effectiveness of the project.

RATIONALE:
We chose outcome improvement IT-10.7 because the ultimate outcome of this project is improve the quality of life for homeless people with behavioral health issues, to promote wellness and adherence to behavioral health treatments, and to promote recovery in the community. Residential options linked to a range of support services can effectively improve health outcomes and decrease hospitalizations, ED visits, and incarcerations for vulnerable individuals, such as the long-term homeless with severe mental illness.

Process milestone P-1 was selected for DY2 to complete the plan, and process milestone 2 was selected for DY3 to establish baseline rates for measuring the outcome improvements in DY4-5.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for substance abuse, emergency room visits, and criminal

justice incarceration. A health economic study that included these factors as well as quality of life was also used to value the project.

096166602.3.17	OD-10 IT-10.7	OD-10, Quality of Life/Functional Status, IT-10.7 Other Outcome Improvement Target	
Spindletop Center			**096166602**
Related Category 1 or 2 Projects:	**096166602.2.10**		
Starting Point/Baseline:	**To be established in Year 3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan- develop project plan including timelines Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment*:* $26,334	**Process Milestone 2 P-2**: Establish baseline rates for outcome measures: reduced homelessness, increased employment, and improved compliance with behavioral health treatment plans Data Source: Spindletop housing records Process Milestone 2 Estimated Incentive Payment*:* $61,046	**Outcome Improvement Target 1** IT-9-2: Improvements in outcomes: reduced homelessness, increased employment, and improved compliance with behavioral health treatment plans Improvement Target: TBD Data Source: Spindletop housing records Outcome Improvement Target 1 Estimated Incentive Payment*:* $65,303	**Outcome Improvement Target 2** IT-9-2: Improvements in outcomes: reduced homelessness, increased employment, and improved compliance with behavioral health treatment plans Improvement Target: TBD Data Source: Spindletop housing records Outcome Improvement Target 2 Estimated Incentive Payment*:* $141,970
Year 2 Estimated Outcome Amount: $26,334	Year 3 Estimated Outcome Amount: $61,046	Year 4 Estimated Outcome Amount: $65,303	Year 5 Estimated Outcome Amount: $141,970
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $294,653			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-10, Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target
Health and Wellness Program for Individuals with Intellectual and Developmental Disabilities

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.18-Pass 3b

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
Spindletop has selected improvement outcome domain OD-10, Quality Of Life/Functional Status and measure IT-10.7 for this project. The measure will be improved cardiovascular health as demonstrated by lowered resting heart rate and blood pressure and reduced total body fat for individuals with IDD/ASDs who are in the Health and Wellness program.

For DY2, the process milestone is P-2, establish baseline rates for cardiac risk factors in the target population. For DY3-5, the improvement target is IT 10.7, defined as the percentage of individuals with IDD/ASDs who are in the Health and Wellness program whose resting heart rate and blood pressure are lowered and total body fat is reduced.

RATIONALE:
With the increase in life-spans of individuals diagnosed with IDD/ASDs, they are more likely to have cardiac conditions, be more prone to obesity than the general population, and experience these conditions at an earlier age. Physical inactivity is directly linked to many secondary health conditions such as coronary artery disease, congestive heart failure, hypertension, stroke, and some cancers. In addition, physical inactivity is known to contribute to obesity. The prevalence of obesity in individuals with intellectual disabilities is higher than that in the general population. Cardiac conditions are 3 to 4 times more likely in individuals with Down syndrome than in the general population. (Hall, Jamie M., and M. Janet Thomas. *"Promoting Physical Activity and Exercise in Older Adults With Developmental Disabilities."* Geriatric Rehabilitation 24.1 (2008): 64-73.) A need exists for this population to have access to programs offering physical activities similar to those which are available to the non-IDD population; however, there is a lack of adequate available facilities in our area for individuals with IDD/ASDs to participate in recreational and physical activities that would allow them to maintain a healthier lifestyle.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for cardiovascular stays and emergency room visits.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.18	OD-10 IT-10.7	Quality of Life/Functional Status, Other Outcome Improvement Target—Improved Cardiovascular Health	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.2.11		
Starting Point/Baseline:	Baseline to be established in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates of resting heart rate and blood pressure and reduced total body fat for target population Data Source: Spindletop EHR Process Milestone 1 Estimated Incentive Payment*:* $14,641	**Outcome Improvement Target 1** IT-10.7: % of individuals in target population served in wellness program with lowered resting heart rate and blood pressure and reduced total body fat Target: TBD Data Source: Spindletop EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $33,942	**Outcome Improvement Target 2** IT-10.7: % of individuals in target population served in wellness program with lowered resting heart rate and blood pressure and reduced total body fat Target: TBD Data Source: Spindletop EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $36,309	**Outcome Improvement Target 3** IT-10.7: % of individuals in target population served in wellness program with lowered resting heart rate and blood pressure and reduced total body fat Target: TBD Data Source: Spindletop EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $78,935
Year 2 Estimated Outcome Amount: $19,434	Year 3 Estimated Outcome Amount: $45,052	Year 4 Estimated Outcome Amount: $48,194	Year 5 Estimated Outcome Amount: $104,773
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $217,453			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-9, Right Care, Right Setting
IT-9.4, Other Outcome Target of decreasing the percentage of clients served by the MHPO's who have behavioral health admissions and readmissions to hospitals and criminal justice settings such as jails or prisons
Mental Health Peace Officers

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.11 - PASS 2

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
Spindletop has selected improvement outcome domain OD-9, Right Care, Right Setting, IT-9.4, Other Outcome Target of decreasing the percentage of clients served by the MHPO's who have behavioral health admissions and readmissions to hospitals and criminal justice settings such as jails or prisons.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. Data will be accumulated regarding behavioral health admissions and readmissions to hospitals and criminal justice settings such as jails or prisons.

RATIONALE:
We chose IT-9.4, Other Outcome Target of decreasing the percentage of clients served by the MHPO's who have behavioral health admissions and readmissions to hospitals and criminal justice settings such as jails or prisons, for this project because the ultimate outcome of this project is to treat behavioral health crisis clients in a more appropriate less-costly setting.

We chose process milestone P-2 to establish baselines for measuring the outcome improvement of the project.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders, emergency room visits, stays at state behavioral health facilities, and criminal justice incarceration. A health economic study that included these factors was also used to value the project.

096166602.3.11	OD-9 IT 9.4	OD-9, Right Care, Right Setting, IT-9.4, Other Outcome Target-Decrease % of Client Admissions to Hospitals & Criminal Justice Settings	
Spindletop Center			**096166602**
Related Category 1 or 2 Projects:	**096166602.2.6**		
Starting Point/Baseline:	**To be established in Year 2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Admission records for hospitals, ED, and jails for behavioral health crisis Process Milestone 1 Estimated Incentive Payment*:* $16,958	**Outcome Improvement Target 1** IT-9-4: Other Outcome Target-Decrease in % of admissions to hospitals & criminal justice settings for clients served by MHPO's Target: TBD Data Source: Admission records for hospitals, ED, and jails for behavioral health crisis Outcome Improvement Target 1 Estimated Incentive Payment*:* $39,314	**Outcome Improvement Target 2** IT-9-4: Other Outcome Target-Decrease in % of admissions to hospitals & criminal justice settings for clients served by MHPO's Target: TBD Data Source: Admission records for hospitals, ED, and jails for behavioral health crisis Outcome Improvement Target 2 Estimated Incentive Payment*:* $42,055	**Outcome Improvement Target 3** IT-9-4: Other Outcome Target-Decrease in % of admissions to hospitals & criminal justice settings for clients served by MHPO's Target: TBD Data Source: Admission records for hospitals, ED, and jails for behavioral health crisis Outcome Improvement Target 3 Estimated Incentive Payment*:* $91,429
Year 2 Estimated Outcome Amount: $16,958	Year 3 Estimated Outcome Amount: $39,314	Year 4 Estimated Outcome Amount: $42,055	Year 5 Estimated Outcome Amount: $91,429
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $189,756			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-6 Patient Satisfaction
IT-6.1 (4) Percent improvement over baseline of patient satisfaction scores- Patients involvement in shared decision making

Peer-to-Peer Support Services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.12 - PASS 2

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
Spindletop has selected improvement outcome domain OD-6 Patient Satisfaction. For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1 (4), percent improvement over baseline of patient satisfaction scores, patients' involvement in shared decision making.

RATIONALE:
The inability to engage consumers in their own recovery is often the result of poor communication skills, emotional crisis reactions, trauma reactions, and adverse childhood experiences. These areas contribute to a lack of commitment to improve their whole health wellness and management of recovery goals. Consumers are more likely to create a healthier lifestyle when their focus is on their interests, and personal strengths are encouraged and supported through a peer provider program. Measuring the whole health plan compliance percentage will gauge the success of the peer program.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and substance abuse disorders, emergency room visits, and criminal justice incarceration.

Another valuation factor used for this project is the monetary value for a behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.12	OD-6 IT-6.1	Patient Satisfaction, Percent improvement over baseline of patient satisfaction scores	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.2.7		
Starting Point/Baseline:	0%		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning— identifying current capacity and needed resources, determining timelines, and documenting implementation plans Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment*:* $14,746	**Outcome Improvement Target 1** IT-6-1(4): Percent improvement over baseline of patient satisfaction scores-Patients involvement in shared decision making Improvement Target: TBD Data Source: Survey results Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $34,186	**Outcome Improvement Target 2** IT-6-1(4): Percent improvement over baseline of patient satisfaction scores-Patients involvement in shared decision making Improvement Target: TBD Data Source: Survey results . Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $36,570	**Outcome Improvement Target 3** IT-6-1(4): Percent improvement over baseline of patient satisfaction scores-Patients involvement in shared decision making Improvement Target: TBD Data Source: Survey Data Source: Survey results s Outcome Improvement Target 3 Estimated Incentive Payment*:* $79,503
Year 2 Estimated Outcome Amount: $14,746	Year 3 Estimated Outcome Amount: $34,186	Year 4 Estimated Outcome Amount: $36,570	Year 5 Estimated Outcome Amount: $79,503
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $165,005			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-10, Quality of Life/Functional Status
IT-10.1 Quality of Life
Outpatient Substance Abuse Services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.13 - PASS 2

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
Spindletop has selected improvement outcome domain OD-10, Quality of Life/Functional Status. For DY2, the process milestone is P-1, project planning— identifying current capacity and needed resources, determining timelines, and documenting implementation plans. For DY3-5, the improvement target is 10.1 Quality of Life as measured by the Texas Department of State Health Services outcome tool. The target will be 70% of the participating clients discharged successfully from the program each year. Successful discharge incorporates such criteria as abstinence from substance abuse, stable housing, and participating in a support system (such as Alcoholics Anonymous).

Rationale:
The expected outcome of this program is to strengthen the recovery of our clients through substance abuse treatment programs and case management services; to improve the quality of life for these clients; and to reduce general and psychiatric hospital recidivism, emergency department usage, and criminal justice system interaction.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and substance abuse disorders, emergency room visits, and criminal justice incarceration.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

096166602.3.13	OD-10 IT-10.7	Quality of Life/Functional Status,	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.2.8		
Starting Point/Baseline:	400 clients served per year		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning— identifying current capacity and needed resources, determining timelines, and documenting implementation plans Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment*:* $14,641	**Outcome Improvement Target 1** IT-10.7: Percentage of clients successfully discharged from program Target: 70% of clients participating in program Data Source: Monthly outcome measures report Outcome Improvement Target 1 Estimated Incentive Payment*:* $33,942	**Outcome Improvement Target 2** IT-10.1: Percentage of clients successfully discharged from program Target: 70% of clients participating in program Data Source: Monthly outcome measures report Outcome Improvement Target 2 Estimated Incentive Payment*:* $36,309	**Outcome Improvement Target 3** IT-10.1: Percentage of clients successfully discharged from program Target70% of clients participating in program Data Source: Monthly outcome measures report Outcome Improvement Target 3 Estimated Incentive Payment*:* $78,935
Year 2 Estimated Outcome Amount: $14,641	Year 3 Estimated Outcome Amount: $33,942	Year 4 Estimated Outcome Amount: $36,309	Year 5 Estimated Outcome Amount: $78,935
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $163,827			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information
Early Childhood Intervention Community Outreach
UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 096166602.3.14-Pass 2

RHP PERFORMING PROVIDER/TPI: Spindletop Center/096166602

OUTCOME MEASURE DESCRIPTION:
The process milestone selected for demonstration year 2 is P-2, establish baseline rates for patient satisfaction. The annual ECI Family Outcome Survey currently proscribed by the ECI program will establish the baseline in DY2. Since mobile devices will be used to expand access for consumers to internet healthcare resources, the ECI Family Outcome Survey will be expanded to measure the effectiveness of mobile devices in providing consumer access to information.

For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores-patients getting timely healthcare information.

Rationale:

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, consumers getting timely ECI and health information. Since mobile devices will be used to expand access for consumers to internet healthcare resources, customer satisfaction surveys will be done to measure the effectiveness of mobile devices in providing consumer access to information. The survey will be designed to produce comparable data on the consumers' perspective on care that will allow objective and meaningful assessment of the program in meeting their needs. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Outcome Measure Valuation:
In valuing this project, Spindletop considered the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention

096166602.3.14	IT-6.1	Percent improvement over baseline of patient satisfaction scores- Patients getting timely healthcare information	
Spindletop Center			096166602
Related Category 1 or 2 Projects:	096166602.2.9		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Establish baseline rates Data Source: ECI Family Outcome Survey results Process Milestone 1 Estimated Incentive Payment*:* $9,522	**Outcome Improvement Target 1** IT-6-2: Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information Improvement Target: TBD Data Source: ECI Family Outcome Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $22,615	**Outcome Improvement Target 2** IT-6-2: Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information Improvement Target: TBD Data Source: ECI Family Outcome Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $23,170	**Outcome Improvement Target 3** IT-6-2: Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information Improvement Target: TBD Data Source: ECI Family Outcome Survey results Outcome Improvement Target 3 Estimated Incentive Payment*:* $53,862
Year 2 Estimated Outcome Amount: $9,522	Year 3 Estimated Outcome Amount: $22,615	Year 4 Estimated Outcome Amount: $23,170	Year 5 Estimated Outcome Amount: $53,862
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $109,169			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-10 Quality of Life/Functional Status
IT-10.1 Quality of Life

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136367307.3.3

RHP PERFORMING PROVIDER/TPI: The Burke Center/136367307

OUTCOME MEASURE DESCRIPTION:
Our primary outcome is OD-10 Quality of Life. We have chosen IT10.1 to improve an individual's Quality of Life as measured by evidenced based and validated assessment tool, for the target population.

For this measure OD- 10 Quality of Life/ Functional Status will be utilized to determine Outcome Domain. The use of peer providers will significantly improve the quality of life of the individuals served. Further individuals moving towards recovery show improvement in identified health risk areas. Needs based services in this area helps eliminate concern over these identified areas leaving the individual the strength to focus on life domains to improve. When individuals are doing well in a health risk area it cuts decreases their need for primary care services as those health risks improve. The entire project relates back to the validated health assessment tool utilized to identify individuals with a health risk need area.

The process outcome we chose is Quality of Life improvements IT-10.1 which will be measured by pre/post validated health assessment tool. Special emphasis will be given to indigent and safety-net populations in the catchment. Currently approximately 50% individuals seeking services meet the safety-net definition and significantly more would fall into the indigent category.

We will establish baseline rates by obtaining baseline data on physical health and quality of life of mental health consumers. We will use an assessment tool on adult mental health clients using a standardized and validated measure such as the SF-36 to identify those with significant health difficulties that impact their quality of life and to obtain a baseline to assess outcome of interventions. We will implement a PDSA cycles to improve data collection and intervention activities. Data is collected and analyzed from the standardized assessment tool such as the SF-36. Our goal will be the utilization of PDSA cycles to address challenges and improve outcomes until an acceptable score is obtained, to be determined at a later date upon further research of tools and consideration of obtained baseline.

RATIONALE:

With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases, other related problematic health concerns, and general quality of life. Improvements can only be known if a baseline is obtained. Continuous improvements will be made as challenges and barriers are identified and successfully addressed. The intent of this outcome measure is to provide a standardized assessment and data collection methodology for measuring an individual's improvement. By measuring improvement, we can determine outcomes and look at other areas in relation to an individual's baseline.

Outcome Measure Valuation:

One in four people are expected to be diagnosed with a mental illness at some point in their lifespan. Therefore, 25% of our population has the potential to be diagnosed with a mental illness and can be target population. In addition, the needs assessment morbidity data indicates there is a 76.8% gap in our area based on the shortage of mental health providers. Recruiting, training and supporting consumers of mental health services to provide peer support services will reduce the gap in care and. These statistics only emphasize the need to ensure satisfaction with our expansion and improvement to access. Training in and implementing services by peer in whole health will help individuals served to prevent or self-manage health risk factors from which they may be suffering.

136367307.3.3	OD-10 IT-10.1	Quality of Life Standalone Measure	
The Burke Center			103367307.2.1
Related Category 1 or 2 Projects:	**136367307.2.1**		
Starting Point/Baseline:	**Baseline will be initial SF-36 filled out by target population seeking service.**		
Year 2 (10/1/2012 – 9/30/2013)	**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: P-2 Establish baseline rates Metric: Obtain baseline data on physical health and quality of life of mental health consumers. Data source: Assessment of adult mental health clients using a standardized and validated measure such as the SF-36. Goal: To identify those with significant health difficulties that impacts their quality of life, and to obtain a baseline to assess outcome of interventions. Rationale: With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases, other related problematic health concerns, and general quality of life. Improvements can only be known if a baseline is obtained. Process Milestone P-2 Estimated Incentive Payment: $14,810	**Process Milestone: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities** Metric: Data is collected and analyzed from the standardized assessment tool. Data source: Data obtained from a standardized and validated measure such as the SF-36. Goal: Utilize PDSA cycles to address challenges and improve outcomes until an acceptable score is obtained, to be determined at a later date upon further research of tools and consideration of obtained baseline. Rationale: Continuous improvements will be made as challenges and barriers are identified and successfully addressed. Process Milestone P-4 Estimated Incentive Payment: $28,485	**Outcome Improvement Target 1** IT-10.1: Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Data Source: Validated assessment tool such as the SF-36 Rationale: Focus is on improvement of symptoms and individual functioning as measured by improvements on a direct client survey via a validated health risk assessment tool. Outcome Improvement Target 1 Estimated Incentive Payment: $28,585	**Outcome Improvement Target 1:** IT-10.1: Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Data Source: Validated assessment tool such as the SF-36 Rationale: Focus is on improvement of symptoms and individual functioning as measured by improvements on a direct client survey via a validated health risk assessment tool. Outcome Improvement Target 2 Estimated Incentive Payment: $56,968
Year 2 Estimated Outcome Amount: $14,810	Year 3 Estimated Outcome Amount: $28,485	Year 4 Estimated Outcome Amount: $28,485	Year 5 Estimated Outcome Amount: $56,968

136367307.3.3	OD-10 IT-10.1	Quality of Life Standalone Measure	
The Burke Center			103367307.2.1
Related Category 1 or 2 Projects:	136367307.2.1		
Starting Point/Baseline:	Baseline will be initial SF-36 filled out by target population seeking service.		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $128,748			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
OD-6 Patient Satisfaction
Project Option: IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information
Project Title: Integrating Primary and Behavioral Health Care Services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136367307.3.4 – PASS 2

RHP PERFORMING PROVIDER/TPI: The Burke Center/136367307

OUTCOME MEASURE DESCRIPTION:
For demonstration years 3-5, The Burke Center has selected improvement outcome measure IT-6.1 (1), percent improvement over baseline of patient satisfaction scores, patients are getting timely care, appointments, and information.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 2.

In addition, Burke will be working with other Community Centers in 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 The University of Houston. The collaborative will develop a strategy for collection for 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:

Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health.

Outcome Measure Valuation:

The Burke Center 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.

136367307.3.4	IT-6.1(1)	Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information	
The Burke Center			136367307
Related Category 1 or 2 Projects:	136367307.3.4		
Starting Point/Baseline:	To be established in Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Survey document; survey results Process Milestone 1 Estimated Incentive Payment*:* $75,957	**Outcome Improvement Target 1** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $149,974	**Outcome Improvement Target 2** IT-6-1(1): Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $144,674	**Outcome Improvement Target 3** IT-6-1(1): Improvement Target: TBD Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information Data Source: Survey results Outcome Improvement Target 3 Estimated Incentive Payment*:* $290,109
Year 2 Estimated Outcome Amount: $75,957	Year 3 Estimated Outcome Amount: $149,974	Year 4 Estimated Outcome Amount: $144,674	Year 5 Estimated Outcome Amount: $290,109
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $660,714			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 - Patient Satisfaction –
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Project Title: Intensive Home and Community-based Specialized Services

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136367307.3.5 - PASS 2

RHP PERFORMING PROVIDER/TPI: The Burke Center/136367307

OUTCOME MEASURE DESCRIPTION:
Our primary outcome is OD-6 Patient Satisfaction. We have chosen IT6.1.1 to improve patients' satisfaction in receiving **timely care, appointments, and information**. Providing intensive specialized services in the home or other community setting will help meet regional needs but must be done in a manner that meets the satisfaction of the individuals served. Individuals within this low-income rural area can enjoy greater mental health by having more timely care, appointments, and information about resources and their mental health. They will also benefit from having appointments with specialized mental health/substance abuse providers and that are provided in their own home or community.

This Burke Center's Project 2.13 is designed to increase patient satisfaction with timely care, appointments, and information, as home/community-based services provide for greater access to mental health providers. This is a priority for the Burke Center because all 12 counties served by the Burke Center are designated by DSHS as whole Mental Health Professional Shortage Areas. According to recent findings by the Health Resources and Services Administration's (HRSA), the number of mental health providers per 100,000 Texas residents is 27.7 (per the Area Resource File). The same findings indicate there are only 4.3 mental health providers per 100,000 Polk County residents and 13.3 mental health providers per 100,000 Angelina County residents. These are two of the largest counties served within the Burke Center's catchment area, yet there are too few mental health providers and current funding limits the amount of assistance the Burke Center can provide. The shortage of mental health providers often results in individuals waiting long periods of time for an appointment with a mental health provider. Intensive home/community-based specialized services would provide individuals with more timely care, appointments, and information. Timely care and appointments would be provided via home/community-based services versus making individuals travel long distances to find a mental health provider. Specialized services, provided by an interdisciplinary team, would increase available mental health/substance abuse information and resources. Individuals would more likely be satisfied with the timeliness of care, appointments, and the information provided if appointments were conveniently located and information targeted their specific mental health needs as well as their local resources.

The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and continually improve the process. We plan to improve

satisfaction as measured by a standardized survey by targeting areas identified as needing improvement. We will begin this milestone in Year 4.

The process outcomes we chose are P-2 Establish Baseline Rates. This process will require us to acquire a statistically valid patient satisfaction tool which includes a telemedicine component and conduct a sample survey to determine a baseline. This will begin in year 2. This process milestone will lead into the process milestone P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Beginning in year 3, we will utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined.

RATIONALE:

Improvements can only be documented when baseline information regarding satisfaction is determined. Continuous improvements will be made as challenges and barriers are identified and successfully addressed.

Outcome Measure Valuation:

Intensive home/community-based services would provide greater patient satisfaction regarding timely care, appointments, and information because these services would be both convenient and specific to each individual and his/her mental health needs within his/her respective community. As stated previously, all 12 counties served by the Burke Center are currently designated by DSHS as whole Mental Health Professional Shortage Areas and disproportionate number of individuals within the Burke Center's service area report being dissatisfied with their current level of social/emotional support. These statistics only emphasize the need to ensure satisfaction with Burke Center services

.

136367307.3.5	OD-6/IT-6.1	Percent improvement over baseline satisfaction scores	
The Burke Center			136367307
Related Category 1 or 2 Projects:	136367307.2.3		
Starting Point/Baseline:	**Determine percentage of patients who are satisfied with timeliness of care, appointments, and information.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-2: Establish baseline rates Metric: Identify current experience of individuals seeking and receiving services regarding timely care, appointments and information. Data source: Appropriate satisfaction survey. Goal: To identify current percentage of rate of patient satisfaction. Rationale: Baseline data is needed in order to measure improvement once interventions are implemented. P-2 Estimated Incentive Payment *(maximum amount):$70,596*	**P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Data is collected and analyzed on consumer satisfaction. Data source: Satisfaction surveys, client services in EHR Goal: Utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined. Rationale: Continuous improvements will be made as challenges and barriers are identified and successfully addressed. P-4 Estimated Incentive Payment : $134,420	**IT-6.1:** TBD% improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Numerator/Denominator: the % improvement in targeted patient satisfaction domain / # of patients who were administered the survey Data Source: Patient Survey IT-6.1 Estimated Incentive Payment*:* $135,080	**IT-6.1:** TBD% improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Numerator/Denominator: the % improvement in targeted patient satisfaction domain / # of patients who were administered the survey Data Source: Patient Survey IT-6.1 Estimated Incentive Payment*:* $271,492
Year 2 Estimated Outcome Amount: $70,596	Year 3 Estimated Outcome Amount: $134,420	Year 4 Estimated Outcome Amount: $135,080	Year 5 Estimated Outcome Amount: $271,492
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $611,588			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 - Patient Satisfaction –
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Project Title:

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 136381405.3.2 - PASS 2

RHP PERFORMING PROVIDER/TPI: Tyler County Hospital/136381405

OUTCOME MEASURE DESCRIPTION:
We plan to hire and appoint an executive accountable for experience performance that will write and disseminate a patient/family experience strategic plan. Press Ganey will be used to assist with designing a training program. All New Hires will be trained and all Full-time staff will also be trained.

Outcome Target: IT 6.1. TCH demonstrate a percent improvement over DY3 baseline of patient satisfaction scores. Hospitals are assessed on 10 different satisfaction scores. Currently TCH is below the Texas rural and United States Rural on six of the ten satisfaction scores. Our goal is to improve our overall score. The U.S. Decile Rank 1 as best for hospitals. We have four-1, two-2, one-3, one-6, one-8, and one-10. We want to be within the top 10% based on performance level.

Rationale

Our county has a high ED utilization rate and a high incidence of chronic disease. The rate for Tyler County was among the worst in Texas, which is in the bottom 25%. A coordinated system of patient centered care that improves the patient experience (increased access to appropriate levels of care), improves the health of the population and use resources more efficiently, effectively, and equitably.

Our 30 day readmission rate for medical discharge, a measure of quality care, was higher than both the Texas and US rates. We also have the worse rates of diabetes and disability and more poor physical and mental health days than the State and National average. There is 20% of the county living at or below the poverty line. TCH spent $2 million in 2012 on uninsured and indigent patients. The project choice is a direct reflection of Tyler County's community needs. The project focuses on training staff and improving patient experience to improve quality of care.

A new study by Press Ganey suggests that performance on readmission metrics is associated with performance on patient experience of care measures, patient readmission to an acute care setting maybe an indication of poor quality care, or inadequate post-acute resources and services (Press Ganey Partners Issue 26/Nov/Dec 2012).

Outcome Measure Valuation

Table A Redesign to Improve Patient Experience

Table B Percent Improvement over baseline scores

Tyler County Hospital considered factors of what affected population, severity, cost effectiveness, and community benefit. The Community Needs Assessment identified many needs for Tyler County. There is 19.9% of county living at or below poverty line and 9% unemployment in Tyler County. The population of on average is older than the State of Texas. The median household income is more than $10,000 less than Texas average. Tyler County has worse rates of diabetes and disability. Tyler County has a very high rate of uninsured which is almost double the US rate. The rate of ED visits for Tyler County was among the worst in Texas. Some of our other disease rates marked as being the worst of 10% or worst of 25% in all Texas Counties. All these factors support the need for this project which will more effectively meet the need of the county uninsured patients, charity patients, indigent patients, and Medicaid patients. It will also aid in reducing high readmission and ED visits. This project will affect a large portion of our community, be cost effective, have the potential to improve mortality rate (Diabetes 27.5 per 100,000) as well as educate patients of better managing their care.

A new study by Press Ganey suggests that performance on readmission metrics is associated with performance on patient experience of care measures, patient readmission to an acute care setting maybe an indication of poor quality care, or inadequate post-acute resources and services (Press Ganey Partners Issue 26/Nov/Dec 2012).

136381405.3.2	IT -6.1	Percent Improvement over baseline of Patient Satisfaction scores	
Tyler County Hospital			136381405
Related Category 1 or 2 Projects:	136381405.2.1		
Starting Point/Baseline:	TBD based on DY3 baseline 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)**
Process Milestone 1 P-2: Establish baseline rates Metric 1: Identify current experience of individuals seeking and receiving services regarding timely care, appointments and information. Data Source: Appropriate Satisfaction Survey Goal: To identify current percentage rate of patient satisfaction Rationale/Evidence: Baseline data is needed in order to measure improvement once interventions are implemented. Process Milestone 1 Estimated Incentive Payment: $ 8,810	**Process Milestone 2** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1: Data is collected and analyzed on consumer satisfaction. Baseline/Goals: Utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined. Data Source: Satisfaction surveys, client services in EHR. Rationale/Evidence: Data is needed to identify challenges to improve performance Process Milestone 2 Estimated Incentive Payment $ 16,866	**Outcome Improvement Target 1:** Improvement Target: IT-6.1. Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients Numerator: Percent improvement in targeted patient satisfaction domain Denominator: Number of patients who were administered the survey Goal: TBD baseline rates established in DY3 Data Source: HCAHPS Patient Survey, CMS Hospital Compare Rationales/Evidence: The intent of the HCAHPS initiative is to provide a	**Outcome Improvement Target 2:** Improvement Target: IT-6.1. Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients Numerator: Percent improvement in targeted patient satisfaction domain Denominator: Number of patients who were administered the survey Goal: TBD baseline rates established in DY3 Data Source: HCAHPS Patient Survey, CMS Hospital Compare Rationales/Evidence: The intent of the HCAHPS initiative is to provide a

136381405.3.2	IT -6.1	Percent Improvement over baseline of Patient Satisfaction scores	
Tyler County Hospital			136381405
Related Category 1 or 2 Projects:	136381405.2.1		
Starting Point/Baseline:	TBD based on DY3 baseline 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)**
		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 Improvement Target 1 Estimated Incentive Payment: $28,543	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 Improvement Target 2 Estimated Incentive Payment: $47,472
Year 2 Estimated Outcome Amount: $8,810	Year 3 Estimated Outcome Amount: $16,866	Year 4 Estimated Outcome Amount: $28,543	Year 5 Estimated Outcome Amount: $47,472
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $101,691			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 - Patient Satisfaction
Project Option: IT-6.1 Percent improvement over baseline of patient satisfaction scores

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.9

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) Are getting timely care, appointments, and information; ***(Standalone measure)***

Metric: Metric: Percent improvement over baseline of patient satisfaction scores asking if patients *(1) are getting timely care, appointments, and information.*

i Numerator: Percent improvement in targeted patient satisfaction domain

j Data Source: patient satisfaction scores for Certain supplemental modules for the adult CG-CAHPS and/or Press Ganey

k Denominator: Number of patients who were administered the survey

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

We recognize there will be outcomes from planning. These include:
P-1 1) Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Meetings held to create implementation plan to Increase number of primary care clinics using medical home model Data source: Agendas Goal: Develop a plan to convert clinics to medical model

RATIONALE/EVIDENCE:

P-1 2) Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Meetings held to create implementation plan to expand primary care team roles and create panels Goal: Development of plan documenting consensus on staffing and patient panels Rationale/Evidence: A variety of partners and staff will need to collaborate to create an effective implementation plan

Data source: Documented plan
P-2 Establish baseline rates Metric: Patient satisfaction questions in Press Ganey and CG CHAPS Goal: Establish baseline scores Data source: EPIC Rationale: Baseline needed to document improvement.

OUTCOME MEASURE VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.9	IT-6.1	Percent improvement over baseline of patient satisfaction scores
The University of Texas Medical Branch at Galveston	094092602	
Related Category 1 or 2 Projects:	094092602.2.1	
Starting Point/Baseline:	TBD year 2	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Meetings held to create implementation plan to Increase number of primary care clinics using medical home model Data source: Agendas Goal: Develop a plan to convert clinics to medical model Rationale/Evidence: A variety of partners and staff will need to collaborate to create an effective implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $41,544 Process Milestone 2 P-2 Establish baseline rates	**Process Milestone 3** P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Meetings held to create implementation plan to expand primary care team roles and create panels Goal: Development of plan documenting consensus on staffing and patient panels Rationale/Evidence: A variety of partners and staff will need to collaborate to create an effective implementation plan Data source: Documented plan Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $83,087	**Outcome Improvement Target 1**IT-6.1 "Top Box" Standard Access patient Satisfaction scores are at or above 70. Data Source: patient satisfaction scores for Certain supplemental modules for the adult CG-CAHPS and/or Press Ganey survey stored in Epic Outcome Improvement Target 1 Estimated Incentive Payment*:* $83,087	**Outcome Improvement Target 2** IT-6.1 "Top Box" Standard Access patient Satisfaction scores are at or above 73. Data Source: patient satisfaction scores for Certain supplemental modules for the adult CG-CAHPS and/or Press Ganey survey stored in Epic Outcome Improvement Target 2 Estimated Incentive Payment $83,087

094092602.3.9	IT-6.1	Percent improvement over baseline of patient satisfaction scores
The University of Texas Medical Branch at Galveston	**094092602**	
Related Category 1 or 2 Projects:	**094092602.2.1**	
Starting Point/Baseline:	**TBD year 2**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Metric: Patient satisfaction questions in Press Ganey and CG CHAPS Goal: Establish baseline scores Data source: EPIC Rationale: Baseline needed to document improvement Process Milestone 3 Estimated Incentive Payment *(maximum amount):*$41,544			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $83,087	Year 3 Estimated Outcome Amount: $83,087	Year 4 Estimated Outcome Amount: $83,087	Year 5 Estimated Outcome Amount: $83,087
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $332,348			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores
UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.10

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
Through studying the value stream of primary care, standardizing work processes we aim, by improving the actual access to care (aforementioned intervention target) measured by Third Next Available Appointment in primary and specialty clinics, ultimately to improve patient satisfaction with access. In DY3, we will establish Family Medicine and Neurology and other specialty clinic baseline CG CAHPS survey module – "are getting timely care, appointments and information" performance results. In DY 4, we aim to reach the 50%ile among Press Ganey vendor large peer group for all Family Medicine clinics, Neurology specialty clinic, Primary Care Pavilion Internal Medicine clinic, and four additional select Specialty clinics (selected based on the spread plan and baseline performance of the clinics). By the end of DY5, we aim to reach 50%ile in all primary care clinics and also achieve Press Ganey vendor large peer group 50%ile for all specialty clinics.

IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores

We will measure the improvement in patient experience with access through percent improvement over baseline of satisfaction score for CG CAHPS survey module –"Are getting timely care, appointments and information". We would set a baseline for the CG CHAPS survey during DY3. Our target in the DY4 would be three Family Medicine clinics and the Primary Care Pavilion Internal Medicine clinic be in top quartile. In DY5, we would be aiming to achieve top quartile score for all primary care clinics.

RATIONALE:
Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have higher satisfaction, will likely return to work sooner, and may well have better medical outcomes. Since we are aiming at patient care scheduling at primary clinics and hybrid adaptive approach in specialty clinics access should be our main outcome target and third next available captures access potential to very good extent. 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. Since we are aiming at patient care scheduling at primary clinics and hybrid adaptive approach in specialty clinics access should be our main outcome target and third next available captures access potential to very good extent. Also the enhancements in scheduling and standardizing workflows will result in better access and better movement through the clinics, which could be well reflected in the patient satisfaction CG CHAPS scores for the supplemental module –"Are getting timely care, appointments and information"

Outcome Measure Valuation

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.10	IT 6.1	Percent Improvement over baseline of patient satisfaction scores (Standalone Measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.2		
Starting Point/Baseline:	Primary care -17 days, Specialty ranging from (1-65) days		
Year 2 (10/1/2012 – 9/30/2013)	**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 plan regarding How the value stream of primary care, standardizing work processes to improve third next available appointment. Metric: Develop a plan using the value stream mapping and standardized work processes to impact the third next available appointment for Family Medicine, Neurology, and other specialty clinics. Baseline: N/A Goal: Finalize plan by 9/30/13. Data source: Documentation of plan. Process Milestone 1 Estimated Incentive Payment: $107,404	**Process *Milestone 2*** *[P-2]:* Establish baseline rates for Patient Satisfaction with access. Metric: CG CAHPS survey module – "Are getting timely care, appointments and information" Baseline: To be determined for Primary care and Specialty care Clinics. Goal: baseline collected for Family Medicine, Neurology and other specialty clinics identified. Data source: Press Ganey vendor large peer group . Process Milestone 2 Estimated Incentive Payment: $152,870	**Outcome Improvement Target 1** [IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores. Metric: CG CAHPS survey module – "Are getting timely care, appointments and information" Baseline: To be determined for Primary care and Specialty care Clinics. Goal: Reach the 50%ile among UHC peers Press Ganey vendor large peer group for all Family Medicine clinics, Neurology specialty clinic, Primary Care Pavilion Internal Medicine clinic, and four additional select Specialty clinics (selected based on the spread plan and baseline performance of the clinics). Data source: CG CAHPS Satisfaction Survey . Outcome Improvement Target 1 Estimated Incentive Payment*:* $318,905	**Outcome Improvement Target 2** *(*IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores. Metric: CG CAHPS survey module – "Are getting timely care, appointments and information" Baseline: To be determined for Primary care and Specialty care Clinics. Goal: Reach 50%ile in all primary care clinics and also achieve UHC Press Ganey large peer group 50%ile for all specialty clinics. Data source: CG CAHPS Satisfaction Survey . Outcome Improvement Target 2 Estimated Incentive Payment*:* $678,459

094092602.3.10	IT 6.1	Percent Improvement over baseline of patient satisfaction scores (Standalone Measure)	
The University of Texas Medical Branch at Galveston			**TPI - 094092602**
Related Category 1 or 2 Projects:	**094092602.2.2**		
Starting Point/Baseline:	**Primary care -17 days, Specialty ranging from (1-65) days**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $107,404	Year 3 Estimated Outcome Amount: $152,870	Year 4 Estimated Outcome Amount: $318,905	Year 5 Estimated Outcome Amount: $678,459
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,257,638			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1 – Chronic Disease management
Project Option: IT 1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.12

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
In year two, the process milestone chosen for this project are: 1) P-1 Conduct project planning to identify needed resources, specifically, identify a validated assessment tool for use in achieving the improvement milestones documented in this project; 2) P-2 will establish baseline rates for hypertension control in the target population.

In year three the process milestone P-3 will develop and test data systems. The project will make necessary modifications to and test the current registry/care management system to be able to report on the improvement milestones and improvement targets identified by this program. The goal will be develop standard reports, necessary to measure improvements.

In years four and five the improvement target is IT- -1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Numerator/Denominator or other metric: The numerator is the number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg)during the measurement year and the denominator is patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. The data source for this information will be the care management data system/patient registry. This outcome measure was chosen as one component of the proposed project focuses on patient education for heart health and hypertension. The improvement target is "to be determined" as a baseline has yet to be established, however, we would expect to see year over year improvement in hypertension control for the patients in this proposed program.

RATIONALE
Process Milestone Rationale: P-1 A validated assessment tool will be necessary to document improvements. Identification of the tool will be documented by meeting minutes and patient records (to verify implementation of the assessment tool). The goal for this process milestone is that an assessment tool will be selected and prepared for use. **P-2** This will be documented by reports from the care management data system. A baseline rate will necessary to determine

improvements. **P-3** The process measures selected for the project are necessary to support the project in achieving the improvement targets selected. Determining baseline hypertension control rates, developing and testing the data systems to produce measurable reports and selecting an assessment tool are vital to the success of the project.

Improvement Target Rationale: The improvement target, IT- -1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure) was chosen because of the project's focus on chronic disease management and heart health/hypertension education and classes, including self-management education and support. The improvement target will be determined in DY2 for implementation in DY3 as a baseline has yet to be established. However, we would expect to see year over year improvement in hypertension control for the patients in this proposed program.

OUTCOME MEASURE VALUATION:

In valuing and providing rational/justification for the outcome improvement target of "Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)", the following was considered: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). In Galveston County, the mortality rate of diseases of the heart is 201.5 – 295.2 per 100,000 and for hypertension specifically, the mortality rate is 8.5 per 100,000, which is in the bottom 25% of Texas counties. In Brazoria County, the mortality rate of diseases of the heart is 223.5 per 100,000 and for hypertension specifically, the mortality rate is 6.9 per 100,000, also in the bottom 25% of all Texas counties. Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

The populations that will be served by this proposed program consists of a significant number of uninsured; 25% uninsured in Galveston County and 26% uninsured in Brazoria County. These counties also have a number of areas that are federally designated as Medically Underserved Areas, 6 in Brazoria County (deemed significantly underserved) and 3 in Galveston County.

The proposed project will be a relatively small scale project that can have a large impact by providing education on heart health and hypertension self-management to underserved areas with a demonstrated need.

094092602.3.12	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)	
The University of Texas Medical Branch at Galveston			TPI- 094092602
Related Category 1 or 2 Projects:	094092602.2.3		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Implementation plan which includes a review and selection of a validated assessment tool for use in achieving the improvement milestones documented in this project. Data source: Implementation plan and patient records (verify implementation of assessment tool). Goal: Draft an implementation plan and select an assessment tool. Rationale: A validated assessment tool will be necessary to document improvements. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $39,129 **Process Milestone 2** [P-2]: Establish baseline rates	**Process Milestone 3** **[**P-3**]:** Develop and test data systems. Metric: Make necessary modifications to and test the current registry/care management system to be able to report on the improvement milestones and improvement targets identified by this program. Data source: Pecsys registry/Access database. Goal: Develop standard reports. Rationale: Standard reports are necessary to measure improvements. Process Milestone 3 Estimated Incentive Payment: $ $78,751	**Outcome Improvement Target 1** [IT-1.7]: Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Numerator: The number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Improvement Target: TBD based upon establishment of baseline in DY2 and DY3. Data Source: Patient registry (Pecsys). Outcome Improvement Target 1 Estimated Incentive Payment*:* $118,866	**Outcome Improvement Target 2** [IT-1.7]: Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Numerator: The number of patients in the denominator who's most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Improvement Target: TBD based upon establishment of baseline in DY2 and DY3. DY5 target would show an improvement over the DY4 target. Data Source: Patient registry (Pecsys). Outcome Improvement Target 2 Estimated Incentive Payment*:* $263,130

094092602.3.12	IT-1.7	Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)	
The University of Texas Medical Branch at Galveston			TPI- 094092602
Related Category 1 or 2 Projects:	094092602.2.3		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric: Determine a baseline rate for hypertension control in target population Data source: Pecsys registry/ Access database Goal: Develop a baseline rate for hypertension control in target population Rationale: A baseline rate will be necessary to determine improvements Process Milestone 2 Estimated Incentive Payment: $39,129			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $78,258	Year 3 Estimated Outcome Amount: $78,751	Year 4 Estimated Outcome Amount: $118,866	Year 5 Estimated Outcome Amount: $263,130
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $539,005			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3 – Potentially Preventable Re-Admissions
Project Option: IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure). Reduce readmission 1% from baseline

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.13

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Patients who meet the criteria below are excluded from being counted as readmission. Several of these circumstances, e.g. non-communication of advance directives, treatment instructions to discharge destination, are amenable to intervention.

Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. These exclusions were originally listed as part of the Heart Failure readmission metric. These were later adopted by the National Quality Forum, and are applied to all other individual-condition metrics for consistency.

- With an in-hospital death (because they are not eligible for readmission);
- Without at least 30 days post-discharge enrollment in Medicare FFS (because the 30-day readmission outcome cannot be assessed in this group;
- Transferred to another acute care facility (When a patient is transferred from one acute care hospital to another, these multiple, contiguous hospitalizations are considered one episode of care. Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute setting);
- Discharged against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge);
- Admitted with heart failure after 30 days of discharge from an index admission (Admissions within 30 days of discharge of an index admission will be considered readmissions. No admission is counted as a readmission and an index admission. The next eligible admission after the 30-day time period following an index admission will be considered an index admission.)

IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline.

Outcome Goal for 5 year period:

IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Confirm baseline during DY2 and DY3. Current baseline is 24% of 65+ year old patients discharged to a nursing home or rehabilitation facility are readmitted to the hospital within 30 days. We anticipate making a 1% improvement in readmission rate during DY4 and realize a total 5% improvement by the end of the 5 year period (DY5).

RATIONALE:

This measure estimates the hospital risk level, risk-standardized rate of unplanned, all cause readmission after admission for any eligible condition within 30 day s of hospital discharge (RSRR) for patients age 18 or older.

The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data.

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to nursing home, and from nursing home to home health in order to prevent increased health care costs and avoidable 30-day re-hospitalizations. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care have been shown to be prone to errors. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. High-risk patients often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases. The discontinuity of care during transitions typically results in patients who may require acute care in the next 30 to 6o days, falling through the cracks, which may lead to otherwise preventable hospital readmission. The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely.

OUTCOME MEASURE VALUATION

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health

care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects. Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.13	IT 3.1	All cause 30 day readmission rate –NFQ 1789 (standalone measure)	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.2.4		
Starting Point/Baseline:	Starting point/baseline for first IT: 16.5% 30 day re-hospitalization rate		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Care Transitions assessment Data source: Care transitions assessment and resource planning documents Goal: To identify opportunity for improvement and estimate financial resources and confirm baseline for measuring improvements in DY4 and DY5. Rationale: It will be important to see how communication is working with different care facilities Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $50,478	**Process Milestone 2** P -5 Disseminate findings, including lessons learned and best practices, to stakeholders Metric: Care Transition Conference Data Source: Meeting notes, slides, and Care Transitions Findings document Goal: Generate a dialogue with distant providers after starting the innovative program to identify barriers to smooth transitions Rationale: There are many barriers to a smooth transition that should be identified early to improve the quality of the program Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $50,478	**Improvement Target 1** IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline. Numerator/Denominator or other metric: a. Numerator: Total number of UTMB patients, 65+, discharged to nursing home, re-hospitalized within 30 days b. Denominator: Total number of UTMB patients discharged 65+ to nursing home c. Data Source: UTMB ADT d. For people with serious and complex illnesses, transitions in setting of care have been shown to be prone to errors. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. Outcome Improvement Target 1 Estimated Incentive Payment: $75,716	**Improvement target 2** IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission by 5% from baseline. a. Numerator: Total number of UTMB patients, 65+, discharged to nursing home, re-hospitalized within 30 days b. Denominator: Total number of UTMB patients discharged 65+ to nursing home c. Data Source: UTMB ADT d. For people with serious and complex illnesses, transitions in setting of care have been shown to be prone to errors. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. Outcome Improvement Target 1 Outcome Improvement Target 2 Estimated Incentive Payment: $*166,576*

094092602.3.13	IT 3.1	All cause 30 day readmission rate –NFQ 1789 (standalone measure)	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.2.4		
Starting Point/Baseline:	Starting point/baseline for first IT: 16.5% 30 day re-hospitalization rate		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $50,478	Year 3 Estimated Outcome Amount: $50,478	Year 4 Estimated Outcome Amount: $75,716	Year 5 Estimated Outcome Amount: $166,576
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $343,248			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3 – Potentially Preventable Re-Admissions
Project Option: IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure). Reduce readmission 1% from baseline

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.14

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
The chosen outcome measure for this project is the Implementation of a care transitions program with a care management registry system. Currently, UTMB-Case Management does not utilize a system, all processes are manual. The outcome target is to decrease the number of potentially preventable 30 day readmissions. The goal is to decrease the percentage of potentially preventable 30 day readmits by 1% each year. By the end of the year 5, the percentage of potentially preventable 30 day readmissions would decrease by 5%. In FY2012 the 30 day readmit rate was 10%.

The metric will be calculated as follows: the numerator for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. The denominator claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or (2) admissions to acute care facilities for patients aged 18 years or older.

After the implementation of the care management registry, we will begin to identify trends and patterns for patients that are readmitted within 30 days of discharge. The data sources, case management registry, EHR and claims will be compared to ensure validity.

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Patients who meet the criteria below are excluded from being counted as readmission. Several of these circumstances, e.g. non-communication of advance directives, treatment instructions to discharge destination, are amenable to intervention.

- Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. These exclusions were originally listed as part of the Heart Failure readmission

metric. These were later adopted by the National Quality Forum, and are applied to all other individual-condition metrics for consistency.

- With an in-hospital death (because they are not eligible for readmission);
- Without at least 30 days post-discharge enrollment in Medicare FFS (because the 30-day readmission outcome cannot be assessed in this group;
- Transferred to another acute care facility (When a patient is transferred from one acute care hospital to another, these multiple, contiguous hospitalizations are considered one episode of care. Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute setting);
- Discharged against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge);
- Admitted with heart failure after 30 days of discharge from an index admission (Admissions within 30 days of discharge of an index admission will be considered readmissions. No admission is counted as a readmission and an index admission. The next eligible admission after the 30-day time period following an index admission will be considered an index admission.).

RATIONALE:

This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data.

The reason for selecting implementation of a case management registry and specifically decreasing potentially preventable readmissions is identify opportunities to improve quality care and transitions of care. The goal is to decrease potentially preventable readmissions by 1% each year.

OUTCOME MEASURE VALUATION

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.14	IT-3.1	All cause 30 day readmission rate –NFQ 1789	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.2.5		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Conduct meetings 2times per year with stakeholders to make them aware of the care transitions program, identify anticipated challenges, obtain "buy-in" and outline expectations. Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2 and continuing in DY3 as the project is implemented. Data Source: Meeting agendas, minutes, sign-in sheets, handouts, etc. Rationale: All of the stakeholders in the metric play a role in the discharge process and therefore, will need to understand the project including any expectations for their involvement. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $56,177 **Process Milestone 2** **[P-3]** Develop and test data systems Metric: Make necessary modifications to care management system and	**Process Milestone 4** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Conduct computer runs to determine the integrity of the data base Goal: Find and improve any errors in implementing a registry that supports our care transition program. Data source: case management registry reports and EHR, claims Rationale: This is a new program and we will have to test the ability of our software expansion and the inclusion of resources and clients for a coordinated care transition Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $56,157 **Process Milestone 5** P-5 Disseminate findings, including lessons learned and best practices, to Metric: reports on protocols, client lists, resource pathways and staffing roles will be shared with extended team. Goal: Data source: case management registry reports and EHR, claims Rationale: This is a new system and needs to be reviewed by concerned parties. Process Milestone Estimated Incentive Payment *(maximum amount):* $56,157	**10. Outcome Improvement Target 1** IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline. a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $168,471	**Outcome Improvement Target 2** First IT: IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline. Numerator/Denominator or other metric: a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EHR, Claims Outcome Improvement Target 3

094092602.3.14	IT-3.1	All cause 30 day readmission rate –NFQ 1789	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.2.5		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
develop reports from both hospital and care management data systems to identify target patients and report on required improvement milestones & metrics Goal: Modification will be made as necessary to care management system and reports will be developed from hospital and care management data systems during DY2 and tested during DY3 with continued modifications made on an as needed basis. Data Source: Hospital and care management data systems. Rationale: Identification of the target population is critical to the project. Reports on activities of the project are Critical for documentation of improvement targets as well as for quality improvement initiatives. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $56,177 **Process Milestone 3** [P-2]: Establish baseline rates. Metric: Determine baseline readmission rates at UTMB for the identified target diagnosis AMI.			Estimated Incentive Payment: $370,636

094092602.3.14	IT-3.1	All cause 30 day readmission rate –NFQ 1789	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.2.5		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Goal: Establish baseline rates to measure against improvement targets. Data Source: Hospital administrative data system reports Rationale: Need to establish a baseline number in order to demonstrate improvement. Process Milestone 3 Estimated Incentive Payment: $56,177			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $168,532	Year 3 Estimated Outcome Amount: $112,314	Year 4 Estimated Outcome Amount: $168,471	Year 5 Estimated Outcome Amount: $370,636
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $819,953			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-3 – Potentially Preventable Re-Admissions
Project Option: IT 3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (standalone measure)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.15

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates.

Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. For all individual conditions, admissions for patients that meet any of the following criteria are excluded. These exclusions were originally listed as part of the Heart Failure readmission metric, obtained from the National Quality Forum, and are applied to all other individual-condition metrics for consistency.

- With an in-hospital death (because they are not eligible for readmission);
- Without at least 30 days post-discharge enrollment in Medicare FFS (because the 30-day readmission outcome cannot be assessed in this group;
- Transferred to another acute care facility (When a patient is transferred from one acute care hospital to another, these multiple, contiguous hospitalizations are considered one episode of care. Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute setting);
- Discharged against medical advice (AMA) (because providers did not have the opportunity to deliver full care and prepare the patient for discharge);
- Admitted with heart failure within 30 days of discharge from an index admission (Admissions within 30 days of discharge of an index admission will be considered readmissions. No admission is counted as a readmission and an index admission. The next eligible admission after the 30-day time period following an index admission will be considered an index admission.)

The Transitions of Care project is specifically focused on reducing readmission rates in adult patients with a diagnosis of AMI, heart failure or pneumonia by providing a "transition coordinator". Therefore, the improvement target that we chose to measure is IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate (Standalone measure) with a Numerator:

The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index AMI admission. If an index admission has more than 1 readmission, only first is counted as a readmission. The denominator is as follows: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of AMI and with a complete claims history for the 12 months prior to admission. The data source for the results will be: Hospital and care management data systems reports. The baseline for this improvement is still to be determined. Current data, while demonstrating that readmissions in the target population is an area for improvement, is out dated and will need to be re-run. We will collect this data in DY2 to form a baseline from which to measure improvements. Outcome improvement targets will be determined in DY2 for implementation in DY3. The over-arching goal of the project is to improve the 30-day readmission rate for adult patients in Galveston County with a discharge diagnosis of AMI over baseline and then to sustain and improve on the readmission rates year over year of the project.

The process measures for the project are as follows: In DY2, P-1 – We will conduct project planning to engage stakeholders by conducting meetings with stakeholders (inpatient care management, patient care facilitators, adult medicine unit nurses, faculty, residents, health unit coordinators) to make them aware of the transitions of care program, identify anticipated challenges, obtain "buy-in" and outline expectations. This will be documented by meeting agendas, minutes, sign-in sheets, handouts, etc. The goal is to conduct meetings with all stakeholders outlined above starting in DY2 and continuing into DY3 as the project is implemented. All of the stakeholders mentioned above play a role in the discharge process and therefore, will need to understand the project including any expectations for their involvement.

We will also need to establish baseline rates (P-2) for the project by determining the baseline 30 day readmission rates at UTMB for the identified target patients: adult patients in Galveston County with a discharge diagnosis of AMI. The data will come from hospital administrative data systems and will establish baseline rates to measure improvement targets.

Another process measure key to this project is P-3, Develop and test data systems. Identification of the target population is critical to the project and therefore, reports will need to be developed to improve identification of the patients in a timely manner. Also, Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives. We will make necessary modifications to the care management data system and develop reports from both the care management and hospital data systems to identify target patients and report on required improvement milestones & metrics. Modification will be made to the care management system and reports will be developed from both hospital and care management data systems during DY2 and tested during DY3 with continued modifications made on an as needed basis.

RATIONALE:

The rationale for selecting the improvement target is as follows:

Current data, while out-dated, shows that the readmission rate at UTMB for adult patients in Galveston County with a discharge diagnosis of AMI, have a higher than average readmission rate – approximately 25% vs. an average of 16-18%. The baseline rate will be determined in DY2, as a starting point to measure improvement.
The rationale for selecting the process milestones is that they each are critical for accurate and timely data from which to measure improvement and also identify quality improvement initiatives. They also include communication with stakeholders which is vital to a successful project.

OUTCOME MEASURE VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation

094092602.3.15	IT 3.5	Acute Myocardial Infarction All cause 30 day readmission rate –NFQ 1789 (standalone measure)	
The University of Texas Medical Branch at Galveston			094092602
Related Category 1 or 2 Projects:	094092602.6		
Starting Point/Baseline:	Starting point/baseline for first IT: 16.5% 30 day rehospitalization rate		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Care Transitions assessment Data source: Care transitions assessment and resource planning documents Goal: To identify opportunity for improvement and estimate financial resources Rationale: It will be important to see how communication is working with different care facilities Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $105,680	**Process Milestone 2** P -5 Disseminate findings, including lessons learned and best practices, to stakeholders Metric: Care Transition Conference Data Source: Meeting notes, slides, and Care Transitions Findings document Goal: Generate a dialogue with distant providers after starting the innovative program to identify barriers to smooth transitions Rationale: There are many barriers to a smooth transition that should be identified early to improve the quality of the program Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $370,517	**Improvement Target 1** IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline. Numerator/Denominator or other metric: a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EHR, Claims Rationale: This measure estimates the hospital risk level, risk-standardized rate of	**Improvement target 2** IT-3.1 All cause 30 day readmission rate- NQF 1789 (standalone measure) Reduce readmission % by 1% from baseline. Numerator/Denominator or other metric: a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EHR, Claims Rationale/evidence: This measure estimates the hospital risk level, risk-standardized rate of

094092602.3.15	IT 3.5	Acute Myocardial Infarction All cause 30 day readmission rate –NFQ 1789 (standalone measure)	
The University of Texas Medical Branch at Galveston			**094092602**
Related Category 1 or 2 Projects:	**094092602.6**		
Starting Point/Baseline:	**Starting point/baseline for first IT: 16.5% 30 day rehospitalization rate**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		unplanned, all cause readmission after admission for any eligible condition within 30 day s of hospital discharge (RSRR) for patients age 18 or older. Outcome Improvement Target 1 Estimated Incentive Payment: $ Outcome Improvement Target 1 Estimated Incentive Payment: $409,737	unplanned, all cause readmission after admission for any eligible condition within 30 day s of hospital discharge (RSRR) for patients age 18 or older. Outcome Improvement Target 2 Estimated Incentive Payment: $1,001,126
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $105,680	Year 3 Estimated Outcome Amount: $370,517	Year 4 Estimated Outcome Amount: $409,737	Year 5 Estimated Outcome Amount: $1,001,126
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,886,699			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-8 – Timeliness of Prenatal/Postnatal Care
Project Option: IT-8.9: Other Outcome Improvement

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.16

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:

Process Milestones 1 - 3 (DY2 and DY3)

P-2 Establish baseline rates

P-3 Develop and Test Data Systems-

Outcome Improvement Target (DY4 and DY5) **IT-8.9: Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia**

Improvement targets to be established in DY2

RATIONALE:

P-2 Establish baseline rates - We will track UTMB readmissions just prior to and during DY2 to establish the rate for a consecutive twelve months using proposed EMR and clinical records to establish the contemporary rate of readmission against which to propose goals for subsequent years and to assist in understanding additional factors that should be prioritized in the registry for active follow-up communications at discharge.

P-3 Develop and Test Data Systems- Increase the number or percent of patients in the obstetric episode specialty registry - Using management reports directly available in the newly established specialty registry along with administrative claims data, we will easily be able to establish the number of mother-baby enrollees and episodes of care that are captured in the new database. Data will be available in real time on a daily basis but will be reported for this purpose in an aggregated rollup by month.

IT-8.9: Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia (Standalone measure)

The ultimate measure of impact of this registry initiative will be hospital readmission for infants for hyperbilirubinemia, comparing baseline rates of infant hospital readmission for hyperbilirubinemia established in DY 2 against resulting rates in DY 4 and DY 5. This measure was first reported in 2008 in a report[1] of a California state-wide cohort over a nine year period, using vital statistics and maternal-infant hospital records. That study population was limited to healthy, routinely discharged infants using multiple exclusion criteria. All linked readmissions

[1] Burgos AE, Schmitt SK, Stevenson DK, Phibbs CS. Readmission for neonatal jaundice in California, 1991-2000: trends and implications. Pediatrics. 2008 Sep;122(3): e864-e869.

occurred within 14 days of birth in that report. ICD-9 codes were used to further limit the sample to readmission for jaundice. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[2] With short maternal stays, readmission for hyperbilirubinemia may not be a failure of care from the primary admission, and re-hospitalization of infants at some level is no doubt necessary to avoid permanent morbidity. We do believe, however, it is a reasonable quantitative index of the communication of at-risk information at handoffs in an important transition of care. Given data limitations, only readmissions to the same facility of the index admission will be included as part of each hospital's rates.

Addressing the issue of potentially avoidable readmissions requires a community approach with input from various actors across the continuum of care. Better health care outcomes are not only dependent on receiving better care in the hospital, but increasingly, on receiving better care at home.[3]

- Several programs to reduce hospital readmissions have proven efficacious and even cost-effective in randomized controlled trials,[4] and this collaborative intervention aims to deploy resources needed to implement them among Region 2 hospitals and supplement local quality improvement expertise to reengineer discharge processes, deploy best practices and engage community resources.

OUTCOME MEASURE VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, Improving the health of the population, Reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.

---

[2] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75-91.

[3] Osei-Anto A, Joshi M, Audet AM, Berman A, Jencks S, *Health Care Leader Action Guide to Reduce Avoidable Readmissions.* Health Research & Educational Trust, Chicago, IL. January 2010.

[4] Coleman EA, Parry C, Chalmers S, Min S-J. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006;166(17):1822-1828.

- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.16	IT-8.9	Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia (Standalone measure)	
University of Texas Medical Branch Hospital			094092602
Related Category 1 or 2 Projects:	094092602.2.7		
Starting Point/Baseline:	TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2 Establish baseline rates Metric: 30 Day readmission rate for participating member facility Data source: EHR or Medical Record, Claims Goal: Collect and track readmission data for 50% of Region 2 members Rationale: Measurement is a vital first step to improvement Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $165,331	**Process Milestone 2** P-3 Develop and test data systems: Increase the number or percent of patients in the obstetric episode specialty registry Metric: Numerator: Number of unique patients in the registry. Denominator: Number of targeted patients Data source: EHR, registry or other program documents Goal: Increase the percentage of obstetric and newborn patient units in the obstetric episode specialty registry Rationale: Periodic reporting is a necessary step to improvement and maintenance of goals Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $47,105	**Outcome Improvement Target 1** IT-8.9: Other Outcome Improvement Target- Newborn bilirubin screening prior to discharge PN-014-07 [1] *(Standalone measure)* Numerator: Normal infants born at 35 or more weeks of gestation who have a serum or transcutaneous bilirubin obtained before discharge enominator: normal infants born at 35 or more weeks of gestation who have a serum or transcutaneous bilirubin obtained before discharge. Baseline: TBD in Year 2 Goal: TBD in Year 2 for UTMB using University Health System Consortium and published rates. Data Source: EHR or Medical Record, Claims Process Milestone 3 Estimated Incentive Payment *(maximum amount):*$70,658	**Outcome Improvement Target 2** IT-8.9: Other Outcome Improvement Target- Newborn bilirubin screening prior to discharge PN-014-07 [2] *(Standalone measure)* Numerator: Normal infants born at 35 or more weeks of gestation who have a serum or transcutaneous bilirubin obtained before discharge Denominator: normal infants born at 35 or more weeks of gestation who have a serum or transcutaneous bilirubin obtained before discharge. Baseline: TBD in Year 2 Goal: TBD in Year 2 for UTMB using University Health System Consortium and published rates. Data Source: EHR or Medical Record, Claims Process Milestone 4 Estimated Incentive Payment *(maximum amount)* $155,448

[1] National Quality Forum (NQF). National Voluntary Consensus Standards for Perinatal Care 2008: A Consensus Report. Washington, DC: NQF; 2009
[2] National Quality Forum (NQF). National Voluntary Consensus Standards for Perinatal Care 2008: A Consensus Report. Washington, DC: NQF; 2009

094092602.3.16	IT-8.9	Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia (Standalone measure)	
University of Texas Medical Branch Hospital			094092602
Related Category 1 or 2 Projects:	094092602.2.7		
Starting Point/Baseline:	TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $165,331	Year 3 Estimated Outcome Amount: $47,105	Year 4 Estimated Outcome Amount: $70,658	Year 5 Estimated Outcome Amount: $155,448
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $438,541			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-5 – Cost of Care
Project Option: IT-5.1 – Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure)*

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.20 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
IT-5.1 – Improved cost savings: Demonstrate cost savings in care delivery for specific DRG's (*Standalone measure)*
Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 – Establish baseline rates for selected DRG's
- DY3:
  - P-3 – Develop and test data systems to track selected DRG's and incorporation of physician cost data.

Outcome Improvement Targets for each year:

- DY4:
  - IT-5.1 Improved cost savings: Demonstrate improved cost savings in care delivery for selected DRG's by 2.5%
- DY5:
  - IT-5.1 Improved cost savings: Demonstrate improved cost savings in care delivery for selected DRG's by 5%

Rationale:
To ascertain the impact of the revised clinical protocols, baseline data needs to be compared on a regular interval, to post implementation results to gauge the effectiveness of the project. Until we have a good basis to measure, stretch goals need to be set to incentivize improvement.

Outcome Measure Valuation:
Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects. Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure)	
The University of Texas Medical Branch at Galveston			**TPI - 094092602**
Related Category 1 or 2 Projects:	**094092602.2.8**		
Starting Point/Baseline:	**Baseline TBD in DY2 based upon cost per case for selected DRG's**		
Year 2 (10/1/2012 – 9/30/2013)	**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 plan as it relates to tracking and pulling cost savings. Metric: Documentation of meetings with key stakeholders in health system administration, finance, physicians and information services to identify data needs for standard reporting of metrics. Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2. Data Source: Meeting agendas, minutes, sign-in sheets, handouts, implementation plans, etc. Rationale: All of the stakeholders in the metric play a role in tracking and reporting cost savings and therefore, will need to understand the project including any expectations for their involvement.	**Process Milestone 3** [P-2]: Establish baseline rates for cost per case for selected DRG's. Metric: DRG's TBD by performing provider Goal: Establish baseline rates for cost per case for selected DRG's to measure against improvement target by 9/30/14. Data Source: Cost-accounting system Rationale: Need to establish a baseline number in order to demonstrate improvement Process Milestone 3 Estimated Incentive Payment (maximum amount): $70,286	**Outcome Improvement Target 1** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery for selected DRG's (Standalone measure). Improvement Target: Reduce the cost per case for selected DRG's by 2.5%. Measure: Compare the pre and post intervention cost per case for selected DRG's. Data Source: Hospital EMR, hospital financial system, and other appropriate health system administrative systems. Outcome Improvement Target 1 Estimated Incentive Payment: $131,901	**Outcome Improvement Target 2** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery for selected DRG's (Standalone measure). Improvement Target: Reduce the cost per case for selected DRG's by 5%. Measure: Compare the pre and post intervention cost per case for selected DRG's. Data Source: Hospital EMR, hospital financial system, and other appropriate health system administrative systems. Outcome Improvement Target 2 Estimated Incentive Payment: $276,602

094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.8		
Starting Point/Baseline:	Baseline TBD in DY2 based upon cost per case for selected DRG's		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Estimated Incentive Payment (maximum amount): $36,591 **Process Milestone 2** [P-3] Develop and test data systems Metric: Make necessary modifications to cost saving data elements and reporting to measure required improvement targets & metrics. Goal: Modification will be made as necessary to hospital cost-accounting system and data elements and reports will be developed and tested during DY3 with continued modifications made on an as needed basis. Data Source: . Hospital EMR, hospital financial system, and other appropriate health system administrative systems. Rationale: Identification of the cost per case of selected DRG's is critical to the project. Reports on activities of the project are critical for documentation of improvement			

094092602.3.20	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure)	
The University of Texas Medical Branch at Galveston			**TPI - 094092602**
Related Category 1 or 2 Projects:	**094092602.2.8**		
Starting Point/Baseline:	**Baseline TBD in DY2 based upon cost per case for selected DRG's**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
targets as well as for quality improvement initiatives. Process Milestone 2 Estimated Incentive Payment: $36,591			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,182	Year 3 Estimated Outcome Amount: $70,286	Year 4 Estimated Outcome Amount: $131,901	Year 5 Estimated Outcome Amount: $276,602
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $551,971			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 – Patient Satisfaction
Project Option: IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores
Project Title: Engage in Population-Based campaigns or programs to promote healthy lifestyles using evidence based methodologies including social medial and text messaging in an identified program.

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.21 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

Outcome Measure Description

This project for Advancing Health Promotion through Social Media aims to have an Outcome Measure Improvement Target focused on patient satisfaction. Our goal is to improve the impact of social media activities on patient satisfaction in relation through effectively serving patients' health information needs through "pushed" information, connecting them to other patients with similar health challenges, and improving communication with caregivers.

We plan to employ the following Process Milestones.

DY2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Development of a plan for improving patient satisfaction in relation to ensuring patients are getting timely care, appointments, and information through the use of social media. Data source: Documentation of plan. Goal: Complete Plan. Rationale: This project planning will provide the structure to develop a creative, coordinated initiative to improve patient satisfaction through the use of social media.

DY3: P-3 Develop and test data systems. Metric: Functionality of data systems. Data source: Results of piloting patient satisfaction among social media users. Goal: Ensure adequate data system for reliable monitoring of improvement targets. Rationale: Developing and testing data systems will support our ability to link with appropriate populations, deliver content effectively, and monitor our effectiveness.

DY3: P-2 Establish baseline rates. Metric: Patient satisfaction. Data source: Patient survey to be administered. Goal: Establish baseline rates. Rationale: Baseline rates are needed to monitor achievement of IT goals.

DY4: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric: Plan resulting from PDSA cycle. Data source: Documentation of plans resulting from PDSA cycles. Goal: Conduct 2 PDSA cycles. Rationale: Conducting PDSA cycles will be especially important for ensuring achievement of the IT goal, as it will allow us to identify weaknesses in our approach and correct them.

DY5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders. Metric: Paper and/or presentation. Data source: Documentation of paper or presentation. Goal: Develop at least 1 paper or presentation and disseminate to stakeholders. Rationale: Such sharing will support Regional Partners as well as others to implement their own evidence-based approaches efficiently and effectively. Metric: Paper and/or presentation.

Improvement Target:

DY4 and DY5: IT-6.1 Percent improvement over baseline of patient satisfaction scores *(Standalone measure).* Numerator: Number of patients receiving social messaging who indicate improved patient satisfaction in relation to timely care appointments, and information. Denominator: Number of patients receiving social messaging. Data source: Patient survey, based on statistically significant survey population size appropriate for extrapolation to the broader social media patient population. Goal: for DY4, to demonstrate improvement in patient satisfaction over the baseline for at least 20% of the target UTMB patient population surveyed (approximately 1,040 individuals); for DY5, to demonstrate improvement in patient satisfaction for at least 30% of the target UTMB patient population surveyed (approximately 1,560 individuals).

Rationale

Improvement Target 6.1 Percent improvement over baseline of patient satisfaction scores was chosen because social media can effectively serve patients' health information needs through "pushed" information, connecting them to other patients with similar health challenges, and improving communication with caregivers. By carefully targeting specific sub-populations, and building communication structures suited to particular information and communication needs, we can create a more responsive health care system that not only provides the right care at the right time in the right setting, but also supports primary prevention and healthy lifestyles and behaviors.

As stated before, according to the Region 2 Community Needs Assessment Galveston County Profile, lifestyle and behavioral factors contribute significantly to regional burden of disease. The community reported "access (insurance, resources, geographic location, and closed systems), education (about disease, medicine, and available resources)... [and] lifestyle (poor choices and attitudes)," among the major barriers to being healthy and suggested "community-based educational/support services" as a way to improve health. Finally, "Galveston County is a federally-designated Health Professional Shortage Area (HPSA) in full for primary care, and partially for dental and mental health providers," indicating a need for the delivery of health information beyond the traditional, in-person doctor-patient encounter.

In order to achieve the Improvement Targets set for DY4 and DY5, a number of Process Milestones will need to be completed, related to planning, ensuring a functional information system, and creating a quality improvement process (PDSA). Combined with Process Milestones from the Category 2 portion of this project focus on evaluation and other quality improvement processes, the final Process Milestone will be dissemination of findings to share strategies and lessons.

Outcome Measure Valuation

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.21	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
University of Texas Medical Branch Hospital			094092602
Related Category 1 or 2 Projects:	094092602.2.9		
Starting Point/Baseline:	TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Development of plan or plans for the use of social media and electronic communication initiatives that will increase patient satisfaction in relation to ensuring patients are getting timely care, appointments, and information. Data source: Documentation of plan Goal: Complete Plan Rationale: This project planning will provide the structure to develop a creative, coordinated initiative to improve patient satisfaction through the use of social media. Process Milestone 1 Estimated Incentive Payment*:* $70,011	**Process Milestone 2** P-3 Develop and test data systems Metric: Functionality of data systems Data source: Results of piloting patient satisfaction among social media users Goal: Ensure adequate data system for reliable monitoring of improvement targets Rationale: Developing and testing data systems will support our ability to link with appropriate populations, deliver content effectively, and monitor our effectiveness. Process Milestone 2 Estimated Incentive Payment*:* $33,507 **Process Milestone 3** P-2 Establish baseline rates Metric: Patient satisfaction Data source: Patient survey to be administered Goal: Establish baseline rates Rationale: Baseline rates are needed to monitor achievement of IT goals. Process Milestone 3 Estimated Incentive Payment*:* $33,506	**Process Milestone 4** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Plan resulting from PDSA cycle Data source: Documentation of plans resulting from PDSA cycles Goal: Conduct 2 PDSA cycles Rationale: Conducting PDSA cycles will be especially important for ensuring achievement of the IT goal, as it will allow us to identify weaknesses in our approach and correct them. Process Milestone 4 Estimated Incentive Payment*:* $50,813 Outcome Improvement Target 1 IT-6.1 Percent improvement over baseline of patient satisfaction scores Numerator: Number of patients receiving social messaging who indicate improved patient satisfaction in relation to timely care, appointments, and information. Denominator: Number of patients receiving social messaging. Data source: Patient survey, based on statistically significant survey	**Process Milestone 5** P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Metric: Paper and/or presentation Data source: Documentation of paper or presentation Goal: Develop at least 1 paper or presentation and disseminate to stakeholders Rationale: Such sharing will support Regional Partners as well as others to implement their own evidence-based approaches efficiently and effectively. Metric: Paper and/or presentation. Process Milestone 5 Estimated Incentive Payment*:* $114,589 Outcome Improvement Target 1 IT-6.1 Percent improvement over baseline of patient satisfaction scores Numerator: Number of patients receiving social messaging who indicate improved patient satisfaction in relation to timely care, appointments, and information. Denominator: Number of patients receiving social messaging.

094092602.3.21	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
University of Texas Medical Branch Hospital			094092602
Related Category 1 or 2 Projects:	094092602.2.9		
Starting Point/Baseline:	TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		population size appropriate for extrapolation to the broader social media patient population. Goal: To demonstrate improvement in patient satisfaction over the baseline for at least 20% of the target UTMB patient population surveyed (20% of 5200 patients = approximately 1,040 individuals). Rationale: Social media can effectively improve patient satisfaction by serving patients' health information needs, connecting them to other patients, and improving communication with caregivers. Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,812	Data source: Patient survey, based on statistically significant survey population size appropriate for extrapolation to the broader social media patient population. Goal: To demonstrate improvement in patient satisfaction for at least 30% of the target UTMB patient population surveyed (30% of 5200 patients = approximately 1,560 individuals). Rationale: Social media can effectively improve patient satisfaction by serving patients' health information needs, connecting them to other patients, and improving communication with caregivers. Outcome Improvement Target 2 Estimated Incentive Payment*:* $114,590
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $70,011	Year 3 Estimated Outcome Amount: $67,013	Year 4 Estimated Outcome Amount: $101,625	Year 5 Estimated Outcome Amount: $229,179
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $467,828			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-8 Perinatal Outcomes
Project Option: IT-8.9 Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)
Project Title: Engage in Population-Based campaigns or programs to promote healthy lifestyles using evidence based methodologies including social medial and text messaging in an identified program.

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.21b – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

Outcome Measure Description

This project for Advancing Health Promotion through Social Media aims to have an Outcome Measure Improvement Target focused on Increasing breastfeeding among new mothers at 6 months post-delivery through the use of social media and other electronic communication activities.

We plan to employ the following Process Milestones.

Process Milestone 1: In **DY2**, the initiative will pursue (P-1) Project planning, including to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. This project planning will provide the structure to develop a creative, coordinated social media initiative to support healthy pregnancies with an emphasis on continuation of breastfeeding through 6 months postpartum. Metric: Development of plan that includes a longitudinal social media support process for expectant and newly delivered mothers. Data source: Documentation of plan. Goal: Complete Plan.

Process Milestone 2: This planning will be followed in **DY3** by efforts to (P-3) Develop and test data systems to support our ability to link with appropriate populations, deliver content effectively, and monitor our effectiveness. Metric: Functionality of data systems. Data source: EHR, claims. Goal: Ensure adequate data system for reliable monitoring of improvement targets.

Process Milestone 3: In **DY3** we will also (P-2) Establish baseline rates to allow monitoring of improvements related to our IT goal. Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at 6 months postpartum between November 6 of the year prior to the measurement year and November 5 of the measurement year. Data source: EHR. Goal: Establish baseline rates.

Process Milestone 4: In **DY4** we will (P-4) Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. This will be especially important for ensuring achievement of the IT goal, as it will allow us to identify weaknesses in our approach and correct them. Metric: Plan resulting from PDSA cycle. Data source: Documentation of plans resulting from PDSA cycles. Goal: Conduct 2 PDSA cycles.

Process Milestone 5: In **DY5** we will (P-5) Disseminate findings, including lessons learned and best practices, to stakeholders. Such sharing will support Regional Partners as well as

others to implement their own evidence-based approaches efficiently and effectively. Metric: Paper and/or presentation. Data source: Documentation of paper or presentation. Goal: Develop 1 paper or presentation and disseminate to stakeholders.

Improvement Target:

Finally, in **DY4 and DY5,** we will monitor achievement of IT-8.9 Perinatal Outcomes: Other Outcome Improvement Target (breastfeeding at 6 months post-delivery). Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at 6 months postpartum between November 6 of the year prior to the measurement year and November 5 of the measurement year. Data source: EHR. Goal: increase breastfeeding rates at 6 months post-partum by an amount TBD in DY3, based on baseline rates established in DY3.

Rationale:

Rationale: While the benefits of breastfeeding to mothers and babies is well established in the literature and rates of breastfeeding at birth often average over 75%, rates of breastfeeding by 6 months post-partum generally decline to under 50%.[1] While Texas' "ever breastfed" average is over 80%, monthly rates among WIC mothers in Galveston County ranged between 56% and 76% in 2012.[2] The Needs Assessment indicates that Galveston also has worse rates than the national average for births to teen mothers (4.2 % vs. 3.4 %) and prenatal care in the first trimester (63.9% vs. 70.8%), and worse rates than both state and national averages for low birth-weight babies (8.6 compared to 8.4 and 8.2, respectively), pre-term birth rates (14.2 compared to 13.6 and 12.5, respectively), and infant mortality (7.5 compared to 6.2 and 6.9, respectively). These rates also demonstrate disparities for Medicaid and Uninsured populations, which increasingly have access to social media. Social media tools can enhance health promotion activities such as breastfeeding, and may be effective in supporting other issues related to healthy pregnancies and healthy births, such as improved patient self-management during pregnancy, information on nutritional needs during pregnancy, healthy weight management, warning signs to alert patients to seek medical care during pregnancy, earlier detection of disease, decreased infectious disease, and prevention of life-threatening conditions, among other opportunities.

More generally, social media can effectively serve patients' health information needs through "pushed" information, connecting them to other patients with similar health challenges, and improving communication with caregivers. By carefully targeting specific sub-populations, and building communication structures suited to particular information and communication needs, we can create a more responsive health care system that not only provides the right care at the right time in the right setting, but also supports primary prevention and healthy lifestyles and behaviors.

As stated before, according to the Region 2 Community Needs Assessment Galveston County Profile, lifestyle and behavioral factors contribute significantly to regional burden of

---

[1] CDC (2013) "Breastfeeding Report Card 2012, United States: Outcome Indicators." http://www.cdc.gov/breastfeeding/data/reportcard2.htm.

[2] Galveston County Health District, citing DSHS data, February 15, 2012.

disease. The community reported "access (insurance, resources, geographic location, and closed systems), education (about disease, medicine, and available resources)... [and] lifestyle (poor choices and attitudes)," among the major barriers to being healthy and suggested "community-based educational/support services" as a way to improve health. Finally, "Galveston County is a federally-designated Health Professional Shortage Area (HPSA) in full for primary care, and partially for dental and mental health providers," indicating a need for the delivery of health information beyond the traditional, in-person doctor-patient encounter.

Outcome Measure Valuation

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.21b	3.IT-8.9	Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)	
University of Texas Medical Branch Hospital			094092602
Related Category 1 or 2 Projects	094092602.2.9		
Starting Point/Baseline	TBD in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning Metric: Development of plan that includes a longitudinal social media support process for expectant and newly delivered mothers to support healthy pregnancies and babies, with a focus on breastfeeding after delivery. Data source: Documentation of plan. Goal: Complete Plan. Rationale: This project planning will provide the structure to develop a creative, coordinated initiative to improve patient satisfaction through the use of social media. Process Milestone 1 Estimated Incentive Payment*:* $70,011	**Process Milestone 2** P-3 Develop and test data systems Metric: Functionality of data systems Data source: EHR, claims Goal: Ensure adequate data system for reliable monitoring of improvement targets Rationale: Developing and testing data systems will support our ability to link with appropriate populations, deliver content effectively, and monitor our effectiveness. Process Milestone 2 Estimated Incentive Payment*:* $33,506.50 **Process Milestone 3** P-2 Establish baseline rates Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at 6 months postpartum between November 6 of the year prior to the measurement year and November 5 of the measurement year.	**Process Milestone 4** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Plan resulting from PDSA cycle Data source: Documentation of plans resulting from PDSA cycles Goal: Conduct 2 PDSA cycles Rationale: Conducting PDSA cycles will be especially important for ensuring achievement of the IT goal, as it will allow us to identify weaknesses in our approach and correct them. Process Milestone 4 Estimated Incentive Payment*:* $50,812.50 Outcome Improvement Target 1 IT-8.9 Other Outcome Improvement Target (breastfeeding as 6 months post-delivery) Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at 6 months postpartum between	**Process Milestone 5** P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Metric: Paper and/or presentation Data source: Documentation of paper or presentation Goal: Develop 1 paper or presentation and disseminate to stakeholders Rationale: Such sharing will support Regional Partners as well as others to implement their own evidence-based approaches efficiently and effectively. Metric: Paper and/or presentation. Process Milestone 5 Estimated Incentive Payment*:* $114,589.50 Outcome Improvement Target 2 IT-8.9 Other Outcome Improvement Target (breastfeeding as 6 months post-delivery) Metric: Rate of breastfeeding at 6 months postpartum. Numerator: Number of mothers at 6 months postpartum who have continued to breastfeed. Denominator: Number of mothers at

094092602.3.21b	3.IT-8.9	Other Outcome Improvement Target (breastfeeding at 6 months post-delivery)	
University of Texas Medical Branch Hospital			**094092602**
Related Category 1 or 2 Projects	**094092602.2.9**		
Starting Point/Baseline	**TBD in DY3**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data source: EHR. Goal: Establish baseline rates. Process Milestone 3 Estimated Incentive Payment*:* $33,506.50	November 6 of the year prior to the measurement year and November 5 of the measurement year. Data source: EHR. Goal: TBD in DY3, based on baseline rates established in DY3. Rationale: the Galveston County Needs Assessment indicates that breastfeeding, healthy pregnancies and healthy births are an important area for improvement (see narrative). Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,812.50	6 months postpartum between November 6 of the year prior to the measurement year and November 5 of the measurement year. Data source: EHR. Rationale: the Galveston County Needs Assessment indicates that breastfeeding, healthy pregnancies and healthy births are an important area for improvement (see narrative). Outcome Improvement Target 2 Estimated Incentive Payment*:* $114,589.50
Year 2 Estimated Outcome Amount: $70,011	Year 3 Estimated Outcome Amount: $67,013	Year 4 Estimated Outcome Amount: $101,625	Year 5 Estimated Outcome Amount: $229,179
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $467,828			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-13 – Palliative Care
Project Option: IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.22 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
Process Milestones 1 - 3 (DY2 and DY3)
P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.

P-2 Establish baseline rates.

P-3 Develop and test data systems.

Outcome Improvement Target (DY4 and DY5)

IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213) The goals related to this improvement target will be determined following establishment of baseline rates in DY2.

RATIONALE:
P-1 This milestone was chosen because participating in business/project planning meetings will be crucial to the development of appropriate, realistic, measurable outcomes.

P-2 This milestone was chosen because measurement is a vital first step to improvement.

P-3 Develop and test data systems. This milestone was chosen because periodic reporting is a necessary step to guide team/program direction, improvement and maintenance of goals.

Outcome Improvement Target (DY4 and DY5)

IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)
This improvement target was chosen because using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

Outcome Measure Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.
Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.22	IT-13.4	Proportion admitted to the ICU in the last 30 days of life (NQF 0213) (Standalone measure)	
University of Texas Medical Branch Hospital			094092602
Related Category 1 or 2 Projects:	094092602.2.10		
Starting Point/Baseline:	TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan Metric: Stakeholder participation in a business/project planning Data source: Palliative Care planning meeting agendas and project meeting minutes Goal: 75% of stakeholders participate in monthly planning / project meetings Milestone 1 Estimated Incentive Payment (maximum amount): $23,009.50 **Milestone 2** [P-2]: Establish baseline rates Metric: ICU usage in the last 30 days of life Data source: EHR or Medical Record, Claims Goal: Collect and track documentation of ICU utilization in order to guide effectiveness of palliative care services	**Milestone 3** [P-3]: Develop and test data systems Metric: Periodic reporting of consults, symptom assessment, and utilization. Data source: EHR, Claims Goal: Current Palliative Care Consult Service performance feedback is available no less than monthly. Milestone 3 Estimated Incentive Payment *(maximum amount):* $65,069	**Milestone 4** [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life (NQF 0213) Metric: Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life. *(Standalone measure)* Numerator: Patients who died from cancer and were admitted to the ICU in the last 30 days of life Denominator: Patients who died from cancer. Goal: % improvement over baseline TBD in DY2 Data Source: EHR, Claims Milestone 6 Estimated Incentive Payment: $146,205	**Milestone 5** [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life (NQF 0213) Metric: Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life. *(Standalone measure)* Numerator: Patients who died from cancer and were admitted to the ICU in the last 30 days of life Denominator: Patients who died from cancer. Goal: % improvement over baseline TBD in DY2 Data Source: EHR, Claims Milestone 6 Estimated Incentive Payment: $400,356

094092602.3.22	IT-13.4	Proportion admitted to the ICU in the last 30 days of life (NQF 0213) (Standalone measure)	
University of Texas Medical Branch Hospital			**094092602**
Related Category 1 or 2 Projects:	**094092602.2.10**		
Starting Point/Baseline:	**TBD in DY2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment (maximum amount): $23,009.50			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $46,019	Year 3 Estimated Outcome Amount: $65,069	Year 4 Estimated Outcome Amount: $146,205	Year 5 Estimated Outcome Amount: $400,356
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $657,648			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9 Right Care, Right Setting **Project Option:** IT – 9.2 ED appropriate utilization (Standalone measure)
UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.23 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
OD – 9 Right Care, Right Setting
IT – 9.2 ED appropriate utilization (Standalone measure)

- Reduce all ED visits (including ACSC)

- Reduce pediatric Emergency Department visits (CHIPRA Core Measures)

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 – Establish baseline rates for ED visits, including targeted population.
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
- IT – 9.2 ED appropriate utilization. Reduce all ED visits and reduce pediatric Emergency Department visits (CHIPRA Core Measures) by 0.1%.DY5:

IT – 9.2 ED Appropriate Utilization. Reduce all ED visits and reduce pediatric Emergency Department visits (CHIPRA Core Measures) by 0.2%.**Rationale:**

Medication management is challenging for many patient populations. The geriatric patient population is often receives prescriptions from multiple providers from primary to specialty care. The greater the number of medical conditions, typically the greater the number of medications prescribed. With an increase number of medications, the patient is at risk for medication errors due to duplications of therapy and/or significant drug-drug interactions. These risks can be positively impacted with the skill and expertise of a clinically trained pharmacist.

Medication management for the pediatric population is also challenging, but for a different set of reasons. When prescribing medication for a pediatric patient, the provider must dose the medication in units per patient weight measurements. Often the dosage forms commercially available are intended for the adult population. Misadventures can occur when using adult formulations of medications for pediatric patients. These risks can be positively impacted with the skill and expertise of a clinically trained pharmacist.

Medication management for the frequent ED visit patient is often multifold and requires time and special attention. The ED environment is often not the most conducive for getting to the root cause of the frequent visits. A dedicated clinically trained pharmacist could spend the time to get to the root cause of any medication management related challenges and develop a plan of action to positively impact each patient.

A three-fold approach to medication management will result in a better informed and compliant patient. This will ultimately lead to fewer ED visits and fewer readmissions. The three-fold approach is as follows: 1) pharmacist intervention in the patient's regimen before the drug is administered or the prescription filled, 2) reconciliation of the patient's medication to eliminate duplication of medications, identify and manage drug-drug interactions and 3) medication counseling to assure the patient understands their regimen and is also able to obtain their medication and adhere to the prescribed regimens.

Process Milestone Rationale:
P-1 A validated data collection tool will be necessary to document improvements. Identification of the tool will be documented by meeting minutes and EPIC intervention data analysis (to verify implementation of the assessment tool). The goal for this process milestone is that a data collection tool will be selected and prepared for use. All of the stakeholders in the metric will play a role in tracking and reporting cost savings and therefore, will need to understand the project including any expectations for their involvement.
Process Milestone 1 [P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan as it relates to tracking and pulling cost savings.

- Metric: Documentation of meetings with key stakeholders in health system administration, finance, physicians and information services to identify data needs for standard reporting of metrics.
- Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2.
- Data Source: Meeting agendas, minutes, sign-in sheets, handouts, implementation plans, etc.
- Rationale: All of the stakeholders in the metric play a role in tracking and reporting cost savings and therefore, will need to understand the project including any expectations for their involvement.

P-3 Identification of the cost for ED visits is critical to the project. Reports on ED visits are critical for documentation of improvement targets as well as for quality improvement initiatives. Intervention data analysis will be used for process improvement of systems. All keep stakeholders including providers will be involved in the performance improvement activities as documented in minutes from meetings.

Process Milestone 3 [P-3] Develop and test data systems

- Metric: Make necessary modifications to cost saving data elements and reporting to measure required improvement targets & metrics.
- Goal: Modification will be made as necessary to hospital cost-accounting system and data elements and reports will be developed and tested during DY3 with continued modifications made on an as needed basis.
- Data Source: Hospital EMR, hospital financial system, and other appropriate health system administrative systems.
- Rationale: Identification of the cost for ED visit is critical to the project. Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives.

Outcome Measure Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.23	IT- 9.2	ED Appropriate Utilization	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.11		
Starting Point/Baseline:	Baseline TBD in DY2 based upon ED visits during the previous fiscal year		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan as it relates to tracking and pulling cost savings. Metric: Documentation of meetings with key stakeholders in health system administration, finance, physicians and information services to identify data needs for standard reporting of metrics. Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2. Data Source: Meeting agendas, minutes, sign-in sheets, handouts, implementation plans, etc. Rationale: All of the stakeholders in the metric play a role in tracking and reporting cost savings and therefore, will need to understand the project including any expectations for their involvement. Process Milestone 1 Estimated	**Process Milestone 3 [P-3]** Develop and test data systems Metric: Make necessary modifications to cost saving data elements and reporting to measure required improvement targets & metrics. Goal: Modification will be made as necessary to hospital cost-accounting system and data elements and reports will be developed and tested during DY3 with continued modifications made on an as needed basis. Data Source: Hospital EMR, hospital financial system, and other appropriate health system administrative systems. Rationale: Identification of the cost for ED visits is critical to the project. Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives. Process Milestone 3 Estimated Incentive Payment (maximum	**Outcome Improvement Target 1** IT – 9.2 ED appropriate utilization (Standalone measure) Improvement Target: Reduce all ED visits and reduce pediatric Emergency Department visits (CHIPRA Core Measures) by 0.1%. Numerator: The outcome for this measure is appropriate utilization of the ED. Specifically, reduce all ED visits and reduce pediatric Emergency Department visits (CHIPRA Core Measures). Denominator: This claims-based measure can be used in either of two patient cohorts: (1) ED visits for patient aged 65 years or older or (2) ED visits for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EHR, claims. Rationale: This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 or older.	**Outcome Improvement Target 2** IT – 9.2 ED appropriate utilization (Standalone measure) Improvement Target: Reduce ED visits and reduce pediatric Emergency Department visits (CHIPRA Core Measures) 0.2%. Numerator: The outcome for this measure is appropriate utilization of the ED. Specifically, reduce all ED visits and reduce pediatric Emergency Department visits (CHIPRA Core Measures). Denominator: This claims-based measure can be sued in either of two patient cohorts: (1) ED visits for patient aged 65 years or older or (2) ED visits for patients aged 18 years or older. We have tested the measure in both age groups. Data Source: EHR, claims. Rationale: This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 or older.

094092602.3.23	IT- 9.2	ED Appropriate Utilization	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.11		
Starting Point/Baseline:	Baseline TBD in DY2 based upon ED visits during the previous fiscal year		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment (maximum amount): $0 **Process Milestone 2** [P-2]: Establish baseline rates for cost of readmission. Metric: TBD by performing provider as appropriate for analysis type. Goal: Establish baseline rates got cost of X to measure against improvement target by 9/30/13. Data Source: Hospital administrative data system reports Rationale: Need to establish a baseline number in order to demonstrate improvement. Process Milestone 2 Estimated Incentive Payment: $0	amount): $61,206	Outcome Improvement Target 1 Estimated Incentive Payment: $86,131	Outcome Improvement Target 2 Estimated Incentive Payment: $219,400
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $61,206	Year 4 Estimated Outcome Amount: $86,131	Year 5 Estimated Outcome Amount: $219,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $366,738			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-9 Right Care, Right Setting
Project Option: IT-9.2 – ED Appropriate Utilization

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.24 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

OUTCOME MEASURE DESCRIPTION:
Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 – Establish baseline rates for average number of ED visits for target population prior to exchange of patient electronic health information in the emergency room.
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-9.2 ED Appropriate Utilization: Decrease ED appropriate utilization from by 5% from DY2 baseline. Improvement target will be determined in DY 2 once baseline is established for implementation in DY 4.
- DY5:
  - IT-9.2 ED Appropriate Utilization: Decrease ED appropriate utilization by 10% from DY2 baseline. Improvement target will be determined in DY 2 once baseline is established for implementation in DY 4.

RATIONALE:

The process milestones were selected to establish a plan for collecting the data, testing the data, and to establish a baseline average number of ED visits per targeted population prior to the exchange of patient electronic health information in the emergency room.

The improvement target was chosen based upon the fact that reducing Emergency Department overuse is estimated nationally as a $38 billion opportunity. Many patients utilizing multiple emergency departments are resulting in repeat exams, laboratory and radiology testing often without a final diagnosis. Nationally it is estimated that 56 percent or roughly 67 million visits, are potentially avoidable. 5 In one study, researchers in San Diego identified a group of "super users," each of whom visited an emergency room 21 or more times in a single year. These patients moved from hospital to hospital. While they represented just 0.2 percent of all patients, they accounted for 4.5 percent of all emergency visits in the region. Having the ability to view the patient's (by ambulance) past medications, allergies, problem summary list, and

past treatment information in real time by the emergency physician will increase quality of care, reduce errors, spot trends and improve outcomes through better care coordination.

Outcome Measure Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.24	IT-9.2	ED Appropriate Utilization (Standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.12		
Starting Point/Baseline:	Baseline TBD by pulling emergency department visits for target population in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan as it relates to pulling emergency department visit data for target population. Metric: Documentation of meetings with key stakeholders in the emergency department, health system finance, and information services to identify data fields in EPIC and standard reporting of metrics. Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2 and continuing in DY3 as the project is implemented. Data Source: Meeting agendas, minutes, sign-in sheets, handouts, etc. Rationale: All of the stakeholders in the metric play a role in the emergency room and therefore, will need to understand the project including any expectations for their involvement.	**Process Milestone 3 [P-3]** Develop and test data systems Metric: Make necessary modifications to UTMB emergency department EPIC EMR/Greater Houston Healthconnect HIE systems and develop reports to identify target patients and report on required improvement milestones & metrics. Goal: Modification will be made as necessary to EPIC EMR/Greater Houston Healthconnect HIE systems and reports will be developed and tested during DY3 with continued modifications made on an as needed basis. Data Source: Hospital EMR, hospital financial system, and Greater Houston Healthconnect HIE. Rationale: Identification of the target population is critical to the project. Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives.	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization for (Standalone measure). Improvement Target: Reduce the number of ED visits per Galveston County patient transported via ambulance to UTMB ED that are enrolled in the care transition process by 5% of DY2 baseline. Measure: Compare the pre and post intervention number of ED visits per patient enrolled in the care transitions process in ED. Reduce average number of ED visits for targeted population. Data Source: Hospital EMR and administrative data systems. Greater Houston Healthconnect HIE. Outcome Improvement Target 1 Estimated Incentive Payment: $143,200	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization (Standalone measure). Improvement Target: Reduce the number of ED visits per Galveston County patient transported via ambulance to UTMB ED that are enrolled in the care transition process by 10% of DY2 baseline. Measure: Compare the pre and post intervention number of ED visits per patient enrolled in the care transitions process in ED. Reduce average number of ED visits for targeted population. Data Source: Hospital EMR and administrative data systems. Greater Houston Healthconnect HIE. Outcome Improvement Target 2 Estimated Incentive Payment: $274,111

094092602.3.24	IT-9.2	ED Appropriate Utilization (Standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.12		
Starting Point/Baseline:	Baseline TBD by pulling emergency department visits for target population in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Estimated Incentive Payment (maximum amount): $42,000 **Process Milestone 2** [P-2]: Establish baseline rates for Galveston County patients arriving to UTMB level 1 emergency room by ambulance. Metric: Determine baseline average number of UTMB emergency department visits for UTMB Galveston County patients arriving by ambulance. Goal: Establish baseline rates to measure against improvement targets. Data Source: Hospital administrative data system reports Rationale: Need to establish a baseline number in order to demonstrate improvement. Process Milestone 2 Estimated Incentive Payment: $42,000	Process Milestone 3 Estimated Incentive Payment (maximum amount): $100,577		

094092602.3.24	IT-9.2	ED Appropriate Utilization (Standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	094092602.2.12		
Starting Point/Baseline:	Baseline TBD by pulling emergency department visits for target population in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,000	Year 3 Estimated Outcome Amount: $100,577	Year 4 Estimated Outcome Amount: $143,200	Year 5 Estimated Outcome Amount: $274,112
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $601,888			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-5 Cost of Care
Project Option: IT-5.1 – Improved Cost Savings

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 094092602.3.25 – PASS 2

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/094092602

Outcome Measure Description:
IT-5.1 – Improved cost savings: Demonstrate cost savings in care delivery (Non-standalone measure)

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 – Establish baseline rates for average cost per ED visits for target population prior to exchange of patient electronic health information in the emergency room.
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery- Decrease average cost per ED visit for target population from by2%
- DY5:
  - IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery- Decrease average cost per ED visit for target population by 5%

Rationale:

Patients often arrive to UTMB Emergency Department via ambulance. Often these patients have gone to other area Emergency Departments within the last 24 to 72 hours. At this time, EMTs and physicians care for these patients not knowing which medications, tests or procedures were performed recently at other institutions unless the patient is able to disclose that information. The improvement target was chosen based upon the fact that reducing Emergency Department overuse is estimated nationally as a $38 billion opportunity. Many patients utilizing multiple emergency departments are resulting in repeat exams, laboratory and radiology testing often without a final diagnosis. IT-5.1 Improved cost savings was chosen to correlate a reduction in the average ED cost per visit of those patients arriving by ambulance due to real time exchange of electronic health information between EMS providers and the 20 county regional Greater Houston Healthconnect health information exchange.

Outcome Measure Valuation:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

094092602.3.25	IT-5.1	Improved Cost Savings: Demonstrate cost savings in care delivery (Non-standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	**094092602.2.12**		
Starting Point/Baseline:	Baseline TBD by pulling average cost per emergency department visit for target population in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. Metric: Documentation of meetings with key stakeholders in the emergency department, health system finance, and information services to identify data fields in EPIC and standard reporting of metrics. Goal: Meetings will be conducted with stakeholders as outlined above starting in DY2 and continuing in DY3 as the project is implemented. Data Source: Meeting agendas, minutes, sign-in sheets, handouts, etc. Rationale: All of the stakeholders in the metric play a role in the emergency room and therefore, will need to understand the project including any expectations for their involvement. Process Milestone 1 Estimated	**Process Milestone 3 [P-3]** Develop and test data systems Metric: Make necessary modifications to UTMB administrative data systems to develop reports to identify target population cost per emergency department encounter and report on required improvement milestones & metrics. Goal: Modification will be made as necessary to develop and test reports during DY3 with continued modifications made on an as needed basis. Data Source: Hospital administrative data systems. Rationale: Identification of the target population is critical to the project. Reports on activities of the project are critical for documentation of improvement targets as well as for quality improvement initiatives. Process Milestone 3 Estimated	**Outcome Improvement Target 1** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery (Non-Standalone measure). Improvement Target: Reduce the average cost per emergency department visit for target population by exchanging patient electronic health information by 2%. Measure: Emergency department visit cost information. Data Source: Hospital EMR and financial data systems. Outcome Improvement Target 1 Estimated Incentive Payment: $143,200	**Outcome Improvement Target 2** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery (Non-Standalone measure). Improvement Target: Reduce the average cost per emergency department visit for target population by exchanging patient electronic health information by 5%. Measure: Emergency department visit cost information. Data Source: Hospital EMR and financial data systems. Outcome Improvement Target 2 Estimated Incentive Payment: $274,112

094092602.3.25	IT-5.1	Improved Cost Savings: Demonstrate cost savings in care delivery (Non-standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	**094092602.2.12**		
Starting Point/Baseline:	Baseline TBD by pulling average cost per emergency department visit for target population in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment (maximum amount): $42,000 **Process Milestone 2** [P-2]: Establish baseline rates. Metric: Determine baseline average cost of UTMB emergency department visits for UTMB Galveston County patients arriving by ambulance. Goal: Establish baseline rates to measure against improvement targets. Data Source: Hospital administrative data systems reports Rationale: Need to establish a baseline number in order to demonstrate improvement. Process Milestone 2 Estimated Incentive Payment: $42,000	Incentive Payment (maximum amount): $100,577		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,000	Year 3 Estimated Outcome Amount: $100,577	Year 4 Estimated Outcome Amount: $143,200	Year 5 Estimated Outcome Amount: $274,112

094092602.3.25	IT-5.1	Improved Cost Savings: Demonstrate cost savings in care delivery (Non-standalone measure)	
The University of Texas Medical Branch at Galveston			TPI - 094092602
Related Category 1 or 2 Projects:	**094092602.2.12**		
Starting Point/Baseline:	Baseline TBD by pulling average cost per emergency department visit for target population in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $601,889			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-6 Patient Satisfaction
Project Option: IT-6.2 Percent Improvement over Baseline of Referring Community Provider Satisfaction Scores
Numerator: Percent improvement in targeted community referring provider satisfaction survey.
Data Source: provider satisfaction survey
Denominator: Number of providers who were administered the satisfaction survey.

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.4

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/109372601

OUTCOME MEASURE DESCRIPTION:
IT-6.2 Percent Improvement over Baseline of Referring Community Provider Satisfaction Scores
Numerator: Percent improvement in targeted community referring provider satisfaction survey.
Data Source: provider satisfaction survey
Denominator: Number of providers who were administered the satisfaction survey.

RATIONALE:
The process milestones were chosen to establish linkages with community based referring providers and the development of a staff and implementation plan that addresses care transitions that will increase community referring provider satisfaction with timely electronic medical records for their patients. A provider survey will be created to establish pre implementation of the web-based EMR portal to post implementation to ensure community referring providers are obtaining their patient's electronic medical record information in a timely manner to improve care transitions from one health care setting to another..

OUTCOME MEASURE VALUATION:
Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.

- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.3.4	IT-6.2	Percent improvement over baseline of referring community provider satisfaction scores	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects:	109372601.2.1		
Starting Point/Baseline:	Baseline to be established in initial referring community provider survey		
Year 2 (10/1/2012 – 9/30/2013)	**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 plan regarding standard care transition processes in specified population Metric: Develop referring provider satisfaction survey to measure current and post implementation satisfaction with referral processes and communication. Goal: Develop referring provider survey by 9/30/13. Data source: Referring provider survey. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline referring provider satisfaction rates with current referral process and communication by administering the survey to all referring community providers trained and using the web-based EMR portal in DY3. Metric: Measure average score of pre implementation satisfaction survey. Baseline: To be determined after train and enroll 25 community referring providers in DY3. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $38,283 **Process Milestone 3** [P-3]: Develop and test data systems Metric: Evaluate web-based portal functionality as to referral processes and timely communication.	**Outcome Improvement Target 1** [IT-6.2]: Percent improvement over baseline of community referring provider survey satisfaction scores. Goal: Percent improvement TBD based upon baseline survey results in DY3. Numerator: Percent improvement in targeted community referring provider satisfaction survey. Denominator: Number of community referring providers who were administered the satisfaction survey. Data Source: Provider survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $81,908	**Outcome Improvement Target 2** [IT-6.2] Percent improvement over baseline of community referring provider survey satisfaction scores. Goal: Percent improvement TBD based upon baseline survey results in DY3. Numerator: Percent improvement in targeted community referring provider satisfaction survey. Denominator: Number of community referring providers who were administered the satisfaction survey. Data Source: Provider survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $178,061

109372601.3.4	IT-6.2	Percent improvement over baseline of referring community provider satisfaction scores	
The University of Texas Medical Branch at Galveston			**109372601**
Related Category 1 or 2 Projects:	**109372601.2.1**		
Starting Point/Baseline:	**Baseline to be established in initial referring community provider survey**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Goal: To assess successful functionality of web-based portal. Data Source: Web-based software and/or process workflows documentation. Process Milestone 3 Estimated Incentive Payment: $38,283		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $76,566	Year 4 Estimated Outcome Amount: $81,908	Year 5 Estimated Outcome Amount: $178,061
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $336,535			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-1 Primary Care and Chronic Disease Management
Project Option: IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR2011, #134) *(Non- standalone measure) (Table B1)*

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.5
RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/109372601

OUTCOME MEASURE DESCRIPTION:
Process Measures: . Initial process measures will focuses on P-2, Establish Baseline Data. A database is already being used at the Brazoria clinic; this database includes an initial questionnaire that includes demographic and socioeconomic data as well as data on social support, lifestyle risks (smoking, ETOH uses, and drug use) and access to health care over the last 12 months. At each clinical encounter, including the first, a separate Clinical Encounter questionnaire is used to collect encounter specific data, e.g. reason for the visit (ICD-9 codes), complexity of the visit (e.g. CPT codes), referrals, and health metrics including the exact date the measure was performed. At the beginning of Year 2, the PHQ-9 questionnaire will be collected on all patients at each visit and these data will be added to the Clinical Encounter Database. All data are entered into the database via a simple Survey Monkey tool and later are exported into SPSS for further analysis. The patient's data are tracked over time using a unique identifier, the patient's UTMB medical record number. . Concurrent with collecting baseline data, we will be actively Developing and Testing Data Collection Systems (P-3) to address not only descriptive data but also to assure that mechanisms for referral and collaboration between primary care and behavioral/mental health clinicians is efficient and effective. Also developed will be the process for evaluating the project, particularly the collection of data described in the Improvement Measures and Outcome Measures sections below. Finally, by Year 3 we will be aggressively implementing our Quality improvement Program (P-4, QI processes using PDSA cycles) to assure full integration of primary care and behavioral/mental health care in the practice.

Improvement Measures:

Data regarding patient participation in the integrated practice will be derived from the Practice Management system which can provide reports on appointments made, kept, and "no shows". Patient Satisfaction will be measured using the Nursing Center Patient Satisfaction Tool. The Nursing Center Patient Satisfaction tool was developed and tested by the Michigan Academic Consortium (Benkerk, et al. 2002), a group of affiliated nursing centers in Michigan. It has content validity specific to nurse practitioner practice and has been well received by patients. It has been tested in a multi-site study coordinated by the Nursing Center Research Network (NC-RN) and has been adopted by the nursing center members of the NC-RN as their preferred patient satisfaction tool. This tool was chosen because of the patient-centered nature of the questions. Sample questions include "the office staff showed me respect and courtesy;" "the clinician considered my beliefs about health and healing;" and "I am treated the same as other people who get care here."

Benkert, R., Barkauskas, V., Pohl, J., Corser, W., Tanner, C., Wells, M., Nagelkirk, J. (2002). Patient satisfaction outcomes in nurse-managed centers. Outcomes Management, 6 (4), 174-181.

Evidence of the level of integration between primary care and mental/behavioral health will include screenshots of the integrated health record that reflect structured team meetings and integrated plans of care.

OUTCOME MEASURES:

IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR2011, #134) *(Non- standalone measure) (Table B1)*

Improvement Target 1a: 100% of patients seen at the Brazoria County Indigent Primary Care Clinic are screened for depression using the PHQ-9 at least one time per year (N=600).

Improvement Target 1b: 100% of patients with a positive screening for depression receive a clinical evaluation to validate the findings.

Improvement Target 1c: 80% of patients determined to be depressed by PHQ-9 and clinical validation are referred for counseling and/or received pharmacological treatment.

Rationale: Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression. Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.

Measure: Screening for depression will be conducted for all patients at each encounter using the PHQ-9._The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure also promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.

Follow-Up Plan: Initial data regarding follow-up on screening will include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider. For patients who are referred details of the treatment plan will be "measured". This process will be developed in Year 2 but will at a minimum include: presence of the plan, evidence that the plan was developed in collaboration with the primary care provider, the counselor, and the patients.

.

109372601.3.5	IT-1.8	Depression Management: Screening and Treatment Plan for Clinical Depression	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects:	109372601.2.2		
Starting Point/Baseline:	Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2 Establish Baseline Rates Metrics: PHQ-9; patient reported behavioral/mental health diagnosis; clinician established diagnosis of behavioral/mental or behavioral health problems Data Source: Health records **Milestone 1: At the end of Year 2, baseline data is collected regarding the behavioral/mental health needs of all patients in the program.** **Process Milestone 2** P-3 Develop and test data systems for identifying need Metrics: PHQ-9, patient self-report and clinician data in record **Milestone 2: By the end of Year 2, the process for identifying behavioral and behavioral/mental health needs in the patient population is established.** **Process Milestone 3** P-3 Develop and test data systems for communication between clinicians. Metrics: Referral forms and referral response forms. Minutes of meetings to clarify processes to optimize	**Process Milestone 4** P-4 QI processes using PDSA cycles are used to implement integration of the practice. Metrics: Records of QI meetings, copies of PDSA reports and outcomes **Milestone 4: By the end of Year 3, the QI process for implementing the integration of primary care and behavioral/behavioral/mental health services at Brazoria Clinic is established.** Process Milestone 4 Estimated Incentive Payment*: $*17,392.50 **Process Milestone 5** P-4 QI processes using PDSA cycles are used to develop and implement methods to collect outcome and evaluation data. Metrics: Copies of PDSA reports; final data collection protocol **Milestone 5: By the end of Year 3, a process for collecting data to measure project outcomes is established.** Process Milestone 5 Estimated Incentive Payment*: $*17,392.50	**Outcome Improvement Target 1** IT-1.8 Depression management : Screening and Treatment Plan for Clinical Depression Non-standalone measure a) Numerator: patient's screening for clinical depression using a standardized tool and follow-up plan is documented (tool: RQP 9 Follow-up plan Eligibility/not appropriate must be documented following criteria Denominator: all patients age 18 and older during the reporting period Data source: EHR Rationale: Detection of depression in the primary care setting is suboptimal but screening efforts can improve detection and successful treatment with *adequate follow-up.* **Improvement Target 1a: 100% of patients seen at the Brazoria County Indigent Primary Care Clinic are screened for depression using the PHQ-9 at least one time per year (N=600).**	**Outcome Improvement Target 1** IT-1.8 Depression management : Screening and Treatment Plan for Clinical Depression Non-standalone measure a) Numerator: patient's screening for clinical depression using a standardized tool and follow-up plan is documented (tool: RQP 9 Follow-up plan Eligibility/not appropriate must be documented following criteria Denominator: all patients age 18 and older during the reporting period Data source: EHR Rationale: Detection of depression in the primary care setting is suboptimal but screening efforts can improve detection and successful treatment with *adequate follow-up.* **Improvement Target 1a: 100% of patients seen at the Brazoria County Indigent Primary Care Clinic are screened for depression using the PHQ-9 at least one time per year (N=900).**

109372601.3.5	IT-1.8	Depression Management: Screening and Treatment Plan for Clinical Depression	
The University of Texas Medical Branch at Galveston			**109372601**
Related Category 1 or 2 Projects:	**109372601.2.2**		
Starting Point/Baseline:	**Year 2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
communication while protecting PHI. **Milestone 3: AT the end of Year 2, communication processes are in place to assure optimal communication between providers while protecting PHI.**		Outcome Improvement Target 1a Estimated Incentive Payment*:* $12,404 **Improvement Target 1b: 100% of patients with a positive screening for depression receive a clinical evaluation to validate the findings.** Outcome Improvement Target 1b Estimated Incentive Payment*:* $12,404 **Improvement Target 1c: 80% of patients determined to be depressed by PHQ-9 and clinical validation are referred for counseling and/or received pharmacological treatment.** Outcome Improvement Target 1c Estimated Incentive Payment*:* $12,404	Outcome Improvement Target 1a Estimated Incentive Payment*:* $26,965.33 **Improvement Target 1b: 100% of patients with a positive screening for depression receive a clinical evaluation to validate the findings.** Outcome Improvement Target 1b Estimated Incentive Payment*:* $26,965.33 **Improvement Target 1c: 80% of patients determined to be depressed by PHQ-9 and clinical validation are referred for counseling and/or received pharmacological treatment.** Outcome Improvement Target 1c Estimated Incentive Payment*:* $26,965.33
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $34,785	Year 4 Estimated Outcome Amount: $37,212	Year 5 Estimated Outcome Amount: $80,896
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $152,893			

CATEGORY 3: QUALITY IMPROVEMENT

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET)

Outcome Measure: OD-1 Primary Care and Chronic Disease Management

Project Option: IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) *(Standalone measure) Table B2)*

Project Title: Expanding Integrated Primary Care and Behavioral /Mental Health Care Access using Advanced Practice Clinicians

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.6

RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch/109372601

OUTCOME MEASURE DESCRIPTION:

Process measures focused on remission of depression with focus on P-3, Develop and Test Data Systems, and P-4, QI Processes. During Year 2 we will address best practices for communicating between primary care and behavioral/mental health providers to assure that mechanisms for referral and collaboration between clinicians are efficient and effective. We will also develop the process for collecting data regarding the metrics, remission of depression. Although the PHQ-9 will be the central outcome measure, there will undoubtedly be other data that might indicate the status of the patient's depression. By Year 3 we will be aggressively implementing our Quality improvement Program (P-4, QI processes using PDSA cycles) to assure full integration of primary care and behavioral/mental health care in the practice.

Improvement Measures:

Data regarding patient participation in the integrated practice will be derived from the Practice Management system which can provide reports on appointments made, kept, and "no shows". Patient Satisfaction will be measured using the Nursing Center Patient Satisfaction Tool. The Nursing Center Patient Satisfaction tool was developed and tested by the Michigan Academic Consortium (Benkerk, et al. 2002), a group of affiliated nursing centers in Michigan. It has content validity specific to nurse practitioner practice and has been well received by patients. It has been tested in a multi-site study coordinated by the Nursing Center Research Network (NC-RN) and has been adopted by the nursing center members of the NC-RN as their preferred patient satisfaction tool. This tool was chosen because of the patient-centered nature of the questions. Sample questions include "the office staff showed me respect and courtesy;" "the clinician considered my beliefs about health and healing;" and "I am treated the same as other people who get care here."

Benkert, R., Barkauskas, V., Pohl, J., Corser, W., Tanner, C., Wells, M., Nagelkirk, J. (2002). Patient satisfaction outcomes in nurse-managed centers. Outcomes Management, 6 (4), 174-181.

Evidence of the level of integration between primary care and behavioral/mental/behavioral health will include screenshots of the integrated health record that reflect structured team meetings and integrated plans of care.

OUTCOME MEASURE VALUATION

IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710)
(Standalone measure) Table B2)

Improvement Target 2: 25% of patients identified as depressed and referred for counseling and/or receiving pharmacotherapy are in remission 12 months after initial diagnosis.

Rationale: To truly know the impact of an integrated practice model on behavioral/mental health, it is essential to monitor the disease over time. The PHQ-9 is ideally suited to this task as it directly reflects the DSM-4 criteria used to make the diagnosis of depression. At the intergrated practices in Brazoria, the PHQ-9 will be administered at all visits.

Measure: To analyze the impact of the practice on patients health, starting in Year 3, every 6 months the most recent PHQ-9 score of all adults (>18) in the practice who had an initial score of PHQ-9 indicating depression will be compared (numerator) with their initial score indicating depression (> 9) (denominator). As described in the RHP Planning Protocol, patients will be excluded if they meet identified exclusion criteria.

Follow-Up Plan: Initial data regarding follow-up on screening will include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider. For patients who are referred details of the treatment plan will be "measured". This process will be developed in Year 2 but will at a minimum include: presence of the plan, evidence that the plan was developed in collaboration with the primary care provider, the counselor, and the patients.

109372601.3.6	IT-1.9	Depression Remission at Twelve Months	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects:	109372601.2.2		
Starting Point/Baseline:	Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-3 Develop and test data systems for communication between clinicians. Metrics: Referral forms and referral response forms. Minutes of meetings to clarify processes to optimize communication while protecting PHI. **Milestone 1: At the end of Year 2, communication processes are in place to assure optimal communication between providers while protecting PHI.**	**Process Milestone 2** P-4 QI processes using PDSA cycles are used to implement integration of the practice. Metrics: Records of QI meetings, copies of PDSA reports and outcomes **Milestone 2: By the end of Year 3, the QI process for implementing the integration of primary care and behavioral/behavioral/mental health services at Brazoria Clinic is established.** Process Milestone 2 Estimated Incentive Payment*: $*17,393 **Process Milestone 3** P-4 QI processes using PDSA cycles are used to develop and implement methods to collect outcome and evaluation data. Metrics: Copies of PDSA reports; final data collection protocol **Milestone 3: By the end of Year 3, a process for collecting data to measure project outcomes is established.** Process Milestone 3 Estimated Incentive Payment*: $*17,393	**Outcome Improvement target 1** IT-1.9 Depression management : Depression Remission at Twelve Months Standalone measure a)numerator: adults age 18 and older with a dx of major depression or dysthmia and an initial PHQ 9 score greater than nine who achieve remission at 12 mo as demonstrated by 12 mo (+/- 30 days)PHQ-9 score of less than five. B) Denominator: adults age 18 and older with a dx of major depression or dysthmia and initial sPHQ-9 score greater than 9. Data source: EMR d) rationale: **Improvement Target 2: 25% of patients identified as depressed and referred for counseling and/or receiving pharmacotherapy are in remission 12 months after initial diagnosis.** Outcome Improvement Target 2 Estimated Incentive Payment*:* $37,212	**Improvement Target 2** IT-1.9 Depression management : Depression Remission at Twelve Months Standalone measure a)numerator: adults age 18 and older with a dx of of major depression or dysthmia and an initial PHQ 9 score greater than nine who achieve remission at 12 mo as demonstrated by 12 mo (+/- 30 days)PHQ-9 score of less than five. B) Denominator: adults age 18 and older with a dx of major depression or dysthmia and and initial sPHQ-9 score greater than 9. Data source: EMR d) rationale: **Improvement Target 2: 25% of patients identified as depressed and referred for counseling and/or receiving pharmacotherapy are in remission 12 months after initial diagnosis.** Outcome Improvement Target 2 Estimated Incentive Payment*:* $37,212

109372601.3.6	IT-1.9	Depression Remission at Twelve Months	
The University of Texas Medical Branch at Galveston			109372601
Related Category 1 or 2 Projects:	109372601.2.2		
Starting Point/Baseline:	Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $34,7866	Year 4 Estimated Outcome Amount: $37,212	Year 5 Estimated Outcome Amount: $80,896
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 152,893			

TITLE OF OUTCOME MEASURE (IMPROVEMENT TARGET):
Outcome Measure: OD-5 Cost of Care
Project Option: IT-5.3: Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). (Standalone measure)

UNIQUE RHP OUTCOME IDENTIFICATION NUMBER: 109372601.3.8
RHP PERFORMING PROVIDER/TPI: The University of Texas Medical Branch at Galveston/109372601

OUTCOME MEASURE DESCRIPTION:
OD-5 Cost of Care
IT-5.3: Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). (Standalone measure)
Process Milestones 1 - 3 (DY2 and DY3):

P-2 Establish baseline rates. During DY2 we will review NQF measures now being implemented via CMS and The Joint Commission and, along with our benchmarking partners, the University Health System Consortium and the Texas Hospital Association, not only establish our own baseline performance for ED throughput, but set goals based on benchmark data.

P-3 Develop and test data systems. Recorded logistic activity from the OR Controls and Emergency Department EMR information systems will be harvested and used to help develop and validate statistical models to optimize the use of all resources. Manual data capture and observational studies will be required to provide information and data about the behaviors of the various staffs involved in all phases of the functioning of the perioperative sub-system. These data and information will be used in the model development, validation, and verification. In parallel, the model will start to be constructed and incrementally tested against the available data as they are collected. This will typically expose variables and/or data needed that were not known in the initial step, and so on – iterating between model development and data collection (but done in "staggered" parallel).
Outcome Improvement Targets 1 and 2 (DY4 and DY5):
IT-5.3 Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1) (Standalone measure)
The baseline and goals for this improvement target will be established in DY2.

Rationale:
There has been national attention on the importance of the emergency department as the front door of the hospital and the challenges of timely care in this demanding setting. As a result, the has been discussion via the National Quality Forum about the harmonization of metrics for ED throughput that has now been institutionalized via CMS' value based purchasing program for measurement in CMS fiscal year 2015 and new capacity management standards from The Joint Commission that go into effect January, 2013. It is a reasonable outcome

measure for this whole systems modeling project because if there are inefficiencies in OR scheduling and management, bed placement, or discharge effectiveness, they will all appear in inefficiencies in ED throughput.

OUTCOME MEASURE VALUATION:

Category 3 Outcomes signify the progress we are making in achieving the triple aim (Improving the care experience, improving the health of the population, reducing per capita costs of health care) for health care transformation in our region. The region adopted a set of valuation guidelines to assist performing providers in assessing and assigning valuation to their projects.

Region 2 Valuation guidelines consist of four critical areas determined to be foundational to all of our region projects:

- Population Affected—Estimate the target population affected by the health/healthcare need and whether the target population includes a significant number of people who are uninsured or on Medicaid.
- Severity-- Estimate the severity of the health/healthcare issue and whether the issue is indicated by the Community Needs Assessment.
- Cost-Effectiveness—Estimate the relative cost of project to the value of services provided to the target population.
- Community Benefit—Estimate the extent to which the project benefits the community and meets the triple aim.

  Final project valuation and funding distribution was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

109372601.3.8	3.IT-5.3	Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1) (Standalone measure)	
The University of Texas Medical Branch Hospital			**109372601**
Related Category 1 or 2 Projects:	**109372601.2.3**		
Starting Point/Baseline:	**The baseline and goals for this improvement target will be established in DY2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates Metric: 30 Day readmission rate for participating member facility Data source: EHR or Medical Record, Claims Goal: Collect and track readmission data for 50% of Region 2 members Rationale: Measurement is a vital first step to improvement Milestone 1 Estimated Incentive Payment *(maximum amount): $*0	**Process Milestone 2 [P-3]:** Develop and test data systems Metric: Periodic reporting of 30 day readmission Data source: EHR, Claims Goal: 50% of members report 30 day readmission on a periodic basis (monthly, quarterly) Rationale: Periodic reporting is a necessary step to improvement and maintenance of goals Milestone 2 Estimated Incentive Payment *(maximum amount):* $99,213	**Outcome Improvement Target 1** [IT-5.3]: Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). Baseline: TBD DY2 Goal: 5% improvement over DY2 baseline Numerator: Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status Denominator: All ED patients admitted to the facility from the ED Data Source: Emergency Department, EMR data Outcome Improvement Target 1 Estimated Incentive Payment: $104,407	**Outcome Improvement Target 2** [IT-5.3]: Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1). Baseline: TBD DY2 Goal: 10% improvement over DY2 baseline Numerator: Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status Denominator: All ED patients admitted to the facility from the ED Data Source: Emergency Department, EMR data Outcome Improvement Target 2 Estimated Incentive Payment: $294,131
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $0	Year 3 Estimated Outcome Amount: $99,213	Year 4 Estimated Outcome Amount: $104,407	Year 5 Estimated Outcome Amount: $294,131

109372601.3.8	3.IT-5.3	Other Outcome Improvement Target: Median time from admit decision time to time of departure from the for all ED patients admitted to inpatient status (NQF 0497 strata ED 2.1) (Standalone measure)	
The University of Texas Medical Branch Hospital			109372601
Related Category 1 or 2 Projects:	109372601.2.3		
Starting Point/Baseline:	The baseline and goals for this improvement target will be established in DY2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $497,751			

SECTION V - CATEGORY 4:

Population-Focused Improvements

Category 4 Population – Focused Improvements
Angleton-Danbury Hospital District – 121805903

Performing Provider Name: Angleton-Danbury Hospital District
Performing Provider TPI #: 121805903
Related Category 1 or 2 Projects: 1.1.1, 1.1.2, 2.9.1
IGT Entity for DYs 1-5: Angleton-Danbury Hospital District
Domain 1: Potentially Preventable Admissions (8 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5
Potentially preventable admission may be impacted by meeting patient needs before they experience exacerbations requiring hospitalization. It is likely that hospital-level potentially preventable admissions reported for Domain 1 will show a decrease during project years due to the impact of the program, depending on the size of the project population relative to the hospital's overall patient population and the degree to which the targeted population makes up those at highest risk for admission of the full population. Our Category 1 and 2 projects will impact RD-1.2 and RD-1.6 directly as there are project that target these specific population and their chronic disease management. Although there are not specific projects targeted to address RD-1.1, RD-1.3, RD-1.4, RD-1.5, RD-1.7, or RD-1.8 with improved access to primary care services as well as navigational services within the community, we anticipate a reduction in these specific preventable admissions.
Valuation and Rational:

	DY3	DY4	DY5	Total DY3-5
Total Value	$46,224	$49,399	$57,527	$153,150
IGT Required	$19,260	$20,582	$23,969	$23,812

Total Category 4 value for each year was calculated as a minimum required for category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable; too avoid emphasis on reporting one domain over the others requested in Category 4.
Systems Changes Necessary to Successfully Report Category 4:
Most processes are in place to gather raw data required for reporting in each domain. Key personnel will process the data and prepare/submit reports required for Category 4.
Domain 2: 30 Day Readmission (7 Measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5
ADHD will report on RD-2.2 and RD-2.6 as related to our projects in Category 1-3 in an effort to gain information on/and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principle diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. ADHD expects that its provision of expanded primary care services through existing local clinics, new clinics, and patient navigational services will allow patients recently discharged from the hospital to access follow up care and support, thereby preventing the likelihood of potentially preventable readmissions. Additionally, ADHDs Category 3 outcome measures (Right Care Right Setting) relates to this reporting domain because patients who are readmitted to the hospital often enter through the ED when their chronic condition worsens subsequent to discharge. Expanded access to primary care and

support at local clinics should have a positive impact on the rate of readmissions to the hospital through the ED.

Valuation / Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$46,224	$49,399	$57,527	$153,150
IGT Required	$19,260	$20,582	$23,969	$23,812

Total Category 4 value for each year was calculated as a minimum required for category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable; too avoid emphasis on reporting one domain over the others requested in Category 4.

System Changes Necessary to Successfully Report Category 4:

Most processes are in place to gather raw data required for reporting in each domain. Key personnel will process the data and prepare/submit reports required for Category 4.

Domain 3: Potentially Preventable Complications (64 Measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5

Potentially Preventable Complications (PPCs) are not expected to be explicitly impacted by these projects. However, there are other quality initiatives being conducted by the hospital towards this end.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value		$49,399	$57,527	$106,926
IGT Required		$20,582	$23,969	$23,812

Total Category 4 value for each year was calculated as a minimum required for category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable; too avoid emphasis on reporting one domain over the others requested in Category 4.

System Changes Necessary to Successfully Report this Domain:

Most processes are in place to gather raw data required for reporting in each domain. Key personnel will process the data and prepare/submit reports required for Category 4.

Domain 4: Patient-Centered Healthcare (2 Measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5

ADHD Category 1-3 projects will have an indirect impact on the Domain 4. The Patient Navigator model that will be utilized by this project will provide support to targeted patients while they are in the hospital and when they leave the hospital. Thus, patients who are admitted to the hospital might be expected to respond favorably to their hospital experience, particularly their care upon leaving the hospital. The targeted population will also be educated regarding their discharge medication list and instruction. In addition, the improved access to primary care services will also aid in patient education in their disease management and medication. Overall Domain 4 measures are tied to the hospital processes, which will not be directly impacted by our projects.

Valuation and Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$46,224	$49,399	$57,527	$153,150
IGT Required	$19,260	$20,582	$23,969	$23,812

Total Category 4 value for each year was calculated as a minimum required for category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable; too avoid emphasis on reporting one domain over the others requested in Category 4.

System Changes Necessary to Successfully Report this Domain:

Most processes are in place to gather raw data required for reporting in each domain. Key personnel will process the data and prepare/submit reports required for Category 4.

Domain 5: Emergency Department (1 Measure)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5

ADHD will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. ADHD strives to reduce the number of ED visits. This reporting domain ties in with ADHD's Category 3 outcomes to reduce inappropriate use of the ED; one cause of extended ED departure times results from an overcrowded ED. ADHD category 1 projects intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situations or due to the overburdened primary care system. With improved access ADHD expects to reduce the number of inappropriate ED visits.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$46,224	$49,399	$57,527	$153,150
IGT Required	$19,260	$20,582	$23,969	$23,812

Total Category 4 value for each year was calculated as a minimum required for category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable; too avoid emphasis on reporting one domain over the others requested in Category 4.

System Changes Necessary to Successfully Report this Domain:

Most processes are in place to gather raw data required for reporting in each domain. Key personnel will process the data and prepare/submit reports required for Category 4.

Optional Domain 6: Children ad Adult Core Measures (13 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5

ADHD can statistically report on all the required children core components listed with the exception of the Pediatric Intensive Care Unit and Neonatal Intensive Care Unit statistics. ADHD currently does not have a Pediatric Intensive Care Unit or Neonatal Intensive Care Unit. All adult core measures can be reported on. ADHD Category 1-3 projects will have a direct relationship on these core measures. With improved access to primary care services along with

navigational services in the community to the targeted populations, individuals should have improved disease management and fewer admissions in the inpatient setting.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$46,224	$49,399	$57,527	$153,150
IGT Required	$19,260	$20,582	$23,969	$23,812

Total Category 4 value for each year was calculated as a minimum required for category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable; too avoid emphasis on reporting one domain over the others requested in Category 4.

System Changes Necessary to Successfully Report this Domain:

Most processes are in place to gather raw data required for reporting in each domain. Key personnel will process the data and prepare/submit reports required for Category 4.

Category 4: Population-Focused Measures *Angleton Danbury Medical Center TPI: 121805903*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 237,644	$137,722		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 137,722	$124,478	$143,179
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 137,722	$124,478	$143,179
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$124,478	$143,179
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		CY 2013	CY 2014	CY 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		CY 2013	CY 2014	CY 2015
Planned Reporting Period: 1 or 2		2	2	2

Domain 4 - Estimated Maximum Incentive Amount		$ 137,722	$124,478	$143,179
Domain 5: Emergency Department				
Measurement period for report		CY 2013	CY 2014	CY 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$ 137,722	$124,478	$143,179
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		CY 2013	CY 2014	CY 2015
Planned Reporting Period: 1 or 2		2	2	2
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		CY 2013	CY 2014	CY 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 6 - Estimated Maximum Incentive Amount		$ 137,722	$124,478	$143,179
Grand Total Payments Across Category 4	$237,644	$826,332	$746,868	$859,074

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Baptist Hospitals of Southeast Texas Beaumont ("Baptist")
Performing Provider TPI #: 094148602

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Baptist will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Baptist plans to implement a Category 2 DSRIP project which shares the goal of addressing the root causes of potentially preventable admissions. Specifically, this Chronic Care Management Model project will provide to patients the medical and professional support they need to manage their medications, diet, activity level, and stress, thus reducing the occurrence of acute episodes requiring hospitalization. Therefore, Baptist expects that this project will reduce potentially preventable admissions.
- **Valuation Rationale/Justification** – The value Baptist has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in Baptist will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Baptist values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Baptist will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Baptist intends to address this problem with both of its Category 2 projects. The Chronic Care Management Model project will involve the implementation of a post-discharge planning program for patients suffering from chronic diseases such as heart failure, pneumonia, and myocardial infarctions, preparing these patients for effective self-management and providing them with the necessary support resources. Additionally, the Expand

Transitions Program project will make care transition services available through a community-wide network and support system for Medicare, Medicaid, and uninsured patients diagnosed with heart failure. Because more patients will be receiving appropriate follow-up care under these Category 2 projects, Baptist expects that the rate of potentially preventable readmissions will decrease.

- **Valuation Rationale/Justification** - The value Baptist placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at Baptist will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Baptist values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Baptist will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Baptist is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Baptist believes that its two Category 2 projects will have the effect of reducing post-discharge complications for patients, since these projects will allow Baptist to more effectively manage the discharge transition for certain patients. While the specific measures to be reported in this domain involve in-hospital complications, Baptist believes that it must holistically emphasize the need to reduce post-discharge complications as well, rather than focusing on the provision of quality care to patients in one setting to the exclusion of other settings. However, Baptist understands that the reporting criteria will be met on an inpatient basis only.

- **Valuation Rationale/Justification** - The value Baptist placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Baptist values this reporting domain at $182,382 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Baptist will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Baptist is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Baptist expects improved patient satisfaction and effective medication management protocols for inpatients to correlate with Baptist's projects to improve care transitions and to strengthen outpatient care models for chronic conditions such as heart failure and pneumonia, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). Baptist currently does not have the capability to generate reports regarding Medication Management; reporting on these measures would require Baptist to review all individual patient charts manually, and Baptist currently lacks the staff and infrastructure needed to conduct such activities. Therefore, Baptist seeks a waiver from reporting on Domain 4's Medication Management measures in DY3. Baptist plans to implement a CPOE system by October 1, 2014, which will enable Baptist to report on the Medication Management measures in DY4 and DY5.
- **Valuation Rationale/Justification** - The value Baptist placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Baptist and how well Baptist performs its primary care and post-discharge functions. Baptist is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Southeast Texas is costly to patients' health and to the delivery system, and Baptist believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the Southeast Texas community. Baptist values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – Baptist will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of Baptist's overall goals and one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Baptist intends to expand post-discharge support for patients suffering from chronic health care conditions, which Baptist expects will reduce the number of inappropriate ED visits. This specific aspect of Baptist's chronic disease project will have a positive impact on RD-5.

- **Valuation Rationale/Justification** - The value Baptist placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Baptist values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures (13 measures)

- **Description** - Baptist will report on CMS' Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. Baptist is committed to providing quality care to all patients, regardless of ability to pay. Accordingly, Baptist has developed and plans to implement two Category 2 projects which will improve the quality of care for Baptist's inpatient and outpatient populations.
- **Valuation Rationale/Justification** – The value Baptist placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices. Understanding our starting point and tracking our improvement is essential to making progress. Baptist values this reporting domain at $264,074 over Demonstration Years 3-5.

96324-3

Category 4: Population-Focused Measures Baptist Hospitals of Southeast Texas Beaumont – TPI: 094148602				
	Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$140,953	$81,692		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$87,391	$94,991
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		N/A	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		N/A	1	1
Domain 4 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30

Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP 5 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 6 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Grand Total Payments Across Category 4	$140,953	$490,152	$524,348	$569,943

96324-3

Category 4 Population Focused Improvements
Brazosport Regional Health System
Performing Provider Name: Brazosport Regional Health System (BRHS), Brazosport Regional Lake Jackson Family Medicine Center, Brazosport Regional Urgent Care Center
Performing Provider TPI #: 112671602
Valuation and Rationale
Total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in Domains 1 through 5. Accordingly we have opted to set our percentages at 9% for all allowable Demonstration Years. Overall allocations for Category 4 from Pass I net to achieve the required and allowable targeted percentage, by year, for the overall plan for Brazosport Regional Health System DSRIP plan. As we are not participating as a provider in Pass II or Pass III, there will be no gross or net effect of Pass II or Pass III on our allocation amounts or percentages.

System Changes Necessary to Successfully Report Category 4:

Domain 1: Potentially Preventable Admissions (8 measures)
Unique Category 4 Domain Identifier: 112671602.4.2

Domain Description
We anticipate that Potentially Preventable Admissions will be affected by addressing patient needs as targeted through and as an extension of our DSRIP proposals. Specifically:

- 112671602.1.1 Expand Primary Care Capacity
    - This project increases primary care capacity for the primary service area of Brazosport Regional Health System while focusing especially on establishing primary care for the Medicaid and uninsured populations.
    - The targeted metric for this project is Percent Improvement over baseline of patient satisfaction scores, but Primary Care and Chronic Disease Management as a whole should also be impacted in a positive manner. The focus on patient satisfaction is to gauge how effectively we are meeting the needs of the population in providing additional appointment availabilities and hopefully decreased preventable admission rates at the hospital.
- 112671602.2.2 Expanding Chronic Care Management Model for Diabetes
    - This project focuses on increasing the chronic care management of the diabetic patient population at LJFMC. The project also plans to expand on the patient capacity in the chronic care management model and addresses the Domain's Diabetes Admission rates measure.
    - The targeted metric for this project is Primary Care and Chronic Disease Management.

Through improvements sought through these proposed projects, we would surmise and anticipate improvements in our abilities to more appropriately accommodate patients' needs and manage their care in a way that should be reflected in a decrease of what is defined as Potentially Preventable Admissions.

Brazosport Regional Health System anticipates that an improvement and expansion of our primary care services and our chronic disease management program, specifically for diabetes, will provide the environment in which our patients will be better able to manage their health and avoid potentially preventable admissions as an inpatient at Brazosport Regional Health System.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Unique Category 4 Domain Identifier: 112671602.4.3

Domain Description
We anticipate that Potentially Preventable Re-admissions will be affected by addressing patient needs as targeted through and as an extension of our DSRIP proposals. Specifically:

- 112671602.1.1 Expand Primary Care Capacity
    - This project increases primary care capacity for the primary service area of Brazosport Regional Health System while focusing especially on establishing primary care for the Medicaid and uninsured populations. This project will likely address the domain's 30-day readmission rates for chronic illnesses such as CHF and COPD.
    - The targeted metric for this project is Percent Improvement over baseline of patient satisfaction scores, but Primary Care and Chronic Disease Management as a whole should also be impacted in a positive manner. The focus on patient satisfaction is to gauge how effectively we are meeting the needs of the population in providing additional appointment availabilities.
- 112671602.2.2 Expanding Chronic Care Management Model for Diabetes
    - This project focuses on increasing the chronic care management of the diabetic patient population at LJFMC. The project also plans to expand on the patient capacity in the chronic care management model and addresses the Domain's Diabetes 30-day Readmission rates.
    - The targeted metric for this project is Primary Care and Chronic Disease Management.

Many of the proposed projects listed above specifically target improvements in Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates. We believe that improvements achieved in these areas will be reflected in the data provided in the domain over the course of the 1115 reporting periods.

Domain 3: Potentially Preventable Complications (64 measures)
Unique Category 4 Domain Identifier: 112671602.4.4

Domain Description
We anticipate that Potentially Preventable Admissions will be affected by addressing patient needs as targeted through and as an extension of our DSRIP proposals. Specifically:

- 112671602.1.1 Expand Primary Care Capacity

    - This project increases primary care capacity for the primary service area of Brazosport Regional Health System while focusing especially on establishing primary care for the Medicaid and uninsured populations.
    - The targeted metric for this project is Percent Improvement over baseline of patient satisfaction scores, but Primary Care and Chronic Disease Management as a whole should also be impacted in a positive manner. The focus on patient satisfaction is to gauge how effectively we are meeting the needs of the population in providing additional appointment availabilities.
- 112671602.2.2 Expanding Chronic Care Management Model for Diabetes
    - This project focuses on increasing the chronic care management of the diabetic patient population at LJFMC. The project also plans to expand on the patient capacity in the chronic care management model and addresses the Domain's Diabetes Potentially Preventable Complications.
    - The targeted metric for this project is Primary Care and Chronic Disease Management.

This broad reporting category is comprised of 64 measures targeted at understanding and improving the cause of Potentially Preventable Complications in the health of our patients. While we anticipate that the proposed projects listed above will certainly help to better understand and improve the outcomes in the measures over time, we recognize that the data in this category cannot be used to show a statistical link to the actions taken through our projects. As a general theory, by providing primary care and preventative care to those patients who do not otherwise have access to care, such as the Medicaid and/or uninsured population, the potentially preventable complications of an inpatient setting associated with the outpatient primary care will decrease. In a sense, these metrics can better inform BRHS of areas in greatest need, particularly within the targeted Medicaid population, but will not be used to show improvement.
The efforts of the Brazosport Regional Health System project proposals are aimed at providing primary care and chronic disease management to improve the overall health of the community and the specific complications for which reporting must be made in this domain do not exactly match our chosen projects. Our projects are strictly for outpatient clinic use and their effects will not be directly measured using any type of inpatient measure, such as those described in the domain. The positive impacts may be seen in the hospital statistics, but there is no manner in which to reasonably quantify the effects of efforts in an outpatient setting with what occurs internally at the hospital.

Domain 4: Patient-Centered Healthcare (2 measures)
Unique Category 4 Domain Identifier: 112671602.4.5

Domain Description
We anticipate that improvements in the two, Patient-Centered Healthcare measures will be affected by addressing patient needs as targeted through and as an extension of the following DSRIP proposals:

- 112671602.1.1 Expand Primary Care Capacity
    - This project increases primary care capacity for the primary service area of Brazosport Regional Health System while focusing especially on establishing primary care for the Medicaid and uninsured populations.
    - The targeted metric for this project is Percent Improvement over baseline of patient satisfaction scores, but Primary Care and Chronic Disease Management as a whole should also be impacted in a positive manner. The focus on patient satisfaction is to gauge how effectively we are meeting the needs of the population in providing additional appointment availabilities.
- 112671602.2.2 Expanding Chronic Care Management Model for Diabetes
    - This project focuses on increasing the chronic care management of the diabetic patient population at LJFMC. The project also plans to expand on the patient capacity in the chronic care management model and addresses the needs of the patient population through unprecedented efforts in the community.
    - The targeted metric for this project is Primary Care and Chronic Disease Management.

One of the proposed projects listed above specifically targets improvements in Patient Satisfaction, one of the two targeted measures. We have aimed to implement a patient satisfaction survey in the outpatient setting, but also believe that outpatient improvements can be seen in the inpatient HCAHPS survey, though not statistically linked to the outpatient efforts of the projects. Though Medication Management is not specifically addressed, we believe that improvements in Chronic Disease Management with emphasis on diabetes management will be reflected in the overall improved management of our patients' medication(s) in an inpatient setting, but not in a way that they can be statistically linked.
The efforts of the Brazosport Regional Health System project proposals are aimed at providing primary care and chronic disease management to improve the overall health of the community and the specific complications for which reporting must be made in this domain do not exactly match our chosen projects. Our projects are strictly for outpatient clinic use and their effects will not be directly measured using any type of inpatient measure, such as those described in the domain. The positive impacts may be seen in the hospital statistics, but there is no manner in which to reasonably quantify the effects of efforts in an outpatient setting with what occurs internally at the hospital.

Domain 5: Emergency Department (1 measure)
Unique Category 4 Domain Identifier: 112671602.4.6

Domain Description
We anticipate that the Emergency Department measures will be most impacted by the following DSRIP proposals:

- 112671602.1.1 Expand Primary Care Capacity
    - This project increases primary care capacity for the primary service area of Brazosport Regional Health System while focusing especially on establishing

primary care for the Medicaid and uninsured populations. This project addresses the domain's admit decision time to ED departure by improving the continuity of care between a primary care clinic associated with the hospital and an emergency department visit preceding an admission.

- The targeted metric for this project is Percent Improvement over baseline of patient satisfaction scores, but Primary Care and Chronic Disease Management as a whole should also be impacted in a positive manner. The focus on patient satisfaction is to gauge how effectively we are meeting the needs of the population in providing additional appointment availabilities. The additional measurements completed in the project include measuring the increased capacity of the primary care clinic. With increased patient volume, especially from those patients with Medicaid or without insurance, the relationship between the hospital and the outpatient primary care clinic will hopefully shorten the time due to health information already available on the patient.

This domain has a very narrow focus in the required reporting metric; admit decision time to ED departure time for admitted patients. As such few, if any, of our proposed projects specifically address this metric. However, improvements achieved through our ability to manage performance improvement and to improve the management of patients before they enter the Emergency Department, through prior established care at the primary care clinic, should be reflected in improvements in the flow of patients at BRHS and throughout other participating facilities in the region.

Optional Domain 6: Children and Adult Core Measures (8 measures)
Unique Category 4 Domain Identifier: 112671602.4.7

Domain Description

The measures in this domain are fairly broad data set, which (as in Domain 5) we anticipate will be improved through the effect of overall improvements driven by our proposed projects. Many of the measures in this domain are the same as, or similar to those in other domains, and we would expect the improvements to reflect those results consistently across the domains, specifically those related to readmissions, admissions, and the management of specific chronic disease diagnoses, specifically diabetes in the case of our Category 2 project.

As such, we would anticipate that the broad spectrum of improvements made by expanding primary care and focus on chronic disease management will potentially be reflected in the measures specific to Domain 6.

Category 4: Population-Focused Measures *Brazosport Regional Health System* *Performing Provider TPI #: 112671602*				
	Year 2 (10/1/2012 - 9/30/2013)	Year 3 (10/1/2013 - 9/30/2014)	Year 4 (10/1/2014 - 9/30/2015)	Year 5 (10/1/2015 - 9/30/2016)
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1,2,3,4,5	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3		
Estimated Maximum Incentive Amount	$1,236,432.00	$238,864.33		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$238,864.34	$255,529.34	$ 277,749.34
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2: Estimated Maximum Incentive Amount		$238,864.34	$255,529.34	$ 277,749.34
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3: Estimated Maximum Incentive Amount			$255,529.33	$277,749.33
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		April 1 – Sept 30	April 1 – Sept 30	April 1 - Sept 30
Planned Reporting Period: 1 or 2		2	2	2

Medication Management				
Measurement period for report		April 1 - Sept 30	April 1 - Sept 30	April 1 - Sept 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 4: Estimated Maximum Incentive Amount		$238,864.33	$255,529.33	$277,749.33
Domain 5: Emergency Department				
Measurement period for report		April 1 - Sept 30	April 1 - Sept 30	April 1 - Sept 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 5: Estimated Maximum Incentive Amount		$238,864.33	$255,529.33	$277,749.33
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		April 1 - Sept 30	April 1 - Sept 30	April 1 - Sept 30
Planned Reporting Period: 1 or 2		2	2	2
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		April 1 - Sept 30	April 1 - Sept 30	April 1 - Sept 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 6: Estimated Maximum Incentive Amount		$238,864.33	$255,529.33	$277,749.33
Grand Total Payments Across Category 4	**$1,236,432.00**	**$1,433,186.00**	**$1,533,176.00**	**$1,666,496.00**

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: CHRISTUS Hospital – St. Elizabeth and St. Mary
Performing Provider TPI #: 138296208

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – CHRISTUS St. Elizabeth will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. CHRISTUS St. Elizabeth plans to implement a Category 1 DSRIP project with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will expand regional primary care capacity by establishing two new primary care clinics. CHRISTUS St. Elizabeth expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. CHRISTUS St. Elizabeth also believes that the increased availability of primary care services in the Southeast Texas community will allow potentially harmful and expensive health conditions to be detected and treated early and inexpensively.
- **Valuation Rationale/Justification** – The value CHRISTUS St. Elizabeth has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at CHRISTUS St. Elizabeth will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. CHRISTUS St. Elizabeth values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – CHRISTUS St. Elizabeth will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. CHRISTUS St. Elizabeth expects that its improvement of access to primary care services through

establishing additional primary care clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Additionally, CHRISTUS St. Elizabeth plans to implement a Category 2 project which will directly target potentially preventable readmissions by establishing team-based clinics to address complex chronic diseases such as congestive heart failure, diabetes, COPD and asthma; these clinics will provide better post-discharge planning and care management for patients diagnosed with these chronic conditions.

- **Valuation Rationale/Justification** - The value CHRISTUS St. Elizabeth placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at CHRISTUS St. Elizabeth will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. CHRISTUS St. Elizabeth values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – CHRISTUS St. Elizabeth will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and CHRISTUS St. Elizabeth is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. CHRISTUS St. Elizabeth expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of CHRISTUS St. Elizabeth's Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout CHRISTUS St. Elizabeth.
- **Valuation Rationale/Justification** - The value CHRISTUS St. Elizabeth placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for

institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. CHRISTUS St. Elizabeth values this reporting domain at $182,382 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – CHRISTUS St. Elizabeth will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. CHRISTUS St. Elizabeth is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. CHRISTUS St. Elizabeth expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with CHRISTUS St. Elizabeth's projects to strengthen primary care access in the Southeast Texas community and to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). The intervention provided by our projects include patient navigation, internal follow up by CHWs, helping patients by Community Healthcare Workers, helping patients establish a medical home, and guiding them into palliative care when appropriate. Those interventions are relationship oriented with the patient in their clinical work. It is that type of increased relationship, direct, and individual that leads to patient centered healthcare.
- **Valuation Rationale/Justification** - The value CHRISTUS St. Elizabeth placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from CHRISTUS St. Elizabeth and how well CHRISTUS St. Elizabeth performs its primary care and post-discharge functions. CHRISTUS St. Elizabeth is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Southeast Texas is costly to patients' health and to the delivery system, and CHRISTUS St. Elizabeth believes that its hospital services must leave these patients

satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the Southeast Texas community. CHRISTUS St. Elizabeth values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – CHRISTUS St. Elizabeth will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. CHRISTUS St. Elizabeth intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the Southeast Texas community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which CHRISTUS St. Elizabeth expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

  Use of the Emergency Department will be directly influenced by CHRISTUS St. Elizabeth projects. When patients are properly navigated from within the ED, they are less likely to continue using the ED inappropriately. Navigators will address the route for them to the most appropriate healthcare. Community Healthcare Workers will provide the needed intense follow up, and the FQHC will provide a medical home for them more appropriate. Together with the preventive care provided by addressing chronic diseases, ED use will be reduced.
- **Valuation Rationale/Justification** - The value CHRISTUS St. Elizabeth placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. CHRISTUS St. Elizabeth values this reporting domain at $264,074 over Demonstration Years 3-5.

Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures (13 measures)

- **Description** - CHRISTUS St. Elizabeth will report on CMS' Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. CHRISTUS St. Elizabeth is committed to providing quality care to all patients,

regardless of ability to pay. Accordingly, CHRISTUS St. Elizabeth has developed and plans to implement a Category 1 project and a Category 2 project which will improve the quality of care for CHRISTUS St. Elizabeth's inpatient and outpatient populations.

- **Valuation Rationale/Justification** – The value CHRISTUS St. Elizabeth placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices. Understanding our starting point and tracking our improvement is essential to making progress. CHRISTUS St. Elizabeth values this reporting domain at $264,074 over Demonstration Years 3-5.

Category 4: Population-Focused Measures CHRISTUS Hospital – St. Elizabeth and St. Mary – TPI: 138296208				
	Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$140,955	$81,692		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$87,391	$94,991
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1

Domain 5 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 6 - Estimated Maximum Incentive Amount		$81,692	$87,391	$94,991
Grand Total Payments Across Category 4	$140,955	$490,152	$524,348	$569,943

96326-2

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: CHRISTUS Jasper Memorial Hospital
Performing Provider TPI #: 112706003

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – CHRISTUS Jasper will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. CHRISTUS Jasper plans to implement several Category 2 projects with the shared goal of addressing some root causes of potentially preventable admissions. Specifically, CHRISTUS Jasper plans to implement a Pre-Diabetes Intervention project that will educate the Southeast Texas pre-diabetes population regarding this condition, and provide better access to outpatient care for the condition. CHRISTUS Jasper expects that this project will reduce potentially preventable admissions by making it easier for more pre-diabetes patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. CHRISTUS Jasper also believes that the successful education of Southeast Texas's pre-diabetes population will enable potentially harmful and expensive health conditions to be detected and treated earlier and more inexpensively. CHRISTUS Jasper will additionally implement a Patient Navigation Program project that will direct patients to the level of care most appropriate to their health care needs; as a result, fewer patients will seek inappropriate inpatient care, and potentially preventable admissions will be reduced.
- **Valuation Rationale/Justification** – The value CHRISTUS Jasper has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at CHRISTUS Jasper will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. CHRISTUS Jasper values this reporting domain at $417,261 over DY 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – CHRISTUS Jasper will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated,

discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. CHRISTUS Jasper expects that its implementation of chronic care models will result in better post-discharge management of patients suffering from chronic health care conditions, reducing the likelihood of unnecessary readmissions by providing community-based care for patients and achieving better outcomes in the outpatient setting.

- **Valuation Rationale/Justification** - The value CHRISTUS Jasper placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at CHRISTUS Jasper will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. CHRISTUS Jasper values this reporting domain at $417,260 over Demonstration Years 3-5. Between 10% and 50% of readmissions are considered to be potentially avoidable. Just over half of 30-day readmissions for all targeted conditions in our projects are for the same major diagnostic category. Patients with chronic diseases are complex. The readmission reduction efforts of our projects address the complexity of chronic disease co- morbidities for maximum effectiveness. By the intense follow up provided by these projects, complex co -morbidities of chronic diseases are targeted, addressed with both quality and access enhancing efforts and results tracked. Such diseases as diabetes, heart failure and asthma are especially out of the locus of control of usual hospital care. The planned interventions will clinically close that gap between the hospital and the outpatient provider.

Domain 3: Potentially Preventable Complications (64 measures)

Description – CHRISTUS Jasper will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and CHRISTUS Jasper is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. CHRISTUS Jasper expects that its expanded provision of primary care interventions and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. CHRISTUS Jasper's Telemedicine for Neurological Care project will allow stroke patients to receive quicker and more effective

treatment, thereby reducing the likelihood of complications for this specific population. By the nature of Potentially Preventable Complications, health interventions that are preventive in scope help to address these. By increasing access to care with interventions to address chronic diseases, hospital stays are reduced. By avoiding a hospital stay, the occurrence of PPCs that are tangent to a stay in the hospital is prevented. By increasing quality, negative outcomes that may result from the process of care and treatment (rather than from the disease itself) are reduced.

- **Valuation Rationale/Justification** - The value CHRISTUS Jasper placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. CHRISTUS Jasper values this reporting domain at $286,617 over DY 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – CHRISTUS Jasper will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. CHRISTUS Jasper is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. CHRISTUS Jasper expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with CHRISTUS Jasper's projects to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). More specifically, CHRISTUS Jasper plans to implement a Category 2 Oncology Navigation project that will focus on providing patient-centered care throughout the course of the cancer treatment process.
- **Valuation Rationale/Justification** - The value CHRISTUS Jasper placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from CHRISTUS Jasper and how well CHRISTUS Jasper performs its primary care and post-discharge functions. CHRISTUS Jasper is committed to improving

patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Southeast Texas is costly to patients' health and to the delivery system, and CHRISTUS Jasper believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the Southeast Texas community. CHRISTUS Jasper values this reporting domain at $417,259 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – CHRISTUS Jasper will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. CHRISTUS Jasper intends to improve follow-up care for discharged patients diagnosed with chronic health conditions, which CHRISTUS Jasper expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions. CHRISTUS Jasper also plans to focus one of its Category 2 projects on the provision of appropriate palliative care to end-of-life patients; this project may have the result of reducing ED overcrowding and ED departure times.
- **Valuation Rationale/Justification** - The value CHRISTUS Jasper placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. CHRISTUS Jasper values this reporting domain at $417,259 over Demonstration Years 3-5.

Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures (13 measures)

- **Description** - CHRISTUS Jasper will report on CMS' Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. CHRISTUS Jasper is committed to providing quality care to all patients, regardless of ability to pay. Accordingly, CHRISTUS Jasper has developed and plans to implement

several Category 1 and 2 projects which will serve the common need of the Southeast Texas community's diverse patient populations for quality and effective care.

- **Valuation Rationale/Justification** – The value CHRISTUS Jasper placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices. Understanding our starting point and tracking our improvement is essential to making progress. CHRISTUS Jasper values this reporting domain at $417,259 over Demonstration Years 3-5.

Category 4: Population-Focused Measures CHRISTUS Jasper Memorial Hospital – TPI: 112706003				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$245,849	$$105,643		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$105,643	$113,457	$118,994
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$105,643	$113,457	118,994
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$113,457	$118,994
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$105,642	$113,456	$118,993
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1

Domain 5 - Estimated Maximum Incentive Amount		$105,642	$113,456	$118,993
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 6 - Estimated Maximum Incentive Amount		$105,642	$113,456	$118,993
Grand Total Payments Across Category 4	$245,849	$633,854	$687,739	$713,961

96332-2

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Liberty Dayton Regional Medical Center

Performing Provider TPI #: 284333601

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** –Liberty Dayton Regional Medical Center (LDRMC) will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. This domain is related to LDRMC Cat. 1 project involving the expansion of primary care capacity in that expanded access to primary care in the clinic setting should help decrease the number of potentially preventable admissions into the hospital, because patients will be receiving earlier interventions and preventative care at primary care clinics before complications escalate into more serious issues that require hospital visits.

- **Valuation**

    - **Rationale/Justification** – The value LDRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in LDRMC's service area will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. LDRMC values this reporting domain at $82,030.00 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – LDRMC will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community without follow-up or support, and

end up back in the hospital inpatient setting soon thereafter. This domain is related to LDRMC's Cat. 1 project involving the expansion of primary care capacity in that expanded access to primary care physicians at clinics should improve follow-up care and thus lower the number of potentially preventable readmissions into the hospital.

- **Valuation**
  - **Rationale/Justification** - The value LDRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in LDRMC's service area will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. LDRMC's values this reporting domain at $82,030.00 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – LDRMC will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and LDRMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. This domain is related to LDRMC's Cat. 1 project involving the expansion of primary care capacity in that having increased access to primary care physicians will lead to greater continuity of care which should increase the knowledge available about patients and their health issues which can prevent complications.

- **Valuation**
  - **Rationale/Justification** - The value LDRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients

and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. LDRMC values this reporting domain at $53,485.00 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – LDRMC will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. In contrast, patients may experience negative health outcomes and be even more unsatisfied. This is related to LDRMC's Category 1 project in that expanding access to primary care in our community will also improve the continuity of care between the hospital and the clinic. Familiarity with their physician and the coordination of care between inpatient and outpatient should improve the patient's satisfaction across all setting including the inpatient setting.

- Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. This domain is related to LDRMC's Cat. 1 project involving the expansion of primary care capacity because there will be increased continuity of care with the same physician attending in both the inpatient and outpatient settings which increases their familiarity with the patient and their medication regiments thus improving all over medication management for the patient.

- **Valuation**

  - **Rationale/Justification** - The value LDRMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from LDRMC and how well LDRMC performs its function of promoting medication management. LDRMC is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Memorial's service area is costly to patients' health and to the delivery system, and LDRMC believes that its hospital services must leave these patients satisfied and confident in the healthcare

delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. LDRMC values this reporting domain at $82,031.00 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – LDRMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. LDRMC is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. This domain is related to LDRMC's Cat. 1 project involving the expansion of primary care capacity in that having increased access to primary care, patients will be better able to receive preventive care and improve care outcomes in the clinic setting before emergency health situations arise that require ER visits and patients will be less reliant on the ED to receive primary care services.

- **Valuation**

    - **Rationale/Justification** - The value LDRMC placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. LDRMC values this reporting domain at $82,030.00 over Demonstration Years 3-5.

Domain 6: Optional Domain—Liberty Dayton Regional Medical Center will not report on this domain

Category 4: Population-Focused Measures *Liberty Dayton Regional Medical Center* *Performing Provider TPI #: 284333601*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$61,465	$28,545		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$28,545	$28,727	$24,758
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$28,545	$28,727	$24,758
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$28,727	$24,758
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$28,546	$28,727	$24,758

Domain 5: Emergency Department				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$28,546	$28,726	$24,758
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		*NA*	*NA*	*NA*
Planned Reporting Period: 1 or 2		*NA*	*NA*	*NA*
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		*NA*	*NA*	*NA*
Planned Reporting Period: 1 or 2		*NA*	*NA*	*NA*
Domain 6 - Estimated Maximum Incentive Amount		*NA*	*NA*	*NA*
Grand Total Payments Across Category 4	**$61,465**	**$142,727**	**$143,634**	**$123,790**

Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Memorial Medical Center of East Texas—Lufkin ("Memorial")

Performing Provider TPI #: 139172412

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Memorial will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. This domain is related to Memorial's Cat. 1 projects involving the expansion of primary care capacity in that expanded access to primary care in the clinic setting should help decrease the number of potentially preventable admissions into the hospital, because patients will be receiving earlier interventions and preventative care at primary care clinics before complications escalate into more serious issues that require hospital visits.
- **Valuation**
    - **Rationale/Justification** – The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in the Memorial's service area will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Memorial's values this reporting domain at $178,906 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Memorial will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community without follow-up or support, and end up back in the hospital inpatient setting soon thereafter. This domain is related to Memorial's Cat. 1 projects involving the expansion of primary care capacity in that expanded access to primary care physicians at clinics should improve the number of potentially preventable readmissions into the hospital. This domain is also related to

Memorial's Cat. 2 projects involving the development and implementation of post-discharge care planning and support processes for patients discharged from the hospital. A comprehensive and reliable post-discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. By concentrating on a coordinated approach by health care providers and providing tools to enable successful adoption of desired compliance, patients will have a greater chance of succeeding in adhering to the discharge plan and thus avoiding readmission.

- **Valuation**
  - **Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in Memorial's service area will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Memorial's values this reporting domain at $178,906 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Memorial will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Like most hospitals, Memorial suffers from shortages of space, staffing, equipment, and protocols for preventing complications like the measures included in this domain, and Memorial is dedicated to ensuring that it takes substantial steps towards improving its provision of healthcare where indicated. Memorial expects that the expanded provision of primary care and enhanced post discharge care coordination provided through Memorial's Cat. 1-2 projects will reduce the volume of unnecessary hospital visits/services, thereby reducing the strain on Memorial's hospital resources (including staff, space, and equipment) which can cause preventable complications for inpatients. Furthermore, with the reduction in avoidable hospital visits/services, Memorial can refocus its efforts and resources on making the change sand/or improvements at the hospital that are needed to help reduce preventable errors and complications for its inpatients. Additionally, having more primary care providers on staff at Memorial will increase the providers' ability to be attentive to the needs of individual patients and reduce the

likelihood of potentially preventable complications that could arise due to staff shortages at Memorial's hospital and clinics.

- **Valuation**
  - **Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial's values this reporting domain at $123,561 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Memorial will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. . Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes. Memorial expects to achieve increased patient satisfaction for inpatients through more effective medication management and Memorial's Cat. 2 projects related to enhanced post-discharge care coordination for the hospital's inpatients, because patients receiving these services will be better prepared to seek and receive the support they need to maintain their health upon discharge from the hospital (including medication management). The domain is also related to Memorial's Cat. 1 projects involving the expansion of primary care capacity in that increasing the availability of primary care services in the hospital and/or clinic setting will decrease the patient backlog for these services at the hospital, and should thereby improve patient satisfaction regarding the timeliness and quality of primary care services provided in the hospital. Lastly, having more primary care providers on staff increases the providers' ability to be attentive to the needs of each individual patient; thereby increasing patient satisfaction with the quality of care received.
- **Valuation**
  - **Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Memorial and how well Memorial performs its function of promoting medication management. Memorial is committed to improving patient

outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Memorial's service area is costly to patients' health and to the delivery system, and Memorial believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Memorial's values this reporting domain at $178,906 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – Memorial will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. Memorial is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. This domain is related to Memorial's Cat. 1 projects involving the expansion of primary care capacity in that having increased access to primary care, patients will be better able to receive preventive care and improve care outcomes in the clinic setting before emergency health situations arise that require ER visits, and patients will be less reliant on the ED to receive primary care services. This domain is also related to Memorial's Cat. 2 projects involving the development and implementation of post-discharge care planning and support processes for patients discharged from the hospital. A comprehensive and reliable post-discharge plan, along with post-discharge support, can reduce the likelihood that discharged patients' conditions will relapse to the point that they require additional ED visits.
- **Valuation**
    - **Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial's values this reporting domain at $178,906 over Demonstration Years 3-5.

<u>Optional</u> Domain 6: Children and Adult Core Measures (8 measures)

Memorial will not be participating in Domain 6.

Category 4: Population-Focused Measures Memorial Medical Center of East Texas– TPI*:* 139172412				
	Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$119,368	$55,345		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$55,345	$59,206	$64,355
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$55,345	$59,206	$64,355
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$59,206	$64,355
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$55,345	$59,206	$64,355
Domain 5: Emergency Department				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$55,345	$59,206	$64,355
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)		N/A	N/A	N/A
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)		N/A	N/A	N/A
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		N/A	N/A	N/A
Grand Total Payments Across Category 4	$119,368	$276,727	$296,030	$321,775

Category 4: Population-Focused Improvements

Performing Provider Name/TPI: **Memorial Hospital/ TPI: 131030203**

Domain 1: Potentially Preventable Admissions

Domain Descriptions:

The measures for Potentially Preventable Admissions (PPAs) can be impacted by the DSRIP projects proposed by Memorial Hospital (MH) that relate to improving Primary and Specialty care and promote care management. In general, the projects identified below will promote quality healthcare, improve patient care management and ensure that appropriate care is provided in the right place at the right time.

Expand Primary Care (131030203.1.1) – this project will expand access to primary care by establishing an additional primary care clinic. The outcome measure identified is to control high blood pressure; this will help prevent PPAs for Congestive Heart Failure (HF), Diabetes, and Hypertension.

Chronic Care Registry (131030203.1.3) – this project will implement a disease management registry at four area clinics. The outcome measure identified is to improve HbA1c control for diabetics; this will help to prevent PPAs for Diabetes. The project will serve all patients with chronic disease; therefore will also impact PPAs for HF, COPD/Asthma, and Hypertension.

Expand Specialty Care (131030203.1.4)-this project will expand access to specialty care by establishing a specialty care clinic. The outcome measure identified is to reduce the AMI 30-day readmission rate; this will indirectly help prevent PPAs for HF and hypertension.

Establish Self-Management Programs for Health Promotion (131030203.2.1) – this project will implement an evidence-based self-management program to improve primary and preventative care for individuals with chronic disease. The outcome measure identified is to improve blood pressure control for diabetics; this will help to prevent PPAs for Diabetes, HF and Hypertension. The project will serve all patients with chronic disease; therefore will also impact PPAs for COPD/Asthma.

Domain Valuation:

The total valuation amount for Domain 1 is $380,801 (for DY3 to DY5). The total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the Memorial Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

Performing Provider Name/TPI: **Memorial Hospital/ TPI: 131030203**
Domain 2: 30 days Readmissions
Domain Descriptions:
The measures for 30-day Readmissions can be impacted by the DSRIP projects proposed by Memorial Hospital (MH) that relate to improving Primary and Specialty care and promote care management. In general, the projects identified below will promote quality healthcare, improve patient care management and ensure that appropriate care is provided in the right place at the right time.

Expand Primary Care (131030203.1.1) – this project will expand access to primary care by establishing an additional primary care clinic. The outcome measure identified is to control high blood pressure; this will help prevent 30-day Readmissions for Congestive Heart Failure (HF), Diabetes, Stroke, and All-Causes.

Chronic Care Registry (131030203.1.3) – this project will implement a disease management registry at four area clinics. The outcome measure identified is to improve HbA1c control for diabetics; this will help to prevent 30-day Readmissions for Diabetes. The project will serve all patients with chronic disease; therefore will also impact 30-day Readmissions for HF, COPD, Stroke, and All-Causes.

Expand Specialty Care (131030203.1.4)-this project will expand access to specialty care by establishing a specialty care clinic. The outcome measure identified is to reduce the AMI 30-day readmission rate; this will indirectly help prevent 30-day Readmissions for HF. This project will improve access to multiple specialties; therefore will also impact 30-day Readmissions for COPD, Diabetes, Stroke, Pediatric Asthma and All-Causes.

Establish Self-Management Programs for Health Promotion (131030203.2.1) – this project will implement an evidence-based self-management program to improve primary and preventative care for individuals with chronic disease. The outcome measure identified is to improve blood pressure control for diabetics; this will help to prevent 30-day Readmissions for Diabetes, HF and Stroke. The project will serve all patients with chronic disease; therefore will also impact 30-day Readmissions for COPD and All-Causes.
Domain Valuation:
The total valuation amount for Domain 2 is $380,800 (for DY3 to DY5). The total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the Memorial Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

Performing Provider Name/TPI: **Memorial Hospital/ TPI: 131030203**

Domain 3: Potentially Preventable Complications
Domain Descriptions:
The measures for Potentially Preventable-Complications (PPCs) can be impacted by the DSRIP projects proposed by Memorial Hospital (MH) that relate to improving Primary and Specialty care and promote care management. In general, the projects identified below will promote quality healthcare, improved patient experience, improved transition of care, and ensure that appropriate care is provided in the right place at the right time. These projects taken in concert improve patient care across the continuum of care and improve the data and knowledge available for each patient. Having better information and knowledge about the patient in the inpatient setting supports providers in detecting and avoiding possible complications while the patient is in the hospital.

Expand Primary Care (131030203.1.1) – this project will expand access to primary care by establishing an additional primary care clinic. The outcome measure identified is to control high blood pressure; this will help reduce PPC rates for Stroke and Intracranial Complications.

Chronic Care Registry (131030203.1.3) – this project will implement a disease management registry at four area clinics. The outcome measure identified is to improve HbA1c control for diabetics; this will also impact PPC rates for Diabetic Ketoacidosis and Coma, Shock, Cellulitis, Moderate Infections and Septicemia and Severe Infections.

Expand Specialty Care (131030203.1.4)-this project will expand access to specialty care by establishing a specialty care clinic. The outcome measure identified is to reduce the AMI 30-day readmission rate; which will impact PPC rates for items 10-16 (access to cardiology). This project will help improve PPC rates for measures 3-8 (access to pulmonary care), 17 – 21 (access to gastroenterology) and 22- 23 (access to urology).

Establish Self-Management Programs for Health Promotion (131030203.2.1) – this project will implement an evidence-based self-management program to improve primary and preventative care for individuals with chronic disease. The outcome measure identified is to improve blood pressure control for diabetics; this will help to reduce PPCs related to diabetes, stroke and cardiology care.

Redesign to Improve Patient Experience (131030203.2.2) - This project will implement processes, specifically a nurse-nurse and nurse-patient/family communication system, at Memorial Hospital to improve the patient experience. The outcome measure identified is to reduce the patient fall rate; this will help to reduce PPCs related to falls, especially item 28 and 64. Improved nurse-patient communication will also impact other PPCs since improved communication will improve the quality of inpatient care.

Domain Valuation:

The total valuation amount for Domain 3 is $262,976 (for DY4 and DY5). The total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the Memorial Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

Performing Provider Name/TPI: **Memorial Hospital/ TPI: 131030203**

Domain 4: Patient-Centered Healthcare
Domain Description:
The measures for Patient-Centered Healthcare (Patient Satisfaction and Medication Management) can be impacted by the DSRIP projects proposed by Memorial Hospital (MH) that relate to improving Primary and Specialty care and promote care management. In general, the project identified below will promote quality healthcare, improve patient experience, improve transition of care, and ensure that appropriate care is provided in the right place at the right time.

Redesign to Improve Patient Experience (131030203.2.2) - This project will implement processes, specifically a nurse-nurse and nurse-patient/family communication system, at Memorial Hospital to improve the patient experience. This project directly impacts patient satisfaction. The 5-year expected outcome for Redesign to Improve Patient Experience is to reduce the Patient Fall Rate at Memorial Hospital. The project expects to improve patient satisfaction with the nurses' response time to the bedside. If nurses are able to respond to the patients in a timely manner, it will prevent patients from getting out of the bed without nurse assistance and reduce falls.
Domain Valuation: The total valuation amount for Domain 4 is $380,799 (for DY3 to DY5). The total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the Memorial Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

Performing Provider Name/TPI: **Memorial Hospital/ TPI: 131030203**

Domain 5: Emergency Department

Domain Description:
The measure for the Emergency Department (admit decision time to ED departure time for admitted patients) can be impacted by the DSRIP projects proposed by Memorial Hospital (MH) that relate to improving Primary and Specialty care and promote care management. In general, the project identified below will promote quality healthcare, improve patient experience, improve transition of care, and ensure that appropriate care is provided in the right place at the right time.

Redesign to Improve Patient Experience (131030203.2.2) - This project will implement processes, specifically a nurse-nurse and nurse-patient/family communication system, at Memorial Hospital to improve the patient experience. This project directly impacts patient satisfaction. The implemented nurse communication system will improve communication between departments and improve the patients' transition from the emergency department to other facilities and/or other hospital departments.

Domain Valuation:
The total valuation amount for Domain 5 is $380,799 (for DY3 to DY5). The total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the Memorial Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

Performing Provider Name/TPI: **Memorial Hospital/ TPI: 131030203**

Optional Domain 6: Children and Adult Core Measures
Domain Descriptions:
The measures for Children and Adult Core Measures can be impacted by the DSRIP projects proposed by Memorial Hospital (MH) that relate to improving Primary and Specialty care and promote care management. In general, the projects identified below will promote quality healthcare, improved patient experience, improved transition of care, and ensure that appropriate care is provided in the right place at the right time.

Expand Primary Care (131030203.1.1) – this project will expand access to primary care by establishing an additional primary care clinic. The outcome measure identified is to control high blood pressure; this will impact Adult Core Measures #7-11, 24 and Children Core Measures #18.

Expand Primary Care – Perinatal Care (131030203.1.2) – this project will expand the capacity of primary care by adding a certified nurse midwife and additional support staff to a Maternal/Child health clinic. The outcome measure identified is to improve prenatal care and to decrease low-birth weight births; this will impact Adult Core Measures #14 and Children Core Measures #3 and 4.

Chronic Care Registry (131030203.1.3) – this project will implement a disease management registry at four area clinics. The outcome measure identified is to improve HbA1c control for diabetics; this will also impact Adult Core Measures #7-11, 24 and Children Core Measures #18.

Expand Specialty Care (131030203.1.4)-this project will expand access to specialty care by establishing a specialty care clinic. The outcome measure identified is to reduce the AMI 30-day readmission rate; which will impact Adult Core Measures #7-11, 24 and Children Core Measures #18.

Establish Self-Management Programs for Health Promotion (131030203.2.1) – this project will implement an evidence-based self-management program to improve primary and preventative care for individuals with chronic disease. The outcome measure identified is to improve blood pressure control for diabetics; which will impact Adult Core Measures #7-11, 15, 24 and Children Core Measures #18.
Domain Valuation:
The total valuation amount for Domain 6 is $380,799 (for DY3 to DY5). The total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the

Memorial Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

Category 4: Population-Focused Measures Memorial Hospital/ TPI: 131030203				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$203,191	$117,822		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$117,824	$125,889	$137,088
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$117,824	$125,889	$137,088
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$125,889	$137,088
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		October 1-September 30	October 1-September 30	October 1-September 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		October 1-September 30	October 1-September 30	October 1-September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive		$117,824	$125,889	$137,088

Amount				
Category 4: Population-Focused Measures Memorial Hospital/ TPI: 131030203				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Domain 5: Emergency Department				
Measurement period for report		October 1-September 30	October 1-September 30	October 1-September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$117,824	$125,889	$137,088
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		October 1-September 30	October 1-September 30	October 1-September 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		October 1-September 30	October 1-September 30	October 1-September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 6 - Estimated Maximum Incentive Amount		$117,822	$125,890	$137,083
Grand Total Payments Across Category 4	$203,191	$706,940	$755,335	$822,523

A. Category 4: Population-Focused Improvements (Hospitals only)

Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital: TPI 200683501

Domain Descriptions:

- RD-1. Potentially Preventable Admissions
- RD-2. 30-day readmissions
- RD-3. Potentially Preventable Complications (PPCs)
- RD-4. Patient-centered Healthcare
- RD-5. Emergency Department

Note:

Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital will not report on RD-6, Initial Core Set of Health Care Quality Measures. SCH does not provide these services in our rural hospital.

Domain Valuation: Preferred Hospital has adopted the regional valuation set forth by RHP 2. 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.

261955689.1.1, 1.1 Expand Primary Care Capacity	Young families with limited resources, particularly Medicaid, and indigent or uninsured patient population.
Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital TPI 200683501, TIN 1261955689 2 003	Opening a new clinic; Extending hours of operations; Training staff; Hiring staff

Domain	Description
Potentially Preventable Admissions	Sabine County Hospital is initiating a project to increase access to primary care. Increasing access to primary care will reduce PPAs. As patients are seen by primary care providers on a regular basis, rather than in the ER when critical situations result, improved care management should result.
Potentially Preventable Readmissions – 30 days	Though we will report this measure, we do not have a DSRIP project directly related to PPRs. With proper follow-up by primary care providers upon discharge at the clinic, PPA's can be avoided or minimized.
Potentially Preventable Complications	Though we will report this measure, we do not have a DSRIP project directly related to PPCs.
Patient-Centered Healthcare	Patient Satisfaction is expected to be impacted as patients are more engaged and direct their health starting with access to primary care. Medication management is not directly related to this project. By having a primary care provider centered base, the patient's care management may be better managed not only medically but financially.
Emergency Department	Though we do not have a project directly tied ED times, we believe that reducing PPVs through expanded access through primary care could increase efficiencies and timeliness in our Emergency Department for our more critical patients. This could impact our NQF 0497 rate.
Children and Adult Core Measures (OPTIONAL)	N/A

Category 4: Population-Focused Measures Preferred Hospital Leasing-Hemphill d.b.a. Sabine County Hospital TPI 200683501				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$68,293	$31,716		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$31,716	$33,796	$36,952
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$31,716	$33,796	$36,952
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$33,796	$36,952
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1		2	2	2
Medication Management				

Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$31,716	$33,796	$36,952
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$31,716	$33,796	$36,952
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A

Domain 6 - Estimated Maximum Incentive Amount		$0.00	$0.00	$0.00
Grand Total Payments Across Category 4	$68,293	$158,580	$169,312	$184,920

Category 4 Population-Focused Improvements
University of Texas Medical Branch Hospital
Performing Provider Name: University of Texas Medical Branch Hospital
Performing Provider TPI #: 094092602
IGT Entity for DYs 1-5: University of Texas Medical Branch Hospital

Valuation and Rational

Total Category 4 value for each year was calculated as the maximum allowed for Category 4 reporting and spread evenly across domains, by project year. We have elected to participate in all domains. Accordingly we have opted to set our percentages at 15% for all allowable Demonstration Years (specifically DY3 through DY5). Overall allocations for Category 4 from Pass I and Pass II net to achieve the required and allowable targeted percentages, by year, for the overall plan for the University of Texas Medical Branch Hospital DSRIP plan. As we are not participating as a provider in Pass III, there will be no gross or net effect of Pass III on our allocation amounts or percentages.

System Changes Necessary to Successfully Report Category 4:

At UTMB, it is anticipated that current available and planned systems and data should adequately meet needs to report in this domain. Health System staff assigned to the 1115 Waiver initiative will be used to assimilate data and prepare/submit reports as required for Category 4.

As stated, "The potentially preventable events measures in Reporting Domains 1 through 3 – Potentially Preventable Readmissions (PPRs), Potentially Preventable Admissions (PPAs), and Potentially Preventable Complications (PPCs) – will be generated by the risk-adjusted 3M tool. HHSC will make this data available to providers."

As required, UTMB will take the data as received from HHSC and enter it into the required reporting templates when requested, as they become available.

Domain 1: Potentially Preventable Admissions (8 measures)
Unique Category 4 Domain Identifier: 094092602.4.2

Domain Description
We anticipate that Potentially Preventable Admissions will be affected by addressing patient needs as targeted though and as an extension of our DSRIP proposals. Specifically:

- 094092602.1.1 Expand Primary Care Access In Galveston and Brazoria Counties
    - This project increases primary care capacity for Galveston and Brazoria counties within UTMB's Community Based Clinics while focusing on controlling high blood pressure of patients.

- The targeted metric for this project is Primary Care and Chronic Disease Management

- 094092602.1.5 Implement and Utilize Disease Management Registry
  - This project implements and utilizes chronic disease registries for diabetes, CHF, asthma, hypertension and COPD. In addition to the registries, the EHR's dash boarding tool, RADAR, will be implemented that will enable providers to view performance at a glance and target patients requiring specific interventions
  - The targeted metric for this project is Primary Care and Chronic Disease Management

- 094092602.1.7 Enhance Performance Improvement and Reporting Capacity
  - This project establishes an improvement collaborative that will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement from subject matter experts, from project staff coaches and from each other. The RHP2 Executive Steering Committee will assist in the selection of improvement topics/targets, monitor the progress of teams and assist in enabling required changes for sustainable improvement.
  - The targeted metric for this project Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates , but Preventable Admissions as a whole should also be impacted in a positive manner

Through improvements sought through these proposed projects, we would surmise and anticipate improvements in our abilities to more appropriately accommodate patients' needs and manage their care in a way that should be reflected in a decrease of what is defined as Potentially Preventable Admissions.

UTMB anticipates that an improvement on our ability to collaborate with our regional partners, measure and track high priority chronic illnesses, (which, when poorly managed, lead to preventable admissions) and the expansion of primary care access within the regions will provide the environment in which our patients will be better able to manage their health.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Unique Category 4 Domain Identifier: 094092602.4.3

Domain Description

We anticipate that Potentially Preventable Admissions – 30 Days will be affected by addressing patient needs as targeted though and as an extension of our DSRIP proposals. Specifically:

- 094092602.2.4 Develop and Implement a Transitional Care Program Between Hospital, Nursing Home, and Home Health Care Home Via A Care Transition Coordinator
    - This project designs and implements an effective care transition program that promotes patient centered care for patients 65+ transitioning from the hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination with the goal of eliminating avoidable 30-day readmissions.
    - It is measured by Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
- 094092602.2.5 Implement a Care Transitions Program - Care Management Registry
    - This project implements a case management registry system with a focus on decreasing potentially preventable 30-day readmissions by 1% each year.
    - It is to be tracked by Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
- 094092602.2.6 Implement Care Transitions Program
    - This project focuses on improving the transitions of care for adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of AMI, heart failure or pneumonia.
    - It is measured by Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
- 094092602.1.1 Expand Primary Care Access In Galveston and Brazoria Counties
    - This project increases primary care capacity for Galveston and Brazoria counties within UTMB's Community Based Clinics while focusing on controlling high blood pressure of patients.
    - The targeted metric for this project is Primary Care and Chronic Disease Management
- 094092602.1.5 Implement and Utilize Disease Management Registry

- This project implements and utilizes chronic disease registries for diabetes, CHF, asthma, hypertension and COPD. In addition to the registries, the EHR's dash boarding tool, RADAR, will be implemented that will enable providers to view performance at a glance and target patients requiring specific interventions

- 094092602.1.7 Enhance Performance Improvement and Reporting Capacity
  - This project establishes an improvement collaborative that will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement from subject matter experts, from project staff coaches and from each other.
  - The targeted metric for this project Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates , but others will most certainly be tracked

- 094092602.2.11 – Pass 2 Conduct Medication Management
  - This project will provide for a clinical pharmacist in the Emergency Department. Better management of the medical condition will result in decreased costs to Emergency Departments and Hospitals throughout the region.
  - The targeted metric for this project is Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates

Many of the proposed projects listed above specifically target improvements in Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates. We believe that improvements achieved in these areas will be reflected in the data provided in the domain over the course of the 1115 reporting periods.

Domain 3: Potentially Preventable Complications (64 measures)
Unique Category 4 Domain Identifier: 094092602.4.4

Domain Description

We anticipate that Potentially Preventable Complications will be affected by addressing patient needs as targeted though and as an extension of the following DSRIP proposals:

- 094092602.1.1 Expand Primary Care Access In Galveston and Brazoria Counties
  - This project increases primary care capacity for Galveston and Brazoria counties within UTMB's Community Based Clinics while focusing on controlling high blood pressure of patients.
  - The targeted metric for this project is Primary Care and Chronic Disease Management

- 094092602.1.3 Expansion of Alvin Primary Care Clinic to Include Adult Care
    - This project expands primary care for both adults and children in Brazoria County. The expansion will increase existing pediatric services with the addition of adult care by expanding primary care to adult services. Project options include expanding primary care clinic space and primary care clinic staffing.
    - The targeted metrics for this project are Patient Satisfaction and Third Next Available Appointment
- 094092602.1.5 Implement and Utilize Disease Management Registry
    - This project implements and utilizes chronic disease registries for diabetes, CHF, asthma, hypertension and COPD. In addition to the registries, the EHR's dash boarding tool, RADAR, will be implemented that will enable providers to view performance at a glance and target patients requiring specific interventions.
    - The targeted metric for this project is Primary Care and Chronic Disease Management; Diabetes Care: HbA1c Poor Control (>9.0%)
- 094092602.1.6 Nurse Advice Line: Texas Regional Health Line (Region 2)
    - This project implements a nurse advice call center for participating counties in Region 2. This call center will be a nurse advice line with designated phone numbers that are given to patient populations in these counties. Highly trained registered nurses will provide urgent medical advice from 4:30pm to 8am Monday thru Friday and 24/7 coverage on weekends and holidays.
    - The targeted metric for this project is Right Care, Right Setting; ED Appropriate Utilization
- 094092602.1.4 – Pass 1 Transplantation Chronic Disease Management Registry
    - This project creates a patient registry that will facilitate the medical management, evaluation and treatment of patients with end stage organ failure that may benefit from transplantation. The population served is primarily focused on patients in communities throughout Texas but also includes those in neighboring states. 094092602.3.5
    - The targeted metric for this project is Primary Care and Chronic Disease Management
- 094092602.1.7 Enhance Performance Improvement and Reporting Capacity

- This project establishes an improvement collaborative that will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement from subject matter experts, from project staff coaches and from each other. The RHP2 Executive Steering Committee will assist in the selection of improvement topics/targets, monitor the progress of teams and assist in enabling required changes for sustainable improvement.
- The targeted metric for this project is Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates , but others will most certainly be tracked

- 094092602.1.9 – Pass 2 Strengthening the UTMB health information system to Reduce Health Disparities
  - This Project will redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care. We will implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes.
  - The targeted metric for this project is Addressing Health Disparities in Minority Populations - Improvement in Clinical Indicator in identified disparity group
- 094092602.1.10 – Pass 2 - Expand High Impact Specialty Care Capacity in most Impacted Medical Specialties: Training for Burn and Trauma Care
  - This Project will provide a mechanism to close the gap for underserved populations related to burn and traumatic injuries
  - The targeted metric for this project is Potentially Preventable Complications and Health Care Acquired Conditions
- 094092602.2.2 – Pass 1 Empowering the care team with systems Engineering/Lean
  - This project improves patient access through patient centered scheduling in primary care clinics, hybrid adaptive approach in specialty clinics and streamlining work flows and more efficiently managing resources using lean and systems engineering approach.
  - The targeted metrics for this project are:
    - Chronic Disease Management - Third Next Available Appointment

        - Patient Satisfaction

- 094092602.2.3 Establish/Expand a Patient Navigation Program-Community Health Program, Chronic Disease Education
    - This project expands the Community Health Program/Chronic Disease Education program that provides care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible and uninsured patients who have chronic diseases. 094092602.3.12
    - The targeted metric for this project is Primary Care and Chronic Disease Management
- 094092602.2.4 Develop and Implement a Transitional Care Program Between Hospital, Nursing Home, and Home Health Care Home Via A Care Transition Coordinator
    - This project designs and implements an effective care transition program that promotes patient centered care for patients 65+ transitioning from the hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination with the goal of eliminating avoidable 30-day readmissions.
    - The targeted metric for this project Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
- 094092602.2.5 – Implement a Care Transitions Program Care Management Registry
    - This project implements a case management registry system with a focus on decreasing potentially preventable 30-day readmissions by 1% each year.
    - Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates; All Cause 30 Day Readmission Rate
- 094092602.2.6 Implement Care Transitions Program
    - This project focuses on improving the transitions of care for adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of AMI, heart failure or pneumonia
    - Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates;Acute Myocardial Infarction (AMI) 30 Day Readmission Rate

- 094092602.2.7 Implement/Expand Care Transitions Programs (STORK)
    - This project will implement specialty obstetric episode database registry in order to integrate obstetric care across UTMB obstetrical clinic and inpatient settings; and streamline the daily tasks of obstetricians, nurses, midwives, clerks, and technologists in creating and maintaining up-to-date obstetric health information records.
    - The targeted metric for this project is Timeliness of Prenatal/Postnatal Care - Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia
- 094092602.2.9 – Pass 2 - Engage in Population-Based Campaigns or Programs to Promote Healthy Lifestyles Using Evidence Based Methodologies including Social Media and Text Messaging in an Identified Population
    - This project seeks to expand UTMB's social media activities to create evidence-based health promotion campaigns. Populations to be served will include specific groups, such as pregnant women in Galveston County on Medicaid as well as broader-based populations.
    - The targeted metric for this project is Perinatal Outcomes - Percentage of Low Birth-Weight Births
- 094092602.2.10 – Pass 2 - Implement a Palliative Care Program to Address Patient with End-of-Life Decisions and Care Needs
    - This project will fully develop the infrastructure to sustain a palliative care consult service for UTMB to better meet physical, psychosocial, and spiritual needs of patients. We will be able to reach more patients and, in a timely way, assist care teams in all clinical services to help clarify patient goals, revise plans accordingly and provide symptom relief.
    - The targeted metric for this project is Palliative Care - Proportion Admitted to the ICU in the Last 30 Days of Life
- 094092602.2.11 Conduct Medication Management
    - This project will provide for a clinical pharmacist in the Emergency Department. Addition of a clinical pharmacist to the patient care team is a systems-level patient safety intervention that serves to make it difficult for medication errors to occur and to absorb errors before harm. Positively impacting the medication

regimen, understanding and adherence to the regimens will result in better management of the medical conditions. Better management of the medical condition will result in decreased costs to Emergency Departments and Hospitals throughout the region.

- Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates; All Cause 30 Day Readmission Rate

This broad reporting category is comprised of 64 measures targeted at understanding and improving the cause of Potentially Preventable Complications in the health of our patients. Through the combined efforts of these DSRIP projects there will be better access to care and better patient management across the continuum of care. By providing improved access to patient care and medical advice in the outpatient setting with better patient management and care transition between the inpatient and outpatient settings the incidence of preventable complications should be reduced.

Domain 4: Patient-Centered Healthcare (2 measures)
Unique Category 4 Domain Identifier: 094092602.4.5

Domain Description

We anticipate that improvements in the two, Patient-Centered Healthcare measures will be affected by addressing patient needs as targeted though and as an extension of the following DSRIP proposals:

Patient Satisfaction

- 094092602.1.2 Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion
  - This project expands pediatric after hours urgent care clinic to better meet the needs of our pediatric population on Galveston Island. This includes: clinic relocation, physical expansion, exam room expansion, staffing increases and additional ancillary services.
  - The primary metric for this project is Patient Satisfaction
- 094092602.1.3 Expansion of Alvin Primary Care Clinic to Include Adult Care
  - This project expands primary care for both adults and children in Brazoria County.
  - The expansion will increase existing pediatric services with the addition of adult care by expanding primary care to adult services. Project options include expanding primary care clinic space and primary care clinic staffing.

- The metrics for this project are Patient Satisfaction and Primary Care and Chronic Disease Management improvement (as measured by (Third Next Available Appointment)

- 094092602.1.6 Nurse Advice Line: Texas Regional Health Line (Region 2)
  - This project implements a nurse advice call center for participating counties in Region 2. This call center will be a nurse advice line with designated phone numbers that are given to patient populations in these counties. Highly trained registered nurses will provide urgent medical advice from 4:30pm to 8am Monday thru Friday and 24/7 coverage on weekends and holidays.
  - The targeted measures concern Right Care, Right Setting and seek to improve appropriate use of the ED

- 094092602.2.1 Implementing Patient Centered Medical Home
  - This project enhances the Patient-Centered Medical Home model and expands it throughout primary care clinics. Restructuring the staffing model into multidisciplinary care teams that manage a panel of patients will enhance the model of primary care by improving the health of the patients in the panels, reducing system costs associated with readmissions and ED visits, and improving the patient experience through improved access to a care provider. 094092602.3.9
  - The primary metric for this project is Patient Satisfaction

- 094092602.1.7 Enhance Performance Improvement and Reporting Capacity
  - This project establishes an improvement collaborative that will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement from subject matter experts, from project staff coaches and from each other. The RHP2 Executive Steering Committee will assist in the selection of improvement topics/targets, monitor the progress of teams and assist in enabling required changes for sustainable improvement.

- 094092602.1.8 – Pass 2 -Enhance Interpretation Services and Culturally Competent Care (Expand Access to Written and Oral Interpretation Services)
  - This Project will allow UTMB Health Language Services to expand its current and future interpretation services which will lead to improved access, improved quality of care and patient satisfaction for our patients and their families

- The primary metric for this project is Patient Satisfaction

- 094092602.1.9 – Pass- 2 Strengthening the UTMB health information system to Reduce Health Disparities
  - This Project will redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care. We will implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes.
  - The targeted metric for this project is Addressing Health Disparities in Minority Populations - Improvement in Clinical Indicator in identified disparity group

- 094092602.2.8 – Pass 2 - Redesign for Cost Containment: Develop an integrated care model with outcome-based payments
  - This project will reduce variation in clinical practice, improve patient outcome and quality metrics and reduce cost to deliver care. This project also correlates with the regional goal of improve the quality of patient care through data collection, analysis, reporting and continuous process improvement. Post pilot, project results and outcomes will be shared within the region.
  - The targeted metric for this project is Cost of Care - Improved Cost Savings

Medication Management

- 094092602.2.11 Conduct Medication Management
  - This project will provide for a clinical pharmacist in the Emergency Department. Addition of a clinical pharmacist to the patient care team is a systems-level patient safety intervention that serves to make it difficult for medication errors to occur and to absorb errors before harm. Positively impacting the medication regimen, understanding and adherence to the regimens will result in better management of the medical conditions. Better management of the medical condition will result in decreased costs to Emergency Departments and Hospitals throughout the region.
  - Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates; All Cause 30 Day Readmission Rate

- 094092602.1.4 – Pass 1 Transplantation Chronic Disease Management Registry

- This project creates a patient registry that will facilitate the medical management, evaluation and treatment of patients with end stage organ failure that may benefit from transplantation. The population served is primarily focused on patients in communities throughout Texas but also includes those in neighboring states. 094092602.3.5
- The targeted metric for this project is Primary Care and Chronic Disease Management

- 094092602.1.10 – Pass 2 - Expand High Impact Specialty Care Capacity in most Impacted Medical Specialties: Training for Burn and Trauma Care
  - This Project will provide a mechanism to close the gap for underserved populations related to burn and traumatic injuries
  - The targeted metric for this project is Potentially Preventable Complications and Health Care Acquired Conditions
- 094092602.2.3 Establish/Expand a Patient Navigation Program-Community Health Program, Chronic Disease Education
  - This project expands the Community Health Program/Chronic Disease Education program that provides care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible and uninsured patients who have chronic diseases. 094092602.3.12
  - The targeted metric for this project is Primary Care and Chronic Disease Management
- 094092602.2.4 Develop and Implement a Transitional Care Program Between Hospital, Nursing Home, and Home Health Care Home Via A Care Transition Coordinator
  - This project designs and implements an effective care transition program that promotes patient centered care for patients 65+ transitioning from the hospital setting to a nursing home/rehabilitation facility, to home health care through centralized care coordination with the goal of eliminating avoidable 30-day readmissions.
  - The targeted metric for this project Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates
- 094092602.2.5 – Implement a Care Transitions Program Care Management Registry

- This project implements a case management registry system with a focus on decreasing potentially preventable 30-day readmissions by 1% each year.
- Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates; All Cause 30 Day Readmission Rate

- 094092602.2.6 Implement Care Transitions Program
  - This project focuses on improving the transitions of care for adult patients (18 & over) of Galveston County who have Medicaid, Medicare/Medicaid (dual eligible) or are uninsured and are discharged from a UTMB inpatient unit with a discharge diagnosis of AMI, heart failure or pneumonia
  - Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates;Acute Myocardial Infarction (AMI) 30 Day Readmission Rate
- 094092602.2.7 Implement/Expand Care Transitions Programs (STORK)
  - This project will implement specialty obstetric episode database registry in order to integrate obstetric care across UTMB obstetrical clinic and inpatient settings; and streamline the daily tasks of obstetricians, nurses, midwives, clerks, and technologists in creating and maintaining up-to-date obstetric health information records.
  - The targeted metric for this project is Timeliness of Prenatal/Postnatal Care - Other Outcome Improvement Target- 14 day readmission rate for hyperbilirubinemia
- 094092602.2.9 – Pass 2 - Engage in Population-Based Campaigns or Programs to Promote Healthy Lifestyles Using Evidence Based Methodologies including Social Media and Text Messaging in an Identified Population
  - This project seeks to expand UTMB's social media activities to create evidence-based health promotion campaigns. Populations to be served will include specific groups, such as pregnant women in Galveston County on Medicaid as well as broader-based populations.
  - The targeted metric for this project is Perinatal Outcomes - Percentage of Low Birth-Weight Births
- 094092602.2.10 – Pass 2 - Implement a Palliative Care Program to Address Patient with End-of-Life Decisions and Care Needs

- This project will fully develop the infrastructure to sustain a palliative care consult service for UTMB to better meet physical, psychosocial, and spiritual needs of patients. We will be able to reach more patients and, in a timely way, assist care teams in all clinical services to help clarify patient goals, revise plans accordingly and provide symptom relief.
- The targeted metric for this project is Palliative Care - Proportion Admitted to the ICU in the Last 30 Days of Life

Many of the proposed projects listed above specifically target improvements in Patient Satisfaction, one of the two targeted measures in this domain. Patient Satisfaction in the inpatient setting should be improved by enhancing the health language and interpretation services and delivery of culturally competent care. Additionally improvements in care transitions should have a direct impact on the patient's satisfaction with their healthcare experience. Medication management will be positively affected by the addition of a clinical pharmacist to the medical care team. Inclusion of the pharmacist will lessen the chance for medication errors to occur plus improve understanding of the medication regimen. Additionally we have multiple DSRIP projects that improve access to urgent and expert medical advice that should improve patient's understanding and compliance with the medication regimen across the continuum of care.

Domain 5: Emergency Department (1 measure)
Unique Category 4 Domain Identifier: 094092602.4.6

Domain Description
We anticipate that the Emergency Department measures will be most impacted by the following DSRIP proposals:

- 094092602.1.6 Nurse Advice Line: Texas Regional Health Line (Region 2)
  - This project implements a nurse advice call center for participating counties in Region 2. This call center will be a nurse advice line with designated phone numbers that are given to patient populations in these counties. Highly trained registered nurses will provide urgent medical advice from 4:30pm to 8am Monday thru Friday and 24/7 coverage on weekends and holidays.
  - The targeted measures concern Right Care, Right Setting and seek to improve appropriate use of the ED
- 094092602.1.7 Enhance Performance Improvement and Reporting Capacity

- This project establishes an improvement collaborative that will serve as a forum for RHP 2 participants to learn both about content and about rapid cycle improvement from subject matter experts, from project staff coaches and from each other. The RHP2 Executive Steering Committee will assist in the selection of improvement topics/targets, monitor the progress of teams and assist in enabling required changes for sustainable improvement.
- The targeted metric for this project Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates , but Preventable Admissions as a whole should also be impacted in a positive manner

- 094092602.1.10 – Pass 2 - Expand High Impact Specialty Care Capacity in most Impacted Medical Specialties: Training for Burn and Trauma Care
  - This Project will provide a mechanism to close the gap for underserved populations related to burn and traumatic injuries
  - The targeted metric for this project is Potentially Preventable Complications and Health Care Acquired Conditions
- 094092602.2.12 – Pass 2 - Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population
  - This project will create an information system exchange between ambulance providers, UTMB emergency department and Greater Houston HealthConnect Health Information Exchange (HIE) to communicate key patient clinical and other information for patient care.
  - The targeted metric for this project is Right Care, Right Setting - ED Appropriate Utilization

This domain has a very narrow focus in the required reporting metric; admit decision time to ED departure time for admitted patients. At UTMB we have a number of projects focused on improvements in the patient flow, utilization and transition from the Emergency and Trauma setting. Improvements achieved through our ability to manage the care of patients before, during and after they encounter the Emergency Medicine setting should be reflected in improvements to the target metric. Additionally many of the DSRIP projects focus on reducing the inappropriate use of the ED which should decrease the high volume burden on the ED which will improve patient throughput.

Optional Domain 6: Children and Adult Core Measures (8 measures)

Unique Category 4 Domain Identifier: 094092602.4.7

Domain Description

We anticipate that the Children and Adult Core Measures will be most impacted by the following DSRIP proposals:

- 094092602.1.1 –Expand Primary Care Access In Galveston and Brazoria Counties
    - This project increases primary care capacity for Galveston and Brazoria counties within UTMB's Community Based Clinics while focusing on controlling high blood pressure of patients
    - Primary Care and Chronic Disease Management ; Controlling High Blood Pressure
- 094092602.1.2 Expand Primary Care Capacity-Pediatric Urgent Care Clinic Expansion
    - This project expands pediatric after hours urgent care clinic to better meet the needs of our pediatric population on Galveston Island. This includes: clinic relocation, physical expansion, exam room expansion, staffing increases and additional ancillary services.
    - Patient Satisfaction; Percent Improvement Over Baseline of Patient Satisfaction Scores.

- 094092602.1.3 –Expansion of Alvin Primary Care Clinic to Include Adult Care
    - This project expands primary care for both adults and children in Brazoria County. The expansion will increase existing pediatric services with the addition of adult care by expanding primary care to adult services. Project options include expanding primary care clinic space and primary care clinic staffing.
    - Patient Satisfaction; Percent Improvement Over Baseline of Patient Satisfaction Scores
    - Primary Care and Chronic Disease Management ; Third Next Available Appointment

- 094092602.1.5 –Implement and Utilize Disease Management Registry
    - This project implements and utilizes chronic disease registries for diabetes, CHF, asthma, hypertension and COPD. In addition to the registries, the EHR's dash boarding tool, RADAR, will be implemented that will enable providers to view performance at a glance and target patients requiring specific interventions.
    - Primary Care and Chronic Disease Management; Diabetes Care: HbA1c Poor Control (>9.0%)

- 094092602.1.6 –Nurse Advice Line: Texas Regional Health Line (Region 2)

- This project implements a nurse advice call center for participating counties in Region 2. This call center will be a nurse advice line with designated phone numbers that are given to patient populations in these counties. Highly trained registered nurses will provide urgent medical advice from 4:30pm to 8am Monday thru Friday and 24/7 coverage on weekends and holidays.
- Right Care, Right Setting; ED Appropriate Utilization

- 094092602.1.10 Expand High Impact Specialty Care Capacity in most Impacted Medical Specialties: Through Training for Burn and
  - This Project will provide a mechanism to close the gap for underserved populations related to burn and traumatic injuries. . By improving today's traditional health care plan for underserved populations through health care system reform, we can improve access to care through education of pre-hospital care and emergency department care providers in order to improve access to specialty care burn and trauma units which will lead to improvements in morbidity and mortality, long term outcomes, patient satisfaction and quality of life
  - Potentially Preventable Complications and Health Care Acquired Conditions; Improvement in Risk-Adjusted Potentially Preventable Complications Rate(s).

- 094092602.2.1 Implementing Patient Centered Medical Home
  - This project enhances the Patient-Centered Medical Home model and expands it throughout primary care clinics. Restructuring the staffing model into multidisciplinary care teams that manage a panel of patients will enhance the model of primary care by improving the health of the patients in the panels, reducing system costs associated with readmissions and ED visits, and improving the patient experience through improved access to a care provider.
  - Patient Satisfaction; Percent Improvement Over Baseline of Patient Satisfaction Scores

- 094092602.2.3 Establish/Expand a Patient Navigation Program-Community Health Program, Chronic Disease Education
  - This project expands the Community Health Program/Chronic Disease Education program that provides care management and disease management services in Galveston and Brazoria counties to adult Medicaid, dual eligible and uninsured patients who have chronic diseases.
  - Primary Care and Chronic Disease Management; Controlling High Blood Pressure

- 094092602.2.10 Implement a Palliative Care Program to Address Patient with End-of-Life Decisions and Care Needs
    - This project will fully develop the infrastructure to sustain a palliative care consult service for UTMB. A comprehensive palliative care team approach will better enable a holistic approach to the care of patients with advanced illness – meeting physical, psychosocial, and spiritual needs of patients. We will be able to reach more patients and, in a timely way, assist care teams in all clinical services to help clarify patient goals, revise plans accordingly and provide symptom relief.
    - Palliative Care; Proportion Admitted to the ICU in the Last 30 Days of Life

- 094092602.2.11 Conduct Medication Management
    - This project will provide for a clinical pharmacist in the Emergency Department. Addition of a clinical pharmacist to the patient care team is a systems-level patient safety intervention that serves to make it difficult for medication errors to occur and to absorb errors before harm. Positively impacting the medication regimen, understanding and adherence to the regimens will result in better management of the medical conditions. Better management of the medical condition will result in decreased costs to Emergency Departments and Hospitals throughout the region.
    - Potentially Preventable Re-Admissions – 30 Day Re-Admission Rates; All Cause 30 Day Readmission Rate

UTMB will participate in the optional Reporting Domain 6 including measurements sets for adult and pediatric patients. We anticipate that much or all of the data is currently being collected and can be adapted to fit reporting requirements. By focusing on assessment, follow-up and management for the specific core indicators we will be able to gauge our progress in raising the health of the population and identify the gaps that need to be addressed.

We anticipate that the measures in this domain will be improved through the effect of improvements driven by many of our proposed projects. Many of the measures in this domain are the same as, or similar to those in other domains, and we would expect the improvements to reflect those results consistently across the domains and as such we anticipate the broad spectrum of improvements sought through the list of proposed projects outlined above will contribute to and be reflected in these measures specific to Domain 6

Category 4: Population-Focused Measures *University of Texas Medical Branch Hospital* *Performing Provider TPI #: 094092602*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$1,534,480	$902,108		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$902,108	$963,092	$1,050,016
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$902,108	$963,092	$1,050,016
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$963,092	$1,050,016
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31

Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$902,108	$963,092	$1,050,016
Domain 5: Emergency Department				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$902,108	$963,092	$1,050,016
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		Sept. 1 to Aug. 31	Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		Sept. 1 to Aug. 31	30 Sept. 1 to Aug. 31	Sept. 1 to Aug. 31
Planned Reporting Period: 1 or 2		2	2	2
Domain 6 - Estimated Maximum Incentive Amount		$902,108	$963,092	$1,050,016
Grand Total Payments Across Category 4	**$1,534,480**	**$5,412,649**	**$5,778,553**	**$6,300,095**

SECTION VI:

RHP Participation Certifications

RHP Participation Certifications in PDF File "Section IV RHP Certifications"

1. Angleton Danbury Hospital District
2. Baptist Hospitals of Southeast Texas
   (dba Baptist Beaumont Hospital and Baptist Orange Hospital)
3. Brazosport Regional Health System
4. CHRISTUS Hospital
5. CHRISTUS Jasper Memorial Hospital
6. CHRISTUS Jasper Memorial Hospital - Pass 2
7. Galveston County Health District
8. Gulf Coast Center
9. Liberty Dayton Regional Medical Center
10. Memorial Health System of East Texas
11. Nacogdoches County Hospital District
12. Preferred Hospital Leasing-Hemphill
    (dba Sabine County Hospital)
13. Spindletop Center
14. Burke Center
15. Tri-County Services
16. Tyler County Hospital
17. The University of Texas Medical Branch at Galveston (UTMB)

SECTION VII:

Addendums

Addendum A:
Private Hospital Certifications

<u>NOTE:</u> Please See Private Hospital Certifications in PDF File "Addendum A"

Addendum B:
DSRIP Projects Considered But Not Selected

RHP 2 DSRIP Projects Considered
(Not included in Health Plan)[1]

Project Name	Provider	Brief Summary
Enhanced 911 System in Rural Communities	Acadian Ambulance Service	The goal of the proposed DSRIP project would be to enhance the current 911 EMS systems in very rural areas by decreasing the average response time for individuals that require an emergency response. A decrease in response time (even seconds) for critical conditions such as the onset of a heart attack or stroke is proven to affect the health outcomes of these patients. The proposal could apply to EMS systems for Counties, Hospital Districts, and/or ESD's.
Population-based Campaign to Promote healthy Lifestyles	Angleton-Danbury Hospital District	Engage in population-based campaign or programs to promote healthy lifestyle using new media such as social media and text messaging.
Expand Primary Care Capacity	Baptist Hospitals of Southeast Texas	Improve patient access to primary care providers by hiring and training primary care provider and staff.
Expand Specialty Care Capacity	Baptist Hospitals of Southeast Texas	Increase capacity to provide specialty care services and the availability of targeted specialty providers.
Expand Specialty Care Capacity- Psychiatry	Baptist Hospitals of Southeast Texas	Recruit psychiatrist to behavioral health clinic.

[1] Full descriptions of projects listed as considered but not included in the RHP 2 Health Plan can be found on the region's Transformation website http://www.utmb.edu/1115/DSRIP.asp

Project Name	Provider	Brief Summary
Pediatric Specialty Telemedicine Clinic	Baptist Hospitals of Southeast Texas	Increase the capacity to provide Pediatric specialty care services via electronic means.
Development of Clinical Pharmacy Programs	Baptist Hospitals of Southeast Texas	Focus on the pharmacy needs of the uninsured and Medicaid beginning with services offered in the ED.
Expand chronic Care Management Models	Baptist Hospitals of Southeast Texas	Using project RED ensures pre-discharge planning, training, medication reconciliation, transitional care, and disposition coordination is completed.
Care Transitions Programs	Baptist Hospitals of Southeast Texas	Partner with community-based/long-term care and home health programs to improve and standardize the transition of patients to and from inpatient and outpatient care settings.
Palliative Care Program	Baptist Hospitals of Southeast Texas	Link diverse hospital departments and services for effective and efficient use of resources to improve quality of life for people with serious illnesses and their families.
Expand Primary Care Access	Baptist Orange Hospital	Recruit primary care providers to Orange county.
Physician Recruitment-Specialist	Baptist Orange Hospital	Expand residency services to residents in Orange County.
Establishing Medical Homes	Brazosport Regional Health System	Enhance current clinical care models to meet the standards of NCQA Patient-Centered medical Home recognition.
Implementing Chronic Care Management	Brazosport Regional Health System	Create a Chronic Care Services Center that integrates chronic disease screening, protocol points of care, follow-up. Community outreach and integration of specialty care.

Project Name	Provider	Brief Summary
Enhance and broaden the training and development of the behavioral health workforce for a medically underserved area	The Burke Center	Increase evidence-based and recovery-oriented training for the current behavioral health workforce. Provide opportunities for those seeking behavioral health and health careers by creating volunteer, internship, preceptor and peer to peer opportunities in the agency. Provide up-to-date, trending, and innovative training to all behavioral health care workforce staff.
Expand and enhance the capacity of the behavioral health services to better meet the needs of the patient population and community so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better outcomes and experience of care.	The Burke Center	Burke Center services are limited to persons in crisis or meeting “priority population” diagnosis. There is a waiting list for outpatient services. Resources are inadequate to provide care for persons with significant mental illnesses outside the “priority population” definitions or with co morbid disorders such as substance use disorders or developmental disabilities.
Integration of Primary and Behavioral Health Care	The Burke Center	Provide targeted care management services across the behavioral and physical health system for persons with severe mental illness at two BH clinics.
Intensive Wrap Around Services for Jail/Hospital Diversion	The Burke Center	Provide intervention and wrap around services for persons with mental illness/substance use disorders at risk of incarceration, re-incarceration, hospitalization or re-hospitalization.

Project Name	Provider	Brief Summary
Disease Management Clinics in SE Texas	Christus Hospitals- St. Elizabeth and St. Mary	To establish innovative team based clinics to address complex chronic diseases such as congestive heart failure, diabetes, COPD, asthma and combinations of these conditions. These clinics will offer intensive care management to optimize health and healthcare utilization.
Oncology Navigation Program	CHRISTUS Health Southeast Texas	Provide individualized assistance to oncology patients, families, and caregivers, overcome health care system barriers and facilitate timely access to quality medical and psychosocial care, from pre-diagnosis through all phases of the cancer experience.
Prevention, Early Detection and Screening Services	CHRISTUS Jasper Memorial Hospital	To provide screening mammograms and education on early detection for those women without adequate resources. To Navigate patients needing follow-up in an appropriate and timely manner.
Community Health Worker	CHRISTUS Jasper Memorial Hospital	Establish a community health worker in the emergency department to inform and educate patients with nonacute and chronic diseases to self management and education programs.

Project Name	Provider	Brief Summary
Hire Additional Primary Care Providers for Jasper Clinics	CHRISTUS Jasper Memorial Hospital	Expand access to primary care for the medically underserved population by providing more primary care services providers in existing CHRISTUS rural health clinics.
Legacy FQHC in Beaumont	CHRISTUS Hospital – St. Elizabeth	Increase the availability of primary care services, pediatric, and obstetric services in the Beaumont area of Jefferson County.
Comprehensive Palliative Care Program	CHRISTUS Health Southeast Texas	Implement a dedicated palliative care team in the inpatient acute care setting with emphasis in the ICU, Oncology and Emergency departments.
Regional Outreach Coordinator & Patient Care Navigation Program	CHRISTUS Hospital – St. Elizabeth	Establish a program wherein the Regional Outreach Coordinator provides support to at risk patient populations who are likely to have trouble navigating the health care system, and who have high rates of ED/inpatient hospital use.
Pre-Diabetes Education	CHRISTUS Hospital – Southeast Texas	To provide pre-diabetes education to prevent/delay the onset of Type 2 diabetes.
Telemedicine for Neurological Care	CHRISTUS Jasper Memorial Hospital	Implement technology-assisted services to support or deliver neurological care to patients in the Jasper area to expedite treatment of acute stroke to increase survival rates.

Project Name	Provider	Brief Summary
Wellness & Recovery for Youth	Gulf Coast Center - Child & Adolescent Mental Health Services	Expand access to psychiatric care for youth. Specifically, development of a Wellness approach that would expand access to psychiatric medication services while promoting physical health as well as psychological health. This approach would prevent the development of serious psychiatric and medical problems in youth directly addressing needs such as nutrition, fitness, self-care, self-esteem, and sleep hygiene. Incorporation of subspecialist child and adolescent psychiatric care will facilitate identification of medical disorders that may impact psychiatric disorders and vice versa.
Crisis Respite/Response System – Intellectual & Developmental Disabilities (IDD)	Gulf Coast Center	Provide short-term emergency respite for persons with IDD/ASD who experience a behavioral crisis that requires intervention from law enforcement, Gulf Coast Center's Mobile Crisis Outreach Team (MCOT) or Emergency Departments. These services would be available to people with IDD/ASD.

Project Name	Provider	Brief Summary
Crisis Respite Expansion to Brazoria County	The Gulf Coast Center	Provide adult residential psychiatric crisis respite 24 hours per day, 7 days per week at 8 bed facility in Angleton, Texas, as an alternative to inpatient psychiatric hospitalization and as a 'step-down' for people discharged from inpatient psychiatric hospitals. The project will provide 24 hr. supervision up to 7 days to insure clients are connected with mental health services and are compliant with taking psychiatric medication. The project will provide alternatives for crisis mental health workers assessing patients in Emergency Departments and law enforcement officials responding to mental crises.
Counseling Supports	The Gulf Coast Center	Provide counseling and therapy supports, not available through existing services, for persons with mental illness and/or intellectual and developmental disabilities (IDD).
Recruitment of Family Practice Physician to Galveston County to Meet Patient Need	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Recruit and operationalize one (1) Family Practice Physician. This physician will have an office in Galveston County.
Recruitment of General Surgeon to Galveston County to Meet Patient Need	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Recruit and operationalize one (1) General Surgeon. This physician will have an office and perform general surgery in Galveston County.

Project Name	Provider	Brief Summary
Recruitment of Internal Medicine Physician to Galveston County to Meet Patient Need	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Recruit and operationalize one (1) Internal Medicine Physician. This physician will have an office in Galveston County.
Recruitment of OB/GYN Specialty Physician to Galveston County to Meet Patient Need	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Recruit and operationalize one (1) OB/GYN specialty trained physician. This physician will have an office in Galveston County.
Improve Patient's Experience and Satisfaction	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Redesign processes through organizational integration and prioritization to improve the patient's experience.
Expand Preventative Care Screenings	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Implement strategies to identify and empower patients to actively seek preventative care screenings.
Increase Access to Primary Care Through Patient Centered Scheduling	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Improve primary care access, patient satisfaction, and efficiency through redesigned patient oriented processes.
Reduce Readmission Rates of Patients with Chronic Conditions	Clear Lake Regional Medical Center / Mainland Medical Center a Campus of Clear Lake Regional Medical Center	Create smooth transitions of care and processes following inpatient admissions so that patients being discharged from inpatient care are at a reduced risk for avoidable readmissions.
Expand Primary Care	Liberty-Dayton Regional Medical Center	Build a new clinic for primary care & increase patient encounters
Recruit Primary Care Providers	Liberty-Dayton Regional Medical Center	Recruit 3 FP and/or IM Physicians; Recruit 2 mid-level providers
Expand QI and performance Department	Liberty-Dayton Regional Medical Center	Create and implement system-wide processes to monitor, measure, report improvement initiatives and benchmarks

Project Name	Provider	Brief Summary
Redirect Chronic patients out of ED & into medical homes	Liberty-Dayton Regional Medical Center	Identify patients with no medical home and connect them to one
Improve Patient Experience	Liberty-Dayton Regional Medical Center	Improve patient communication with their caregivers adopting a standardized model
Maternal Fetal Health Medicine Program	The Medical Center of Southeast Texas	Develop a Maternal Fetal Health clinic staffed with clinical and behavioral specialist.
Expand Inpatient Psychiatric Program	The Medical Center of Southeast Texas	Convert existing GeroPsyc Program into a general population model.
Neurology Telemedicine in the ED	The Medical Center of Southeast Texas	Bring in telemedicine with video live streaming from our ER to a Neurologist consulting in Houston, available 24/7, who will analyze the patient's condition.
Urgent Care Clinic X2	The Medical Center of Southeast Texas	Build 2 Urgent Care centers staffed with Nurse p The Medical Center of Southeast Texas Practioners or Physician Assistants with oversight by a physician.
Expand Primary Care Capacity Through Physician Recruitment	Memorial Health System of East Texas	Increase primary care capacity at the Health District to ensure that the growing number of uninsured and Medicaid eligible citizens have a medical home/primary care provider other than local Emergency Rooms.

Project Name	Provider	Brief Summary
ER Diversion Program for Behavioral Health Patients	Memorial Health System of East Texas	Expand behavioral health services capacity and coordination with physical healthcare services to better meet the needs of patient population, so that patients can receive care in the most appropriate and cost effective setting, instead of inefficiently relying on the ER.
Reduction of Potentially Preventable Readmissions	Memorial Health System of East Texas	In order to reduce targeted readmissions, we will develop a fully integrated patient care management program that addresses the full continuum of a patient's path from secondary preventions measures (that minimize the risk of a need for an admission) to post acute care initiatives that assure optimization of the patient's path during the 90 days after a hospitalization, and beyond.
Expand Primary Care Capacity through Physician Recruitment	Memorial Health System of East Texas	We will first assess the current level of primary care capacity (measured by number of visits, encounters, and number of physicians) available in the community. We will then develop and implement a plan to address this need through the recruitment of a new primary care provider.

Project Name	Provider	Brief Summary
Redesign of Cost Containment	Memorial Health System of East Texas	Improve cost-effectiveness of care through improved care delivery for individuals, families, employers and the government. Provide insights into both improved opportunities for healthcare delivery and health care cost-effectiveness.
Implement Computerized Physician Order Entry	Memorial Health System of East Texas	We will implement a Computerized Physician Order Entry system to access and monitor medications delivered in the hospital setting so that patients have the right medications at the right time and in order to reduce medication errors and adverse effects from medication use.
Sepsis Resuscitation and management	Memorial Health System of East Texas	Implement the Sepsis Resuscitation Bundle, Implement Sepsis Management Bundle, Assess resulting improvements in patient outcomes
Reduction of Potentially Preventable Admissions	Memorial Health System of East Texas	In order to reduce potentially preventable admissions of targeted diagnosis's , we will develop a program that addresses the patient's condition and options other than admission. This could require new approaches and coordination among the team within the hospital for assessment and classification of patient risks, transition planning and communication with alternate care providers.

Project Name	Provider	Brief Summary
Reduction of Potentially Preventable Readmissions	Memorial Health System of East Texas	Reduce readmissions among all patient populations, for all diagnostic classes.
Emergency Department Care Quality	Memorial Health System of East Texas	Improve the quality of care in the Emergency Department by providing Board Certified ED physicians and training for hospital staff
Expand primary Care Access Through Physician Recruitment	Memorial Health System of East Texas	We will first assess the current level of primary care capacity (measured by number of visits, encounters, and number of physicians) available in the community. We will then develop and implement a plan to address this need through the recruitment of new primary care physicians.
Implement a Chronic Disease management Directory	Memorial Health System of East Texas	Memorial Medical Center—Lufkin will implement a Diabetes management registry system to help enhance chronic disease management and outreach for Region 2 residents, including the poor and needy.
Redesign for Cost Containment	Memorial Health System of East Texas	Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, ad the government. Provide insights into both improved opportunities for healthcare delivery and health care cost-effectiveness.
Expand Behavioral Health Access	Nacogdoches Memorial Hospital	Partner with the Burke Center to provide telemedicine services for underserved patients with behavioral needs.

Project Name	Provider	Brief Summary
Develop Patient Centered Home Infrastructure	Nacogdoches Memorial Hospital	Implement patient-centered home infrastructure into primary care clinics.
Improve Emergency Medical Service	Nacogdoches Memorial Hospital	Provide a NCHD ambulance in Shelby County to increase outcomes of trauma, stroke, and chest pain patients.
Shared Obstetrical Management	San Jacinto Methodist Hospital	Integrated Prenatal Care Program and continuity of care through collaboration between Harris County Clinic and SJMH Family Medicine Residency including case coordination, insurance screening, participation in community outreach, shared medical record, (Health IT through Health Connect or Harris County Medical Society Program). This will be accomplished through recruiting a care coordinator/ Care navigator (RN), fostering collaboration between clinics in Baytown, shared health records, group and individual prenatal visits, and outreach to the community through advertising and health fairs, (schools, malls). This includes "Care Navigation" for patients who present to Harris County Emergency Room for diagnosis of pregnancy.
Expanding Primary Care Physician Supply through PCMH Educational Expansion	Expanding Mental Health Care Access and Professional Education in Psychiatry and Mental Health in Baytown	Increase Primary Care Workforce through the multidisciplinary education of Primary Care Residents within a Patient Centered Medical Home (PCMH)

Project Name	Provider	Brief Summary
Expanding Mental Health Care Access and Professional Education in Psychiatry and Mental Health in Baytown	Expanding Mental Health Care Access and Professional Education in Psychiatry and Mental Health in Baytown	Incorporation of community mental workers, (and trainees?) for population management of psychiatric patients, to decrease readmission rates and keep out of other expensive services. Second Goal, Enhanced and integrated education system for Psychiatric Residents and other mental health professionals in the county-health system, with placement of residents.
Develop an EB Center of Excellence at SHC-Galveston.	Shriner's Hospital for Children	Increase access to health care by development of an Epidermolysis Bullosa (EB) Center of Excellence for Texas and the southern United States. Prevention of infection in children with EB. Provide wound management and ambulatory surgery as needed. Provide pain management. Preserve function and improve activities of daily living in children with EB. Provide nutritional, psychosocial and family support. Our ultimate goal is to increase access to healthcare, improve outcomes, decrease cost, improve efficiency, and improve patient/family satisfaction for EB patients.

Project Name	Provider	Brief Summary
Expand, or Enhance Telemedicine through partnerships with the University of North Texas and investment in technology to increase access to health care.	Shriner's Hospital for Children	SHC-Galveston currently conducts telemedicine clinics at four sites (El Paso Texas, La Feria Texas, Oklahoma City and Tulsa Oklahoma) in order to better serve its patient population from those geographic locations. Currently, there are approximately a 100 patients who reside in the immediate Dallas-Fort Worth area who are being followed by SHC-Galveston for their burn reconstructive needs. We seek to expand the Galveston's current telemedicine program and become engaged in collaboration with the University of North Texas Health Science center (UNTHSC) in order to better serve the needs of these identified burn survivors. The goal of the project is to expand SHC-Galveston's Telemedicine (Telehealth) Clinic and partner with UNTHSC Department of Pediatrics in order to provide follow-up services to children from North and West Texas who are recovering from burns and who require the expertise available at SHC-Galveston. The patients will have been cared for initially in Galveston and then released home, anticipating frequent follow-up visits with the SHC-Galveston health care team.

Project Name	Provider	Brief Summary
In SHAPE Program for Behavioral Health Clients	Spindletop Center	Patients with chronic conditions receive proactive, ongoing care that keeps patients healthy and empowers them to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care. Spindletop will develop care management functions that integrate primary and behavioral health needs for behavioral health ("BH") clients with chronic diseases by implementing the In-Shape wellness program to increase client's engagement through education, coordination with community resources, and making lifestyle changes to stay healthy. This project will be designed to reduce the risk of preventable diseases, decrease the symptoms of existing ones, improve quality of life, and decrease ED utilization or inpatient care.

Project Name	Provider	Brief Summary
Pediatric Project	Stephen F. Austin Community Health Center	Stephen F. Austin Community Health Center (SFACHC) in collaboration with another member of the regional partnership will recruit and employ a pediatrician to serve in the health center one day per week to take newborns and children with special needs. Stephen F. Austin Community Health Center is located within a Medically Underserved Population (MUP) census tract and is adjacent to others MUP census tracts. The Center serves as the medical home for low income individuals and families many of whom are limited in English proficiency (LEP). SFACHC has midlevel practitioners that see pediatric patients but there are patients that need the care of a pediatrician. A pediatrician on staff will help meet the needs of patients with special health need and back up the midlevel practitioners for problems that may present outside their scope.
Mental health outreach	Sweeney Community Hospital	Provide early intervention by having a presence in schools by which children in need of services can be identified and provide counseling for the children and family.
Establish a Primary Care clinic	Sweeney Community Hospital	Establish a full time primary Care clinic.

Project Name	Provider	Brief Summary
Establishing a patient Care Navigation Program	Sweeney Community Hospital	Provide a program whereby patients can obtain transportation to the medical facilities of the Hospital District and assist in enrollment of public program including Medicaid through The Benefits Bank.
Interpretation Services	Sweeney Community Hospital	Ensure all patients receive appropriate and safe care by ensuring culturally competent care by bridging the gap in language barriers.

Addendum C:
Collaboration Letters

<u>NOTE:</u> Please See Collaboration Letters in PDF File "Addendum C"

Addendum D:
Affiliation Agreements

<u>NOTE:</u> Affiliation Agreements are in PDF file "Addendum D"

Addendum E:
Medical Society Letters of Support

<u>NOTE:</u> The following Medical Society Letters of Support are in PDF file "Addendum E"

1. Brazoria County Medical Society
2. Galveston County Medical Society
3. Hardin-Tyler Bi-County Medical Society

Addendum F:
CNA – Additional Information

Website Access to Important Community Needs Supporting Data

Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver Region 2 website http://www.utmb.edu/1115/

Region 2 county Information (includes County Profiles, Qualitative community Health Assessments and County Summary Reports) http://www.utmb.edu/1115/

Region 2 Health partnership Summary Report http://www.utmb.edu/1115/

Healthcare Costs and 30 Day Readmission Rates www.dartmouthatlas.org

General Notes, Sources, & Description of Data

General Notes

1 Numbers are rounded to the nearest tenth. Consequently, where a category (such as population by age) should total to 100%, it may appear to total to 99%, or 100.2%, etc.

2 Only mortality, natality, cancer incidence, and communicable diseases were ranked, because the data for other measures were not appropriate/adequate for meaningful ranking.

3 State-county images are from Wikimedia Commons: Commons:United States county locator maps. Accessed 06-28-2012 from http://commons.wikimedia.org/wiki/Commons:United_States_county_locator_maps. The RHP2 map on the coverpage was derived from a map provided by the Texas Parks and Wildlife GIS Lab at http://www.tpwd.state.tx.us/landwater/land/maps/gis/map_downloads/map_gallery/.

4 Unless otherwise indicated, US Averages are from same source and reference year(s) as data.

Geography & Population Density

Population Per Square Mile	Derived from U.S. Census Bureau, 2010 Census Summary File 1 and HRSA Area Resource File, 2011-2012.
Area in Square Miles	Source: HRSA Area Resource File 2011-2012
Population Rank Among Texas Counties	Derived from U.S. Census Bureau, 2010 Census Summary File 1.

Demography/Population

Total County & Texas Population	Source: U.S. Census Bureau, 2010 Census Summary File 1, Table P12. Note: Derived from 2010 Census Summary File 1 data by the Texas State Data Center.
Population by Age	Source: U.S. Census Bureau, 2010 Census Summary File 1, Table P12. Note: Derived from 2010 Census Summary File 1 data by the Texas State Data Center
Population by Race/Ethnicity	Source: U.S. Census Bureau, 2010 Census Summary File 1, Tables P8, PCT4, PCT5, and PCT8. Note: Derived from 2010 Census Summary File 1 data by the Texas State Data Center

Socioeconomic Indicators

Poverty Level, Median Household Income, Unemployed	Source: U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. Unemployed US Average: 2006 - 2010 ACS. Median Household Income & Percent below Poverty Line US Average: Source: U.S. Census Bureau, Small Area Estimates Branch, Release date: 11.2011
Incarcerated Population (Est. %)	Estimated based on Federal Bureau of Prisons Weekly Population Report from June 14, 2012 and the Texas Department of Criminal Justice Annual Report for FY 2011. Where only capacity data was available, incarcerated population was estimated to be 90% of total facility capacity.
ESL speakers not proficient in English	2009. Annual Population Estimates. Among people who speak English as a second language, this measure represents the percent of the population that reports speaking English less than "very well." Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey most recent 5-year estimates. US Average: Annual Population Estimates for 2006 - 2008.
Uninsured population & Population on Medicaid	2009. State and County by Demographic and Income Characteristics. SAHIE. U.S. Census Bureau and the Centers for Disease Control and Prevention.
Education Levels	U.S. Census. 2010 American Community Survey 5-year Estimates (2006-2010). File S1501, Educational Attainment. Accessed with American Fact Finder on July 3, 2012.

Natality

Births to teen mothers	2008. NCHS (National Center for Health Statistics). Percent births to women less than 18 years. http://www.healthstatus2020.com/owh/. US Average: 2005 - 2008, NCHS http://www.cdc.gov/nchs/hus/contents2010.htm
Women receiving prenatal care during the 1st trimester (%)	2005-2009. DSHS Birth Statistics. Rates per 100. US Average: 2007 - 2008 http://www.cdc.gov/nchs/hus/contents2010.htm
Low birth weight births (%)	2005-2009. DSHS Birth Statistics. Low Birth Weight= birth weight of less than 2,500 grams (5.5 pounds). Denominator- Births with known birth weight. Rates per 100. US Average: 2005 - 2008 http://www.cdc.gov/nchs/hus/contents2010.htm
Premature births (%)	2005-2009. Premature- less than 37 known weeks' gestation. Denominator- Births with known length of pregnancy. Rates per 100. US Average: 2005-2009, NCHS http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_03.pdf
Infant Mortality Rate	2000-2004. per 1000 live births US DHHS: http://www.healthstatus2020.com/owh/select_variables.aspx. Infant Mortality rates are suppressed for counties with the number of births more than 0 and less than 5. US Average: 2000-2002 NCHS

Health Environment & Behaviors

Physical Inactivity	2009. National Center for Chronic Disease Prevention and Health Promotion. Physical inactivity is the estimated percent of adults aged 20 and over reporting no leisure time physical activity. Estimates of physical inactivity by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor.

Excessive drinking	2004-2010. Behavioral Risk Factor Surveillance System. The excessive drinking measure reflects the percent of the adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average. This measure was calculated by the National Center for Health Statistics using data was obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.
Adult Smoking	2004-2010. Behavioral Risk Factor Surveillance System. Adult smoking prevalence is the estimated percent of the adult population that currently smokes every day or "most days" and has smoked at least 100 cigarettes in their lifetime. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.
Limited access to healthy foods	2006. U.S. Department of Agriculture. Limited access to healthy foods measures the proportion of the population who are both living in poverty and do not live close to a grocery store. Living close to a grocery store is defined differently in metro and non-metro counties; in metro counties, it means living less than 1 mile from a grocery store, in non-metro counties, less than 10 miles. This measure comes from the United States Department of Agriculture (USDA) Food Environment Atlas, a resource which assembles statistics on food environment indicators to stimulate research on the determinants of food choices and diet quality.
Availability of recreational facilities	2009. Census County Business Patterns. This measure represents the number of recreational facilities per 100,000 population in a given county. Recreational facilities are defined as establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports. This measure is based on a measure from United States Department of Agriculture (USDA) Food Environment Atlas, and is calculated using the most current County Business Patterns data set. Recreational facilities are identified by North American Industrial Classification System (NAICS) code 713940.

Mortality Rates

2005-2009. DSHS Death Statistics. Age-adjusted rates per 100,000 using 2000 standardized U.S. Census. ~Indicates numerator too small for stable rate calculation. In instances wherein there are few counties with calculable rates, it is possible for a county to have a rate that is lower than the state rate, but still be in the bottom 25% or 10% of Texas counties. One such instance is the HIV Disease mortality rate. Only 26 counties had enough cases to calculate stable rates. The range for the HIV Disease mortality rates is 0.9-10.4, with 11 counties out of the 26 having rates higher than the State rate. US Averages: NCHS 2009: http://www.cdc.gov/nchs/data/dvs/deaths_2009_release.pdf

Morbidity

Cancer Incidence Rates	Data is for 2005-2009. Rates are age-adjusted to the 2000 U.S. Standard Population. ~indicated where <16 cases were reported. ***Where <16 cases are reported, stable age-adjusted rates could not be calculated. Texas Cancer Registry, Cancer Incidence File, January, 2012. Accessed May 30, 2012. VA and military hospital reporting is incomplete for 2008-2009. Consequently, rates are underestimated. ***For Mesothelioma, there are only 10 counties in Texas that had enough cases to calculate stable rates (range was 0.6-2.4), with Jefferson at the very bottom, followed immediately by Galveston.** US Averages (where given): NCHS 2008: http://www.cdc.gov/nchs/data/hus/hus11.pdf#045.
Communicable Disease Rates	2009- AIDS, TB, Varicella, Pertussis. 2010- Syphilis, Gonorrhea, Chlamydia. DSHS. Health Currents. Rates Per 100,000. ~Numerator too small for rate calculation. The cases for TB and Aids exclude counts for the Texas Department of Criminal Justice. The rate is calculated net of the prison population provided by the TDCJ as of December 31, 2009. Age Adjustment Uses 2000 Standard Population. State totals include those where the county is unknown. 2009 data updated as of July 2010. STD and TB US Average: NCHS 2009: http://www.cdc.gov/nchs/data/hus/hus11.pdf#044. Varicella US Average: 2009 reported cases in US http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5853a1.htm. Rate is per 100,000

Other Measures of Morbidity

Diabetes Mellitus & Adult Obesity	2009. National Center for Chronic Disease Prevention and Health Promotion. This measure is an estimate of the percent of adults age 20 and older in a county who have diagnosed diabetes. Estimates of diabetes prevalence by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using three years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. Diabetic US Average: NCHS 2005 - 2008: http://www.cdc.gov/nchs/data/hus/hus10.pdf#050
Disability	2008-2010 ACS. Accessed from American Fact Finder (http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml). ~Numerator too small for rate calculation.

Poor physical health days	2004-2010. Behavioral Risk Factor Surveillance System. The poor physical health days measure represents one of four measures of morbidity used in the County Health Rankings, and is based on responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" We present the average number of days a county's adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of poor physical health days.
Poor mental health days	2004-2010. Behavioral Risk Factor Surveillance System. The poor mental health days measure is a companion measure to the poor physical health days reported in the County Health Rankings. The estimates are based on responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" We present the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. NCHS used seven years of data to generate more stable estimates of poor mental health days.
Inadequate emotional support	2006-2010. Behavioral Risk Factor Surveillance System. The social and emotional support measure is based on responses to the question: "How often do you get the social and emotional support you need?" The County Health Rankings reports the percent of the adult population that responds that they "never," "rarely," or "sometimes" get the support they need. This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone.

Pediatric Blood Lead Levels

% of children <6 tested	DSHS (2010)
% of children <6 w/BLL >10 μg/dL	DSHS (2010) Percentage of children tested with an elevated blood lead level. ~ designates 0 children tested.
Number of zip codes of concern for pediatric blood lead testing / Total number of zip codes in the county	DSHS (2010). Number of zip codes in county targeted for pediatric blood lead testing / Total number of zip codes in the county

Health Services & Resources

Providers (ratio per 100,000 population)

Primary Care, Specialty Care, & Mid-Level Care Providers	Texas Medical Board - September 1, 2011. Ratio is per 100,000, 2011 Population. Data rounded to nearest whole number. Excludes: Federal and military physicians, residents and fellows. "Primary Care" Physicians are those who indicate that they have a primary specialty of General Practice, Family Practice/Medicine, Internal Medicine, Pediatrics, Obstetrics and/or Gynecology, or Geriatrics. Texas Board of Nursing - September 14, 2011. National rates are from the HRSA Area Resource File for 2008. Rates are per 100,000 population and categorized for primary care in the same way Texas DSHS derived the data from the Texas Medical Board.
Dentists	All Dentists (ADN) by County of Residence - September, 2011. Data rounded to nearest whole number
Pharmacists	Data Source: Texas State Board of Pharmacy - October 5, 2011. Pharmacists by County of Practice - September, 2011. Data rounded to nearest whole number. Excludes: Pharmacists with a status code of "retired," "revoked," "expired," "canceled," "inactive," "probation," "restricted," "surrender," "suspended," or "deceased." Prepared by: Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center, November 23, 2011. Last updated November 23, 2011
Mental Health Providers	2007. Health Resources & Services Administration. Rate per 100,000. Mental health providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet certain qualifications and certifications. This measure represents the population per one provider. Data on mental health providers comes from the Health Resources and Services Administration's (HRSA) Area Resource File (ARF).

Facilities & Beds

Number of Community Health Clinics	Data gathered from Texas Association of Community Health Centers, June 2012
Acute Care Beds Ratio	2009 Texas DSHS. Ratio is per 100,000 population.
Psychiatric Care Beds Ratio	2012. Ratio is per 100,000 population. Per email correspondence sent by Mark Severns, Administrator, Behavioral Health Services Baptist Hospitals of Southeast Texas, on August 13, 2012.

Access & Quality Measures

Health Professional Shortage Areas (HPSAs)	Source: US Dept of Health and Human Services, Health Resources and Services Administration (http://bhpr.hrsa.gov/shortage/). The data reflect the HPSA data as of June 29, 2012. A HPSA is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals).
30 day readmission rates, all surgical & all medical	2009. Dartmouth Atlas http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=30. Based on Medicare FFS data. ~Measures based on a count of fewer than 11 patients are not displayed for reasons of patient confidentiality. Rates with fewer than 26 expected events are also suppressed because of a lack of statistical precision. These cells are marked "~."
Preventable hospitalizations	2010. DSHS. Source is Center for Health Statistics, Texas. Rate is per 100,000 population (2010) Department of State Health Services; the number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS. Annual hospitalizations less than 5 are reported as 0.
Percent of adults who could not see a doctor due to cost	2004-2010. Behavioral Risk Factor Surveillance System. This measures shows the proportion of adults who reported that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. Seven years of data are used to generate more stable estimates. US average is for 2010 only (BRFSS).
Percent of diabetics not receiving HbA1c screening	2009. Medicare/Dartmouth Institute. Diabetic screening is calculated as the percent of diabetic Medicare patients whose blood sugar control was screened in the past year using a test of their glycated hemoglobin (HbA1c) levels. Estimates of diabetic screening were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data. Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented. Percent of diabetics not receiving HbA1c screening was calculated by subtracting the percent of those receiving from 100.

Population Insurance Coverage & Ethnicity Estimates for Medicaid 1115 Waiver Region 2 Counties:

Regional Summary

September 10, 2012

Author: Bob Skaggs

utmb Health Marketing

Notes about Data and Presentations

- Geography covers Medicaid 1115 Waiver RHP 2 counties assigned to UTMB Health: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler.

- Data source for population estimates is The Nielsen Company using Thomson Reuters Market Expert, last updated June 2012. Per the requestor, only current year (2012) insurance coverage estimates are shown. Ethnicity estimates are provided for the current year as well as year 5 (2017). No intermediate year data are available.

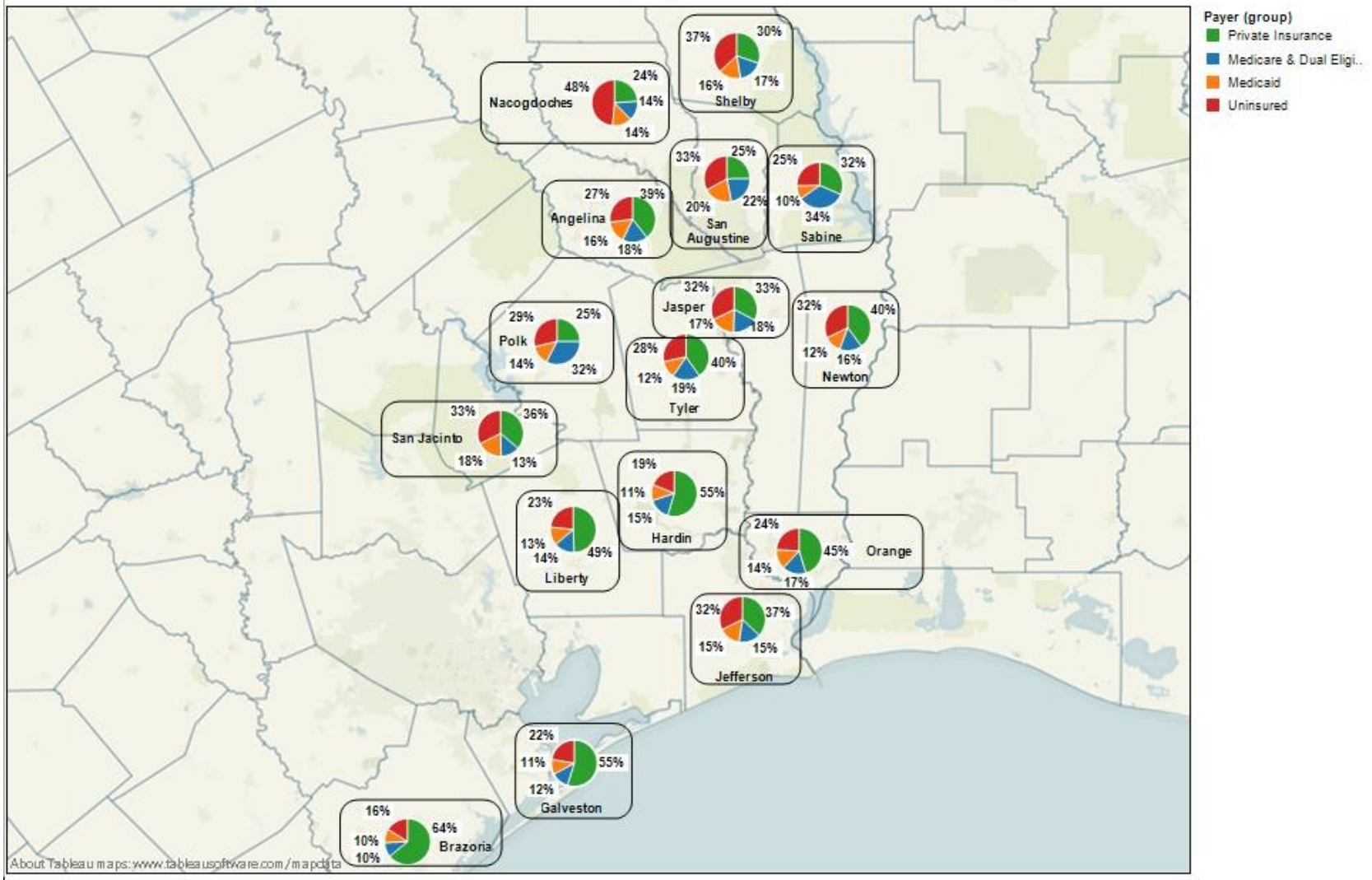
- There may be slight variations between population totals based on insurance coverage versus ethnicity. This is due to different statistical models used by The Nielsen Company.

- Market Expert insurance estimates use the following payer classifications: Private – ESI (Employer Supplied Insurance), Private – Direct (purchased by individual), Private – Exchange (purchased through PPAC initiated insurance exchanges), Medicare, Medicare Dual Eligible, Medicaid, and Uninsured. Private Insurance categories and Medicare categories are grouped on the maps and charts for easier display.

- Market Expert data tables use only main residential zip codes. Data are combined for PO Boxes within a residential zip code along with any small adjacent zip codes.

- Please note the axis scales vary between charts to better display the range of data.

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 Insurance Coverage Estimates



utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 Insurance Coverage Estimates cont.

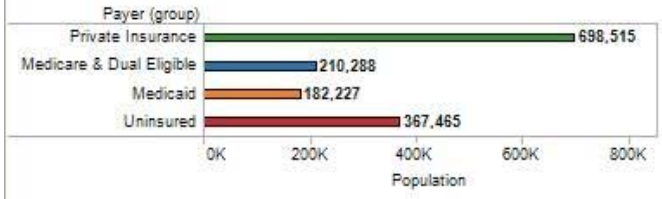
2012 Region 2 Insurance Coverage Estimates by Population

County	Private Insurance	Medicare & Dual Eligible	Medicaid	Uninsured	Total Population
Brazoria	218,146	34,726	33,047	54,599	340,518
Galveston	173,495	39,208	33,433	70,675	316,811
Jefferson	93,672	38,361	38,215	81,770	252,018
Angelina	34,761	15,524	13,893	23,853	88,031
Orange	37,973	14,044	11,667	20,200	83,884
Liberty	36,276	10,520	9,457	17,091	73,344
Nacogdoches	16,005	9,210	9,203	32,355	66,773
Hardin	30,571	8,570	6,295	10,498	55,934
Polk	11,588	14,977	6,358	13,245	46,168
Jasper	11,662	6,346	6,226	11,473	35,707
Shelby	7,908	4,436	4,135	9,622	26,101
Tyler	8,877	4,276	2,673	6,240	22,066
San Jacinto	6,788	2,475	3,340	6,084	18,687
Newton	5,328	2,109	1,599	4,297	13,333
Sabine	3,448	3,689	1,042	2,764	10,943
San Augustine	2,017	1,817	1,644	2,699	8,177
Region 2 Sum	698,515	210,288	182,227	367,465	1,458,495

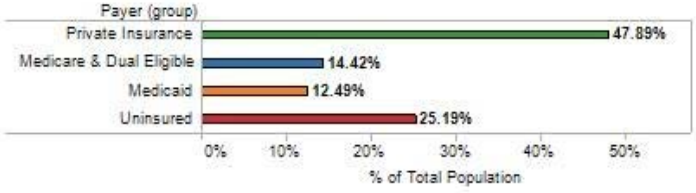
2012 Region 2 Insurance Coverage Estimates by Percent of Population

County	Private Insurance	Medicare & Dual Eligible	Medicaid	Uninsured
Brazoria	64.06%	10.20%	9.70%	16.03%
Galveston	54.76%	12.38%	10.55%	22.31%
Jefferson	37.17%	15.22%	15.16%	32.45%
Angelina	39.49%	17.63%	15.78%	27.10%
Orange	45.27%	16.74%	13.91%	24.08%
Liberty	49.46%	14.34%	12.89%	23.30%
Nacogdoches	23.97%	13.79%	13.78%	48.46%
Hardin	54.66%	15.32%	11.25%	18.77%
Polk	25.10%	32.44%	13.77%	28.69%
Jasper	32.66%	17.77%	17.44%	32.13%
Shelby	30.30%	17.00%	15.84%	36.86%
Tyler	40.23%	19.38%	12.11%	28.28%
San Jacinto	36.32%	13.24%	17.87%	32.56%
Newton	39.96%	15.82%	11.99%	32.23%
Sabine	31.51%	33.71%	9.52%	25.26%
San Augustine	24.67%	22.22%	20.11%	33.01%
Region 2 Sum	47.89%	14.42%	12.49%	25.19%

2012 Region 2 Insurance Coverage Estimates by Population



2012 Region 2 Insurance Coverage Estimates by Percent of Population



Payer (group)
- Private Insurance
- Medicare & Dual Eligible
- Medicaid
- Uninsured

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 Insurance Coverage Estimates cont.

2012 County Estimates by Population for Payer Category

		Population
Private Insurance	Angelina	34,761
	Brazoria	218,146
	Galveston	173,495
	Hardin	30,571
	Jasper	11,662
	Jefferson	93,672
	Liberty	36,276
	Nacogdoches	16,005
	Newton	5,328
	Orange	37,973
	Polk	11,588
	Sabine	3,448
	San Augustine	2,017
	San Jacinto	6,788
	Shelby	7,908
	Tyler	8,877
Medicare & Dual Eligible	Angelina	15,524
	Brazoria	34,726
	Galveston	39,208
	Hardin	8,570
	Jasper	6,346
	Jefferson	38,361
	Liberty	10,520
	Nacogdoches	9,210
	Newton	2,109
	Orange	14,044
	Polk	14,977
	Sabine	3,689
	San Augustine	1,817
	San Jacinto	2,475
	Shelby	4,436
	Tyler	4,276

0K 50K 100K 150K 200K 250K
Population

2012 County Estimates by Percent Population for Payer Category

		% of Total Population
Private Insurance	Angelina	39.49%
	Brazoria	64.06%
	Galveston	54.76%
	Hardin	54.66%
	Jasper	32.66%
	Jefferson	37.17%
	Liberty	49.46%
	Nacogdoches	23.97%
	Newton	39.96%
	Orange	45.27%
	Polk	25.10%
	Sabine	31.51%
	San Augustine	24.67%
	San Jacinto	36.32%
	Shelby	30.30%
	Tyler	40.23%
Medicare & Dual Eligible	Angelina	17.63%
	Brazoria	10.20%
	Galveston	12.38%
	Hardin	15.32%
	Jasper	17.77%
	Jefferson	15.22%
	Liberty	14.34%
	Nacogdoches	13.79%
	Newton	15.82%
	Orange	16.74%
	Polk	32.44%
	Sabine	33.71%
	San Augustine	22.22%
	San Jacinto	13.24%
	Shelby	17.00%
	Tyler	19.38%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 Insurance Coverage Estimates cont.

2012 County Estimates by Population for Payer Category

		Population
Medicaid	Angelina	13,893
	Brazoria	33,047
	Galveston	33,433
	Hardin	6,295
	Jasper	6,226
	Jefferson	38,215
	Liberty	9,457
	Nacogdoches	9,203
	Newton	1,599
	Orange	11,667
	Polk	6,358
	Sabine	1,042
	San Augustine	1,644
	San Jacinto	3,340
	Shelby	4,135
	Tyler	2,673
Uninsured	Angelina	23,853
	Brazoria	54,599
	Galveston	70,675
	Hardin	10,498
	Jasper	11,473
	Jefferson	81,770
	Liberty	17,091
	Nacogdoches	32,355
	Newton	4,297
	Orange	20,200
	Polk	13,245
	Sabine	2,764
	San Augustine	2,699
	San Jacinto	6,084
	Shelby	9,622
	Tyler	6,240

0K 10K 20K 30K 40K 50K 60K 70K 80K 90K
Population

2012 County Estimates by Percent Population for Payer Category

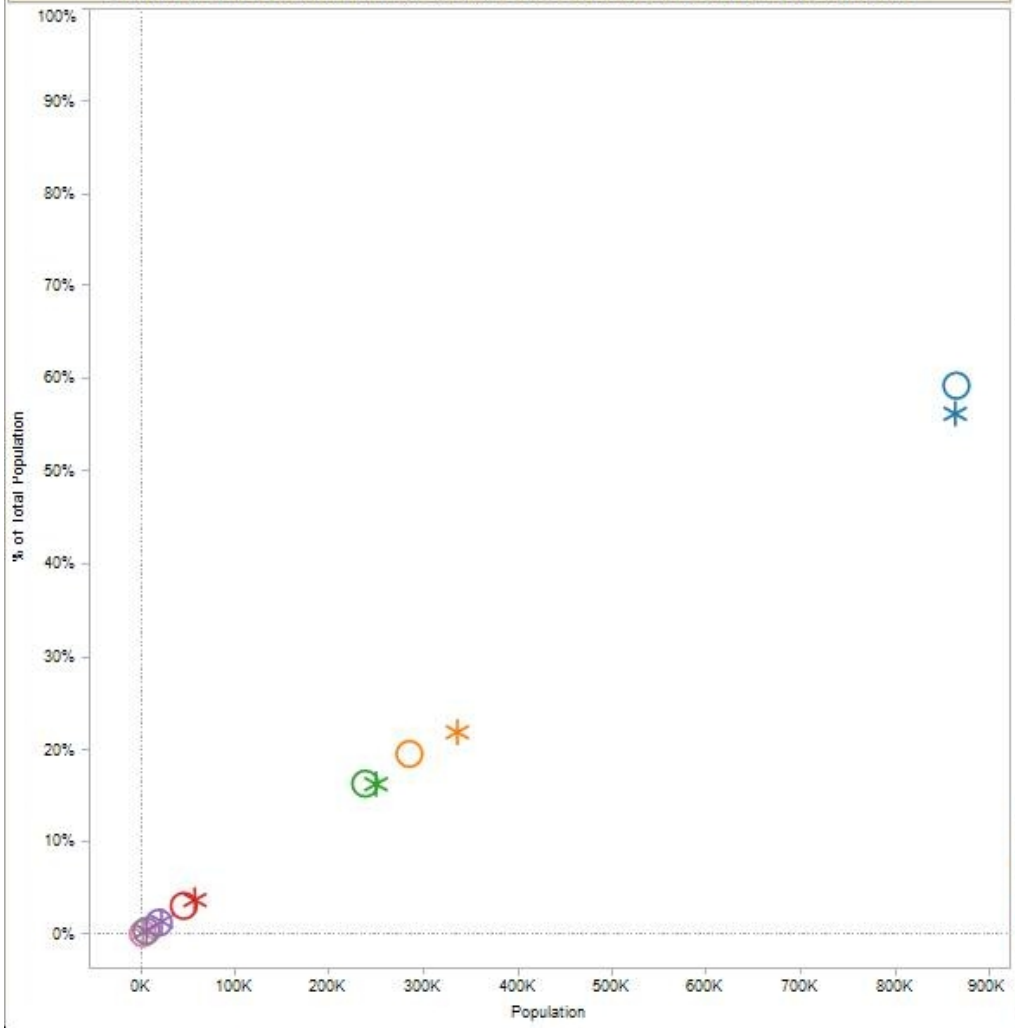
		% of Total Population
Medicaid	Angelina	15.78%
	Brazoria	9.70%
	Galveston	10.55%
	Hardin	11.25%
	Jasper	17.44%
	Jefferson	15.16%
	Liberty	12.89%
	Nacogdoches	13.78%
	Newton	11.99%
	Orange	13.91%
	Polk	13.77%
	Sabine	9.52%
	San Augustine	20.11%
	San Jacinto	17.87%
	Shelby	15.84%
	Tyler	12.11%
Uninsured	Angelina	27.10%
	Brazoria	16.03%
	Galveston	22.31%
	Hardin	18.77%
	Jasper	32.13%
	Jefferson	32.45%
	Liberty	23.30%
	Nacogdoches	48.46%
	Newton	32.23%
	Orange	24.08%
	Polk	28.69%
	Sabine	25.26%
	San Augustine	33.01%
	San Jacinto	32.56%
	Shelby	36.86%
	Tyler	28.28%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity

Scatter Plot of Population Ethnicity Change 2012-2017: Medicaid 1115 Waiver Region 2



Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

	2012		2017	
Ethnicity (group)	Population	% of Total Population	Population	% of Total Population
White	864,548	59.28%	863,357	56.23%
Hispanic (of any descent)	284,596	19.51%	335,468	21.85%
Black	237,659	16.29%	249,298	16.24%
Asian/Pacific Islander	45,347	3.11%	57,143	3.72%
2+ Races	18,885	1.29%	21,821	1.42%
American Indian & Alaska Native	5,660	0.39%	6,067	0.40%
Other Non-Hispanic	1,785	0.12%	2,177	0.14%
Total	1,458,480	100.00%	1,535,331	100.00%

Ethnicity (group)
- White
- Hispanic (of any descent)
- Black
- Asian/Pacific Islander
- 2+ Races
- American Indian & Alaska Nati..
- Other Non-Hispanic

Year
- 2012
- 2017

utmb Health Marketing

7

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity cont.

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

County	Year	White	Hispanic (of any descent)	Black	Asian/Pacific Islander	2+ Races	American Indian & Alaska Native	Other Non-Hispanic	Total
Brazoria	2012	173,183	96,577	42,906	21,251	4,981	1,078	543	340,519
	2017	170,735	114,930	53,121	29,588	6,052	1,149	698	376,273
Galveston	2012	184,994	73,049	41,155	11,256	4,762	1,113	483	316,812
	2017	188,533	84,102	41,054	13,304	5,476	1,168	562	334,199
Jefferson	2012	108,868	45,607	84,805	8,834	2,867	765	268	252,014
	2017	101,872	53,601	85,796	9,526	3,125	816	303	255,039
Angelina	2012	54,788	18,181	13,063	794	825	271	108	88,030
	2017	54,406	21,132	13,679	906	912	314	144	91,493
Orange	2012	69,409	5,126	6,972	876	1,070	347	82	83,882
	2017	68,918	5,994	7,083	973	1,201	332	107	84,608
Liberty	2012	50,579	13,276	7,872	365	859	270	124	73,345
	2017	51,056	16,214	7,472	432	971	274	148	76,567
Nacogdoches	2012	40,063	12,311	12,326	868	898	246	60	66,772
	2017	39,441	14,958	13,353	1,076	1,084	279	77	70,268
Hardin	2012	49,097	2,612	3,166	306	540	192	19	55,932
	2017	52,224	3,292	3,101	403	640	221	19	59,900
Polk	2012	33,206	6,346	5,098	193	511	800	15	46,169
	2017	34,332	7,476	4,989	204	572	872	21	48,466
Jasper	2012	26,755	2,143	5,941	230	436	175	24	35,704
	2017	27,201	2,490	5,895	280	484	200	28	36,578
Shelby	2012	16,758	4,516	4,469	81	196	61	19	26,100
	2017	16,672	5,425	4,341	93	219	56	20	26,826
Tyler	2012	17,648	1,634	2,379	55	224	108	18	22,066
	2017	17,829	2,008	2,331	62	233	120	20	22,603
San Jacinto	2012	14,115	1,976	2,078	120	299	91	5	18,684
	2017	14,585	2,491	1,980	155	360	107	6	19,684
Newton	2012	9,783	344	2,888	59	187	70	0	13,331
	2017	9,898	285	2,861	69	217	72	0	13,402
Sabine	2012	9,651	367	682	37	139	60	6	10,942
	2017	9,934	446	573	49	165	71	8	11,246
San Augustine	2012	5,651	531	1,859	22	91	13	11	8,178
	2017	5,721	624	1,669	23	110	16	16	8,179

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity cont.

Medicaid 1115 Waiver Region 2 Percent Population Esimates by Ethnicity

County	Year	White	Hispanic (of any descent)	Black	Asian/Pacific Islander	2+ Races	American Indian & Alaska Native	Other Non-Hispanic	Total
Brazoria	2012	50.9%	28.4%	12.6%	6.2%	1.5%	0.3%	0.2%	100.0%
	2017	45.4%	30.5%	14.1%	7.9%	1.6%	0.3%	0.2%	100.0%
Galveston	2012	58.4%	23.1%	13.0%	3.6%	1.5%	0.4%	0.2%	100.0%
	2017	56.4%	25.2%	12.3%	4.0%	1.6%	0.3%	0.2%	100.0%
Jefferson	2012	43.2%	18.1%	33.7%	3.5%	1.1%	0.3%	0.1%	100.0%
	2017	39.9%	21.0%	33.6%	3.7%	1.2%	0.3%	0.1%	100.0%
Angelina	2012	62.2%	20.7%	14.8%	0.9%	0.9%	0.3%	0.1%	100.0%
	2017	59.5%	23.1%	15.0%	1.0%	1.0%	0.3%	0.2%	100.0%
Orange	2012	82.7%	6.1%	8.3%	1.0%	1.3%	0.4%	0.1%	100.0%
	2017	81.5%	7.1%	8.4%	1.2%	1.4%	0.4%	0.1%	100.0%
Liberty	2012	69.0%	18.1%	10.7%	0.5%	1.2%	0.4%	0.2%	100.0%
	2017	66.7%	21.2%	9.8%	0.6%	1.3%	0.4%	0.2%	100.0%
Nacogdoches	2012	60.0%	18.4%	18.5%	1.3%	1.3%	0.4%	0.1%	100.0%
	2017	56.1%	21.3%	19.0%	1.5%	1.5%	0.4%	0.1%	100.0%
Hardin	2012	87.8%	4.7%	5.7%	0.5%	1.0%	0.3%	0.0%	100.0%
	2017	87.2%	5.5%	5.2%	0.7%	1.1%	0.4%	0.0%	100.0%
Polk	2012	71.9%	13.7%	11.0%	0.4%	1.1%	1.7%	0.0%	100.0%
	2017	70.8%	15.4%	10.3%	0.4%	1.2%	1.8%	0.0%	100.0%
Jasper	2012	74.9%	6.0%	16.6%	0.6%	1.2%	0.5%	0.1%	100.0%
	2017	74.4%	6.8%	16.1%	0.8%	1.3%	0.5%	0.1%	100.0%
Shelby	2012	64.2%	17.3%	17.1%	0.3%	0.8%	0.2%	0.1%	100.0%
	2017	62.1%	20.2%	16.2%	0.3%	0.8%	0.2%	0.1%	100.0%
Tyler	2012	80.0%	7.4%	10.8%	0.2%	1.0%	0.5%	0.1%	100.0%
	2017	78.9%	8.9%	10.3%	0.3%	1.0%	0.5%	0.1%	100.0%
San Jacinto	2012	75.5%	10.6%	11.1%	0.6%	1.6%	0.5%	0.0%	100.0%
	2017	74.1%	12.7%	10.1%	0.8%	1.8%	0.5%	0.0%	100.0%
Newton	2012	73.4%	2.6%	21.7%	0.4%	1.4%	0.5%	0.0%	100.0%
	2017	73.9%	2.1%	21.3%	0.5%	1.6%	0.5%	0.0%	100.0%
Sabine	2012	88.2%	3.4%	6.2%	0.3%	1.3%	0.5%	0.1%	100.0%
	2017	88.3%	4.0%	5.1%	0.4%	1.5%	0.6%	0.1%	100.0%
San Augustine	2012	69.1%	6.5%	22.7%	0.3%	1.1%	0.2%	0.1%	100.0%
	2017	69.9%	7.6%	20.4%	0.3%	1.3%	0.2%	0.2%	100.0%

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: White

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	Population
White	Angelina	2012	54,788
		2017	54,406
	Brazoria	2012	173,183
		2017	170,735
	Galveston	2012	184,994
		2017	188,533
	Hardin	2012	49,097
		2017	52,224
	Jasper	2012	26,755
		2017	27,201
	Jefferson	2012	108,868
		2017	101,872
	Liberty	2012	50,579
		2017	51,056
	Nacogdoches	2012	40,063
		2017	39,441
	Newton	2012	9,783
		2017	9,898
	Orange	2012	69,409
		2017	68,918
	Polk	2012	33,206
		2017	34,332
	Sabine	2012	9,651
		2017	9,934
	San Augustine	2012	5,651
		2017	5,721
	San Jacinto	2012	14,115
		2017	14,585
	Shelby	2012	16,758
		2017	16,672
	Tyler	2012	17,648
		2017	17,829

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Percent Population Esimates by Ethnicity

Ethnicity (group)	County	Year	% of Total Population
White	Angelina	2012	62.2%
		2017	59.5%
	Brazoria	2012	50.9%
		2017	45.4%
	Galveston	2012	58.4%
		2017	56.4%
	Hardin	2012	87.8%
		2017	87.2%
	Jasper	2012	74.9%
		2017	74.4%
	Jefferson	2012	43.2%
		2017	39.9%
	Liberty	2012	69.0%
		2017	66.7%
	Nacogdoches	2012	60.0%
		2017	56.1%
	Newton	2012	73.4%
		2017	73.9%
	Orange	2012	82.7%
		2017	81.5%
	Polk	2012	71.9%
		2017	70.8%
	Sabine	2012	88.2%
		2017	88.3%
	San Augustine	2012	69.1%
		2017	69.9%
	San Jacinto	2012	75.5%
		2017	74.1%
	Shelby	2012	64.2%
		2017	62.1%
	Tyler	2012	80.0%
		2017	78.9%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: Hispanic

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	Population
Hispanic (of any descent)	Angelina	2012	18,181
		2017	21,132
	Brazoria	2012	96,577
		2017	114,930
	Galveston	2012	73,049
		2017	84,102
	Hardin	2012	2,612
		2017	3,292
	Jasper	2012	2,143
		2017	2,490
	Jefferson	2012	45,607
		2017	53,601
	Liberty	2012	13,276
		2017	16,214
	Nacogdoches	2012	12,311
		2017	14,958
	Newton	2012	344
		2017	285
	Orange	2012	5,126
		2017	5,994
	Polk	2012	6,346
		2017	7,476
	Sabine	2012	367
		2017	446
	San Augustine	2012	531
		2017	624
	San Jacinto	2012	1,976
		2017	2,491
	Shelby	2012	4,516
		2017	5,425
	Tyler	2012	1,634
		2017	2,008

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	% of Total Population
Hispanic (of any descent)	Angelina	2012	20.7%
		2017	23.1%
	Brazoria	2012	28.4%
		2017	30.5%
	Galveston	2012	23.1%
		2017	25.2%
	Hardin	2012	4.7%
		2017	5.5%
	Jasper	2012	6.0%
		2017	6.8%
	Jefferson	2012	18.1%
		2017	21.0%
	Liberty	2012	18.1%
		2017	21.2%
	Nacogdoches	2012	18.4%
		2017	21.3%
	Newton	2012	2.6%
		2017	2.1%
	Orange	2012	6.1%
		2017	7.1%
	Polk	2012	13.7%
		2017	15.4%
	Sabine	2012	3.4%
		2017	4.0%
	San Augustine	2012	6.5%
		2017	7.6%
	San Jacinto	2012	10.6%
		2017	12.7%
	Shelby	2012	17.3%
		2017	20.2%
	Tyler	2012	7.4%
		2017	8.9%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: Black

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	Population
Black	Angelina	2012	13,063
		2017	13,679
	Brazoria	2012	42,906
		2017	53,121
	Galveston	2012	41,155
		2017	41,054
	Hardin	2012	3,166
		2017	3,101
	Jasper	2012	5,941
		2017	5,895
	Jefferson	2012	84,805
		2017	85,796
	Liberty	2012	7,872
		2017	7,472
	Nacogdoches	2012	12,326
		2017	13,353
	Newton	2012	2,888
		2017	2,861
	Orange	2012	6,972
		2017	7,083
	Polk	2012	5,098
		2017	4,989
	Sabine	2012	682
		2017	573
	San Augustine	2012	1,859
		2017	1,669
	San Jacinto	2012	2,078
		2017	1,980
	Shelby	2012	4,469
		2017	4,341
	Tyler	2012	2,379
		2017	2,331

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	% of Total Population
Black	Angelina	2012	14.8%
		2017	15.0%
	Brazoria	2012	12.6%
		2017	14.1%
	Galveston	2012	13.0%
		2017	12.3%
	Hardin	2012	5.7%
		2017	5.2%
	Jasper	2012	16.6%
		2017	16.1%
	Jefferson	2012	33.7%
		2017	33.6%
	Liberty	2012	10.7%
		2017	9.8%
	Nacogdoches	2012	18.5%
		2017	19.0%
	Newton	2012	21.7%
		2017	21.3%
	Orange	2012	8.3%
		2017	8.4%
	Polk	2012	11.0%
		2017	10.3%
	Sabine	2012	6.2%
		2017	5.1%
	San Augustine	2012	22.7%
		2017	20.4%
	San Jacinto	2012	11.1%
		2017	10.1%
	Shelby	2012	17.1%
		2017	16.2%
	Tyler	2012	10.8%
		2017	10.3%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: Asian/Pacific Islander

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	Population
Asian/Pacific Islander	Angelina	2012	794
		2017	906
	Brazoria	2012	21,251
		2017	29,588
	Galveston	2012	11,256
		2017	13,304
	Hardin	2012	306
		2017	403
	Jasper	2012	230
		2017	280
	Jefferson	2012	8,834
		2017	9,526
	Liberty	2012	365
		2017	432
	Nacogdoches	2012	868
		2017	1,076
	Newton	2012	59
		2017	69
	Orange	2012	876
		2017	973
	Polk	2012	193
		2017	204
	Sabine	2012	37
		2017	49
	San Augustine	2012	22
		2017	23
	San Jacinto	2012	120
		2017	155
	Shelby	2012	81
		2017	93
	Tyler	2012	55
		2017	62

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	% of Total Population
Asian/Pacific Islander	Angelina	2012	0.9%
		2017	1.0%
	Brazoria	2012	6.2%
		2017	7.9%
	Galveston	2012	3.6%
		2017	4.0%
	Hardin	2012	0.5%
		2017	0.7%
	Jasper	2012	0.6%
		2017	0.8%
	Jefferson	2012	3.5%
		2017	3.7%
	Liberty	2012	0.5%
		2017	0.6%
	Nacogdoches	2012	1.3%
		2017	1.5%
	Newton	2012	0.4%
		2017	0.5%
	Orange	2012	1.0%
		2017	1.2%
	Polk	2012	0.4%
		2017	0.4%
	Sabine	2012	0.3%
		2017	0.4%
	San Augustine	2012	0.3%
		2017	0.3%
	San Jacinto	2012	0.6%
		2017	0.8%
	Shelby	2012	0.3%
		2017	0.3%
	Tyler	2012	0.2%
		2017	0.3%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: 2+ Races

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	Population
2+ Races	Angelina	2012	825
		2017	912
	Brazoria	2012	4,981
		2017	6,052
	Galveston	2012	4,762
		2017	5,476
	Hardin	2012	540
		2017	640
	Jasper	2012	436
		2017	484
	Jefferson	2012	2,867
		2017	3,125
	Liberty	2012	859
		2017	971
	Nacogdoches	2012	898
		2017	1,084
	Newton	2012	187
		2017	217
	Orange	2012	1,070
		2017	1,201
	Polk	2012	511
		2017	572
	Sabine	2012	139
		2017	165
	San Augustine	2012	91
		2017	110
	San Jacinto	2012	299
		2017	360
	Shelby	2012	196
		2017	219
	Tyler	2012	224
		2017	233

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	% of Total Population
2+ Races	Angelina	2012	0.9%
		2017	1.0%
	Brazoria	2012	1.5%
		2017	1.6%
	Galveston	2012	1.5%
		2017	1.6%
	Hardin	2012	1.0%
		2017	1.1%
	Jasper	2012	1.2%
		2017	1.3%
	Jefferson	2012	1.1%
		2017	1.2%
	Liberty	2012	1.2%
		2017	1.3%
	Nacogdoches	2012	1.3%
		2017	1.5%
	Newton	2012	1.4%
		2017	1.6%
	Orange	2012	1.3%
		2017	1.4%
	Polk	2012	1.1%
		2017	1.2%
	Sabine	2012	1.3%
		2017	1.5%
	San Augustine	2012	1.1%
		2017	1.3%
	San Jacinto	2012	1.6%
		2017	1.8%
	Shelby	2012	0.8%
		2017	0.8%
	Tyler	2012	1.0%
		2017	1.0%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: Am. Indian/AK Native

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	Population
American Indian & Alaska Native	Angelina	2012	271
		2017	314
	Brazoria	2012	1,078
		2017	1,149
	Galveston	2012	1,113
		2017	1,168
	Hardin	2012	192
		2017	221
	Jasper	2012	175
		2017	200
	Jefferson	2012	765
		2017	816
	Liberty	2012	270
		2017	274
	Nacogdoches	2012	246
		2017	279
	Newton	2012	70
		2017	72
	Orange	2012	347
		2017	332
	Polk	2012	800
		2017	872
	Sabine	2012	60
		2017	71
	San Augustine	2012	13
		2017	16
	San Jacinto	2012	91
		2017	107
	Shelby	2012	61
		2017	56
	Tyler	2012	108
		2017	120

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	% of Total Population
American Indian & Alaska Native	Angelina	2012	0.3%
		2017	0.3%
	Brazoria	2012	0.3%
		2017	0.3%
	Galveston	2012	0.4%
		2017	0.3%
	Hardin	2012	0.3%
		2017	0.4%
	Jasper	2012	0.5%
		2017	0.5%
	Jefferson	2012	0.3%
		2017	0.3%
	Liberty	2012	0.4%
		2017	0.4%
	Nacogdoches	2012	0.4%
		2017	0.4%
	Newton	2012	0.5%
		2017	0.5%
	Orange	2012	0.4%
		2017	0.4%
	Polk	2012	1.7%
		2017	1.8%
	Sabine	2012	0.5%
		2017	0.6%
	San Augustine	2012	0.2%
		2017	0.2%
	San Jacinto	2012	0.5%
		2017	0.5%
	Shelby	2012	0.2%
		2017	0.2%
	Tyler	2012	0.5%
		2017	0.5%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

Region 2 Medicaid 1115 Waiver Counties, Regional View 2012 & 2017 Population Estimates by Ethnicity: Other Non-Hispanic

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	
Other Non-Hispanic	Angelina	2012	108
		2017	144
	Brazoria	2012	543
		2017	698
	Galveston	2012	483
		2017	562
	Hardin	2012	19
		2017	19
	Jasper	2012	24
		2017	28
	Jefferson	2012	268
		2017	303
	Liberty	2012	124
		2017	148
	Nacogdoches	2012	60
		2017	77
	Newton	2012	0
		2017	0
	Orange	2012	82
		2017	107
	Polk	2012	15
		2017	21
	Sabine	2012	6
		2017	8
	San Augustine	2012	11
		2017	16
	San Jacinto	2012	5
		2017	6
	Shelby	2012	19
		2017	20
	Tyler	2012	18
		2017	20

0K 50K 100K 150K 200K 250K
Population

Medicaid 1115 Waiver Region 2 Population Esimates by Ethnicity

Ethnicity (group)	County	Year	
Other Non-Hispanic	Angelina	2012	0.1%
		2017	0.2%
	Brazoria	2012	0.2%
		2017	0.2%
	Galveston	2012	0.2%
		2017	0.2%
	Hardin	2012	0.0%
		2017	0.0%
	Jasper	2012	0.1%
		2017	0.1%
	Jefferson	2012	0.1%
		2017	0.1%
	Liberty	2012	0.2%
		2017	0.2%
	Nacogdoches	2012	0.1%
		2017	0.1%
	Newton	2012	0.0%
		2017	0.0%
	Orange	2012	0.1%
		2017	0.1%
	Polk	2012	0.0%
		2017	0.0%
	Sabine	2012	0.1%
		2017	0.1%
	San Augustine	2012	0.1%
		2017	0.2%
	San Jacinto	2012	0.0%
		2017	0.0%
	Shelby	2012	0.1%
		2017	0.1%
	Tyler	2012	0.1%
		2017	0.1%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
% of Total Population

utmb Health Marketing

16

Insurance Estimates by Payer Category for U.S. and Texas

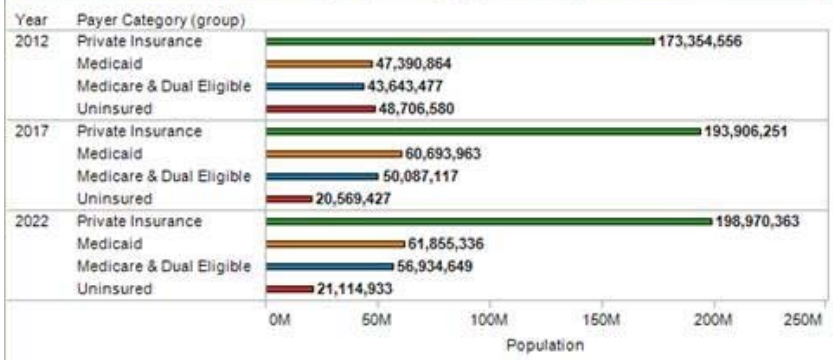
Insurance Estimates by Payer Category - U.S. Population

Payer Category (group)	2012 Population	2012 Payer % Pop	2017 Population	2017 Payer % Pop	2022 Population	2022 Payer % Pop
Private Insurance	173,354,556	55.37%	193,906,251	59.62%	198,970,363	58.71%
Medicaid	47,390,864	15.14%	60,693,963	18.66%	61,855,336	18.25%
Medicare & Dual Eligible	43,643,477	13.94%	50,087,117	15.40%	56,934,649	16.80%
Uninsured	48,706,580	15.56%	20,569,427	6.32%	21,114,933	6.23%
Total	313,095,477	100.00%	325,256,758	100.00%	338,875,281	100.00%

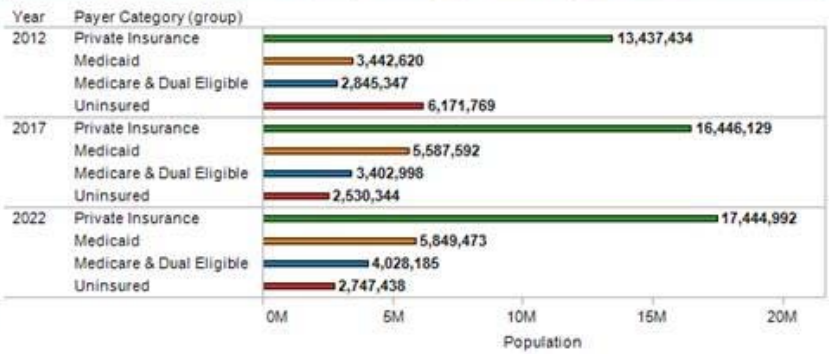
Insurance Estimates by Payer Category - Teas Population

Payer Category (group)	2012 Population	2012 Payer % Pop	2017 Population	2017 Payer % Pop	2022 Population	2022 Payer % Pop
Private Insurance	13,437,434	51.89%	16,446,129	58.81%	17,444,992	58.01%
Medicaid	3,442,620	13.29%	5,587,592	19.98%	5,849,473	19.45%
Uninsured	6,171,769	23.83%	2,530,344	9.05%	2,747,438	9.14%
Medicare & Dual Eligible	2,845,347	10.99%	3,402,998	12.17%	4,028,185	13.40%
Total	25,897,170	100.00%	27,967,063	100.00%	30,070,088	100.00%

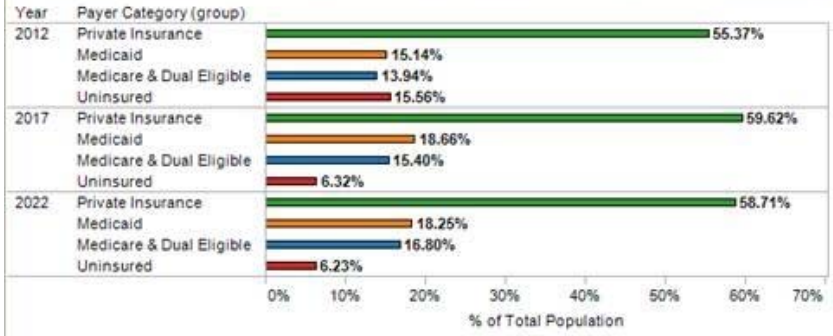
Insurance Estimates by Payer Category - U.S. Population Count



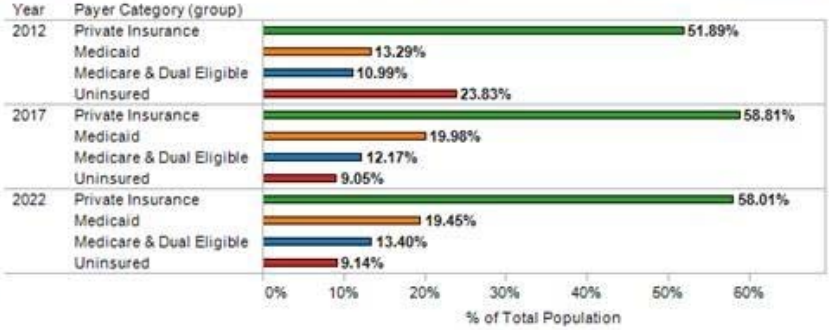
Insurance Estimates by Payer Category - Texas Population Count



Insurance Estimates by Payer Category - U.S. Percent of Population



Insurance Estimates by Payer Category - Texas Percent of Population



Population Ethnicity Estimates for U.S. and Texas

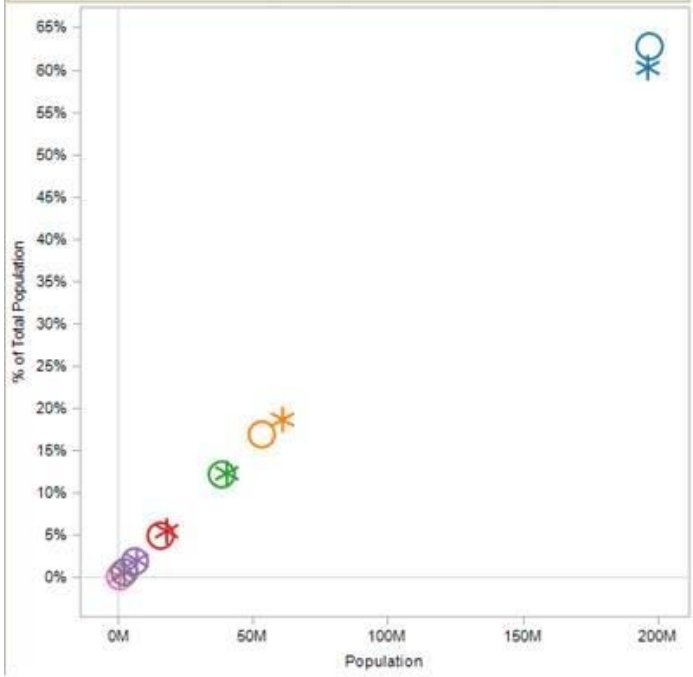
Ethnicity Estimates - U.S. Population

Ethnicity (group)	2012 Population	2012 Ethnicity % Pop	2017 Population	2017 Ethnicity % Pop
White	196,688,448	62.82%	196,078,577	60.28%
Hispanic (of any descent)	53,183,325	16.99%	60,901,826	18.72%
Black	38,363,633	12.25%	40,277,045	12.38%
Asian/Pacific Islander	15,746,621	5.03%	18,029,279	5.54%
2+ Races	6,207,345	1.98%	6,910,214	2.12%
American Indian & Alaska Native	2,277,183	0.73%	2,359,246	0.73%
Other Non-Hispanic	628,949	0.20%	700,648	0.22%
Total	313,095,504	100.00%	325,256,835	100.00%

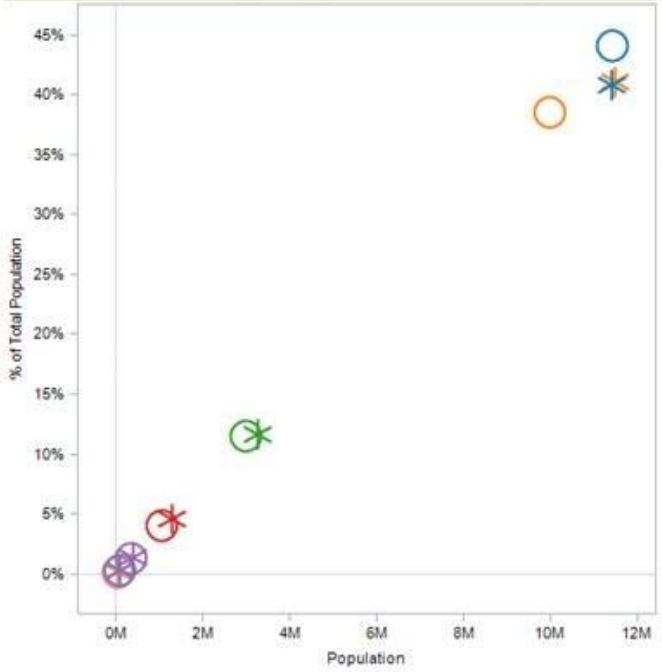
Ethnicity Estimates - Texas Population

Ethnicity (group)	2012 Population	2012 Ethnicity % Pop	2017 Population	2017 Ethnicity % Pop
White	11,425,945	44.12%	11,416,218	40.82%
Hispanic (of any descent)	9,986,060	38.56%	11,492,213	41.09%
Black	2,983,462	11.52%	3,258,054	11.65%
Asian/Pacific Islander	1,046,197	4.04%	1,282,289	4.58%
2+ Races	336,546	1.30%	385,703	1.38%
American Indian & Alaska Native	82,620	0.32%	88,290	0.32%
Other Non-Hispanic	36,688	0.14%	44,609	0.16%
Total	25,897,508	100.00%	27,967,376	100.00%

Scatter Plot of Ethnicity Change 2012-2017: U.S. Population

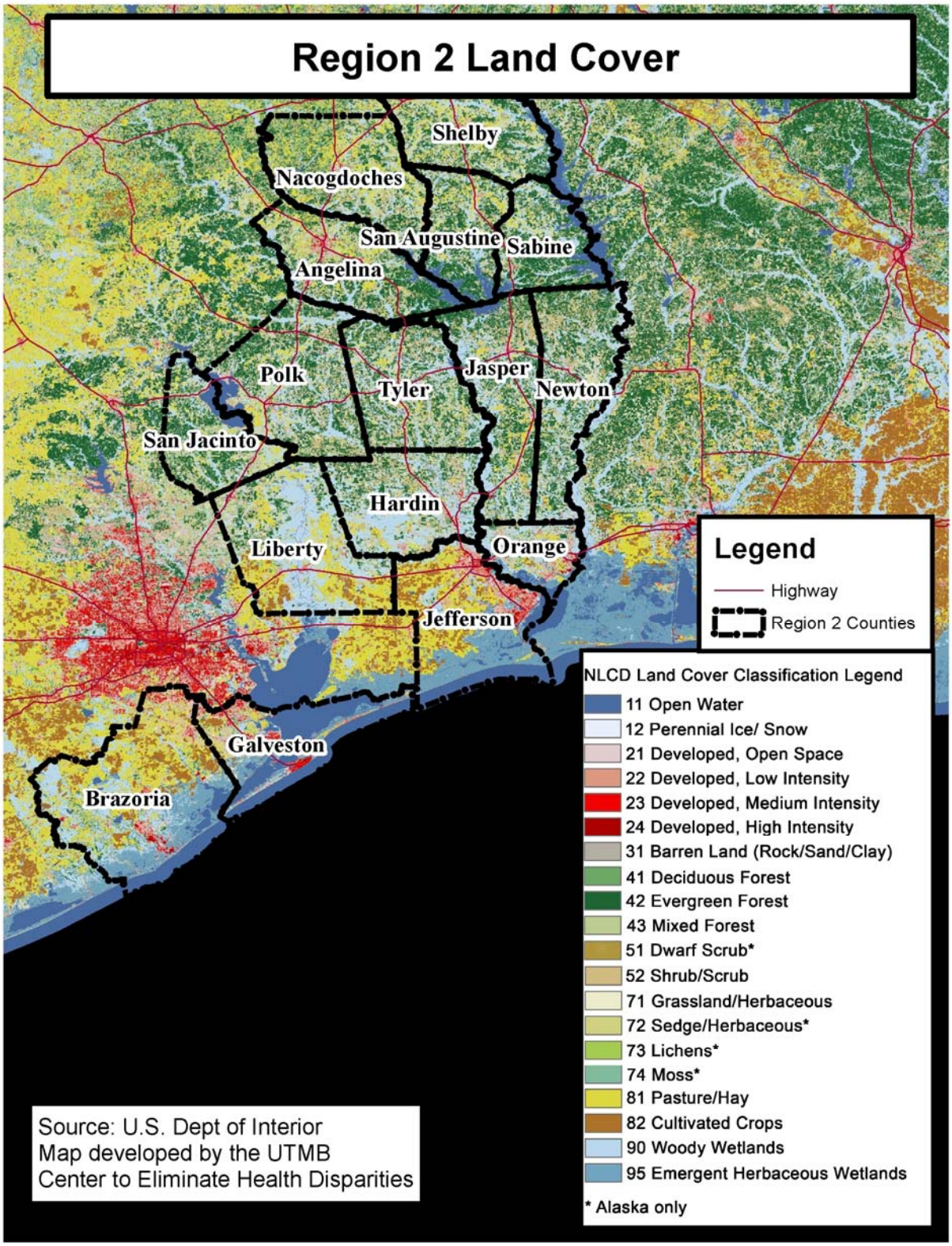


Scatter Plot of Ethnicity Change 2012-2017: Texas Population



Ethnicity (group)
- White
- Hispanic (of any descent)
- Black
- Asian/Pacific Islander
- 2+ Races
- American Indian & Alaska Native
- Other Non-Hispanic

Year
- 2012
- 2017


Region 2 Land Cover
Shelby
Nacogdoches
San Augustine
Sabine
Angelina
Polk
Tyler
Jasper
Newton
San Jacinto
Hardin
Liberty
Orange
Jefferson
Galveston
Brazoria
Legend
Highway
Region 2 Counties
NLCD Land Cover Classification Legend
11 Open Water
12 Perennial Ice/ Snow
21 Developed, Open Space
22 Developed, Low Intensity
23 Developed, Medium Intensity
24 Developed, High Intensity
31 Barren Land (Rock/Sand/Clay)
41 Deciduous Forest
42 Evergreen Forest
43 Mixed Forest
51 Dwarf Scrub*
52 Shrub/Scrub
71 Grassland/Herbaceous
72 Sedge/Herbaceous*
73 Lichens*
74 Moss*
81 Pasture/Hay
82 Cultivated Crops
90 Woody Wetlands
95 Emergent Herbaceous Wetlands
* Alaska only
Source: U.S. Dept of Interior
Map developed by the UTMB
Center to Eliminate Health Disparities