

# **Texas Healthcare Transformation and Quality Improvement Program**

## **REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN**

*December 19, 2012*

*RHP #18/Collin, Grayson & Rockwall Counties*

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## Section I. RHP Organization

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type State-owned non-state public or private	Organization Name	Lead Representative	Lead Representative Contact Information
<b>Anchoring</b> Governmental entity	1268658-02	756000873	State-County	Collin County	Judge Keith Self	<a href="mailto:Keith.self@collincountytexas.gov">Keith.self@collincountytexas.gov</a> 972/548.4631 2300 Bloomdale Rd, Suite 4192 McKinney, TX 75071
<b>IGT Entities</b>						
County	1268658-02	756000873	State-County	Collin County	Judge Keith Self Cheryl Williams, Commissioner Bill Bilyeu, County Administrator	<a href="mailto:keith.self@collincountytexas.gov">keith.self@collincountytexas.gov</a> <a href="mailto:cdwilliams@collincountytexas.gov">cdwilliams@collincountytexas.gov</a> <a href="mailto:bill.bilyeu@collincountytexas.gov">bill.bilyeu@collincountytexas.gov</a> 972/548/4631 2300 Bloomdale Rd, Suite 4192 McKinney, TX 75071
County		756000969	State-County	Grayson County	Judge Drue Bynum	<a href="mailto:bynumd@co.grayson.tx.us">bynumd@co.grayson.tx.us</a> 903/813-4228 100 S. Crockett Sherman, TX 75090
County			State-County	Rockwall County	Judge Jerry Hogan Dennis Bailey, Commissioner	<a href="mailto:jhogan@rockwallcountytexas.com">jhogan@rockwallcountytexas.com</a> <a href="mailto:dbailey@rockwallcountytexas.com">dbailey@rockwallcountytexas.com</a> 101 E. Rusk Street Rockwall, TX 75087 972/204-6000
Health Science Center	126686802	126686802	Public	UT Southwestern	Alice Marcee	<a href="mailto:Alice.marcee@utsouthwestern.edu">Alice.marcee@utsouthwestern.edu</a> 214/648-7907 5323 Harry Hines Blvd. Dallas, TX 75390-9008

Hospital District	135235306	1752302928	Public	Ector County Hospital District	John Riggs	500 West 4 <sup>th</sup> Street Odessa, Texas 79761
Community Mental Health	0840019-01	75-1761911	Non-state	LifePath Systems	Randy Routon	<a href="mailto:rrouton@LifePathSystems.org">rrouton@LifePathSystems.org</a> 214/578-0450 1416 North Church Street McKinney, TX 75069
Community Mental Health	1307233-06	75-1452360	Non-state	Texoma Community Center	Tony Maddox	<a href="mailto:tmaddox@mhmrst.org">tmaddox@mhmrst.org</a> 903/957-4867 315 West McLain Drive Sherman, TX 75092
Community Mental Health	1219883-04	<a href="tel:1752833832700">1752833832700</a> 0	Non-state	Lakes Regional MHMR Center	John Delaney	<a href="mailto:johnd@LRMHMRC.org">johnd@LRMHMRC.org</a> 972/524-4159 971/948-5173 Lakes Region MHMR Center 400 Airport Road Terrell, TX 75160

Performing Providers						
Health Science Center	126686802	126686802	Public	UT Southwestern	Alice Marcee	<a href="mailto:Alice.marcee@utsouthwestern.edu">Alice.marcee@utsouthwestern.edu</a> 214/648-7907 5323 Harry Hines Blvd. Dallas, TX 75390-9008
Community Mental Health	0840019-01	75-1761911	Non-state	LifePath Systems	Randy Routon	<a href="mailto:rrouton@LifePathSystems.org">rrouton@LifePathSystems.org</a> 214/578-0450 1416 North Church Street McKinney, TX 75069

Community Mental Health	1307233-06	75-1452360	Non-state	Texoma Community Center	Tony Maddox	<a href="mailto:tmaddox@mhmrst.org">tmaddox@mhmrst.org</a> 903/957-4867 315 West McLain Drive Sherman, TX 75092
Community Mental Health	1219883-04	<a href="tel:1752833832700">1752833832700</a>	Non-state	Lakes Regional MHMR Center	John Delaney	<a href="mailto:johnd@LRMHMRC.org">johnd@LRMHMRC.org</a> 972/524-4159 971/948-5173 Lakes Region MHMR Center 400 Airport Road Terrell, TX 75160
Hospital	1949976-01	75-6000969	Private Hospital	Texoma Medical Center	Justin Kendrick	<a href="mailto:jkendrick@thcs.org">jkendrick@thcs.org</a> 903/416.5123 5016 S. U.S. 75 Denison, TX 75020
Hospital	2203515-01		Private Hospital	Texas Health Presbyterian Hospital - WNJ	Vance Reynolds	<a href="mailto:vreynolds@wnj.org">vreynolds@wnj.org</a> 903/870-4611 500 N. Highland Avenue Sherman, TX 75092
Hospital	138910807	17508006289	Private	Children's Medical Center	Matt Moore	<a href="mailto:Matt.Moore@childrens.com">Matt.Moore@childrens.com</a> 214/456-1971 1935 Medical District Dr Dallas, TX 75235 214/456-1971
Hospital	169553801	460477873	Private	Tenet - Centennial Medical Center Frisco	Corey Davidson	<a href="mailto:Corey.davison@tenethealth.com">Corey.davison@tenethealth.com</a> 469/893-2293 1445 Ross Ave, Suite 1400 Dallas, TX 752-2703
<b>UC-only Hospitals</b>						
Hospital	092407002	17527707388004	Private	Texas Health Presbyterian Hospital Plano	Aaron Bujnowski	<a href="mailto:AaronBujnowski@TexasHealth.org">AaronBujnowski@TexasHealth.org</a> 682/236-7546 612 E. Lamar Blvd, Suite 1000 Arlington, TX 75611-4018

Other Stakeholders						
Hospital			Private	Texas Health Presbyterian Hospital Allen	Aaron Bujnowski	<a href="mailto:AaronBujnowski@TexasHealth.org">AaronBujnowski@TexasHealth.org</a> 682/236-7546 612 E. Lamar Blvd, Suite 1000 Arlington, TX 75611-4018
Hospital			Private	Tenet - Lake Point Hospital Rowlett	Corey Davidson	<a href="mailto:Corey.davison@tenethealth.com">Corey.davison@tenethealth.com</a> 469/893-2293 1445 Ross Ave, Suite 1400 Dallas, TX 752-2703
Hospital			Private	Texas Health Presbyterian Hospital Rockwall	Aaron Bujnowski	<a href="mailto:AaronBujnowski@TexasHealth.org">AaronBujnowski@TexasHealth.org</a> 682/236-7546 612 E. Lamar Blvd, Suite 1000 Arlington, TX 75611-4018
Hospital			Private	Medical Center of Plano	Kathleen Sweeney	<a href="mailto:Kathleen.sweeney@hcahealthcare.com">Kathleen.sweeney@hcahealthcare.com</a> 972/401-8757 HCA North Texas Division 6565 N. MacArthur Blvd. Ste. 350 Irving, TX 75039
Hospital			Private	Green Oaks Hospital	Kathleen Sweeney	<a href="mailto:Kathleen.sweeney@hcahealthcare.com">Kathleen.sweeney@hcahealthcare.com</a> 972/401-8757 HCA North Texas Division 6565 N. MacArthur Blvd. Ste. 350 Irving, TX 75039
Hospital			Private	Children and Community Health Center McKinney	Kathleen Sweeney	<a href="mailto:Kathleen.sweeney@hcahealthcare.com">Kathleen.sweeney@hcahealthcare.com</a> 972/401-8757 HCA North Texas Division 6565 N. MacArthur Blvd. Ste. 350 Irving, TX 75039
Hospital			Private	Columbia Medical Center of McKinney	Kathleen Sweeney	<a href="mailto:Kathleen.sweeney@hcahealthcare.com">Kathleen.sweeney@hcahealthcare.com</a> 972/401-8757 HCA North Texas Division 6565 N. MacArthur Blvd. Ste. 350 Irving, TX 75039

Hospital			Private	Baylor Medical Center at Frisco	Niki Shah	<a href="mailto:Nikita.Shah@BaylorHealth.edu">Nikita.Shah@BaylorHealth.edu</a> 214/265-3724 8080 N. Central Expressway Ste. 900 Dallas, TX 75206
Hospital			Private	The Heart Hospital Baylor Plano	Niki Shah	<a href="mailto:Nikita.Shah@BaylorHealth.edu">Nikita.Shah@BaylorHealth.edu</a> 214/265-3724 8080 N. Central Expressway Ste. 900 Dallas, TX 75206
Hospital			Private	Baylor Regional Medical Center at Plano	Niki Shah	<a href="mailto:Nikita.Shah@BaylorHealth.edu">Nikita.Shah@BaylorHealth.edu</a> 214/265-3724 8080 N. Central Expressway Ste. 900 Dallas, TX 75206
Hospital			Private	Baylor Medical Center McKinney	Niki Shah	<a href="mailto:Nikita.Shah@BaylorHealth.edu">Nikita.Shah@BaylorHealth.edu</a> 214/265-3724 8080 N. Central Expressway Ste. 900 Dallas, TX 75206
Clinic			FQHC	Health Services of North Texas	Ronald G. Aldridge	<a href="mailto:raldridge@healthntx.org">raldridge@healthntx.org</a> 940/381-1501 2540 K Ave. Plano, TX 75074
Clinic			Non-profit	Collin County Adult Clinic	John Ernst	<a href="mailto:johne.ccac@verizon.net">johne.ccac@verizon.net</a> 972/423-4941 2520 K Ave. #100 Plano, TX 75074
County Medical Associations/ Societies			Non-profit	Collin-Fannin Medical Society	Art Auer  On behalf of Dr. Kweller Hunt-Rains-Grayson Medical Society Grayson County	Collin-Fannin Medical Society 972/369-6707 11 North Tennessee St, Suite 309-C McKinney, TX 75069-4319  Hunt-Rains-Grayson Medical Society 214/202-7814 903/416-6250

Regional Public Health Directors			State	Texas Department Health Services Region 2/3	<b>Dr. James A. Zoretic</b> Regional Medical Director Earlene Quinn, Deputy Regional Director	<b>Regional Headquarters:</b> 1301 South Bowen Road, Ste. 200 Arlington, TX 76013 Mail Code 1905 817/264-4500
County Public Health Directors/Health Authorities			State & County	Collin County Health Care Services	Candy Blair Dr. Muriel Marshall	Collin County Health Care Services 825 N. McDonald ST #130 McKinney, TX 75069
County Public Health Directors/Health Authorities			State-County	Grayson County Public Health Department	John Teel-Director, Director	Grayson County Health Dept. <a href="mailto:teelj@co.grayson.tx.us">teelj@co.grayson.tx.us</a> 515 North Walnut St. Sherman, TX
Clinic			Non-profit	Plano Children's Medical Clinic	Susan Shuler	6853 Cot Road Plano, TX 75024 972/312-1288
Advocacy Group for FQHC			Non-profit	Healthcare Committee of Collin County	Marge Langteau	<a href="mailto:margelangteau@verizon.net">margelangteau@verizon.net</a>



## Section II. Executive Overview of RHP Plan

### Overarching RHP goals

*Regional Healthcare Partnership (RHP) 18 will implement, and evaluate through learning collaboratives, programs that are innovative and sufficiently large to make a significant impact on current unnecessary use of more restrictive, intensive, and expensive hospital services.*

Between 2012 and 2016, performing providers in RHP-18 will be conducting transformational and expansion activities associated with 14 consensus areas of need identified in Table 10 of Section III.

### Healthcare System Vision for RHP-18

*By 2016, the healthcare system in the three counties that form RHP-18, will exhibit characteristics of true transformation in its Medicaid health and behavioral healthcare systems. RHP-18 will provide seamless and timely access to a range of evidence-based health and medical services of such quantity and quality that will promote optimum outcomes for its eligible residents.*

*This Medicaid health and behavioral healthcare system will be interconnected across innovative models with multiple levels of appropriate care. Together, the healthcare providers in RHP-18 will deliver consumer health education, encourage the appropriate use of primary care and prevention, facilitate early intervention, provide advocacy, and ensure follow-up while protecting individual choice and privacy, and the public health and safety of the community.*

### High-level summary of existing RHP healthcare environment

Collin County ranks 1st of all Texas counties in *Health Indicators*, published by the Population Health Institute (PHI) at the University of Wisconsin. Rockwall County ranks 3rd, and Grayson County ranks 125th among Texas' 254 counties. Health indicators are discussed in Section III of this plan. Health indicators computed by the PHI are only one aspect of the total health portrait of RHP-18. This urban/rural area of Texas is growing at a remarkable speed. In one year Collin and Rockwall counties' populations grew by 3.8% each, and Grayson's by 0.4%, with a total of an estimated 1.01 million residents in these three counties as of July 2011. Per-capita income in Collin and Rockwall counties is higher than the average for the State of Texas; and in Grayson County it approximates the Texas average of \$24,870. Nearly 77,000 (7.6%) of these individuals are estimated to be living in poverty (6.5% in Collin, 4.5% in Rockwall and 12.6% in Grayson County)<sup>1</sup>, and about 124,196 (12%) are uninsured. Approximately 64,288 (6.3%) men, women and children are enrolled in Medicaid in RHP-18.

These counties face similar health challenges as other counties in this State. Among the key health challenges among underserved and uninsured populations are gaps in primary care access to prevent possibly avoidable use of local and remote emergency departments, limited availability of "after-hours" continuity of care clinics that address co-morbid medical/psychiatric conditions, effective linkages with nursing homes, in-home family based care for at-risk youth.

The location of health providers in RHP-18 is outdated and has not kept pace with the growth to the north, or reached out to remote areas to the northeast. Approximately 6,790 individual uninsured admission events were reported by all hospitals that treated residents from RHP 18 in 2010. If the average annual increase from 2008 to 2010 continues, an estimated 9,000 uninsured admission events would occur in 2015.

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<sup>1</sup> United Way report on file, 2011-2015 Texoma Needs Assessment, Texoma Council of Governments  
RHP Plan for RHP 18

In 2010, uncompensated care (UC) represented an average of 4.2% (\$197.6 million) of the gross patient revenue for all hospitals in Collin, 7.5% (\$69.5 million) in Grayson, and 4.5% (\$26.8 million) in Rockwall counties. With planned changes in how UC is managed and paid, this is likely to decrease, putting some pressures on community providers that cannot serve local needs sufficiently to prevent hospitalization, thus putting additional pressure on Dallas County facilities.

Hospitals and community providers must begin to cooperate in transforming health care in RHP-18.

RHP-18 providers participating in this Medicaid Transformation Waiver are focused on five of the 12 health indicators identified by the U.S. Center for Disease Control in **Healthy People 2020**. These five have emerged as important areas of need in the planning process for the Texas Healthcare Transformation and Quality Improvement Program in Collin, Grayson, and Rockwall counties.

- Access to health services
- Clinical preventive services
- Maternal, Infant, and Child Health
- Nutrition, Physical Activity and Obesity
- Social Determinants of medical and behavioral health problems

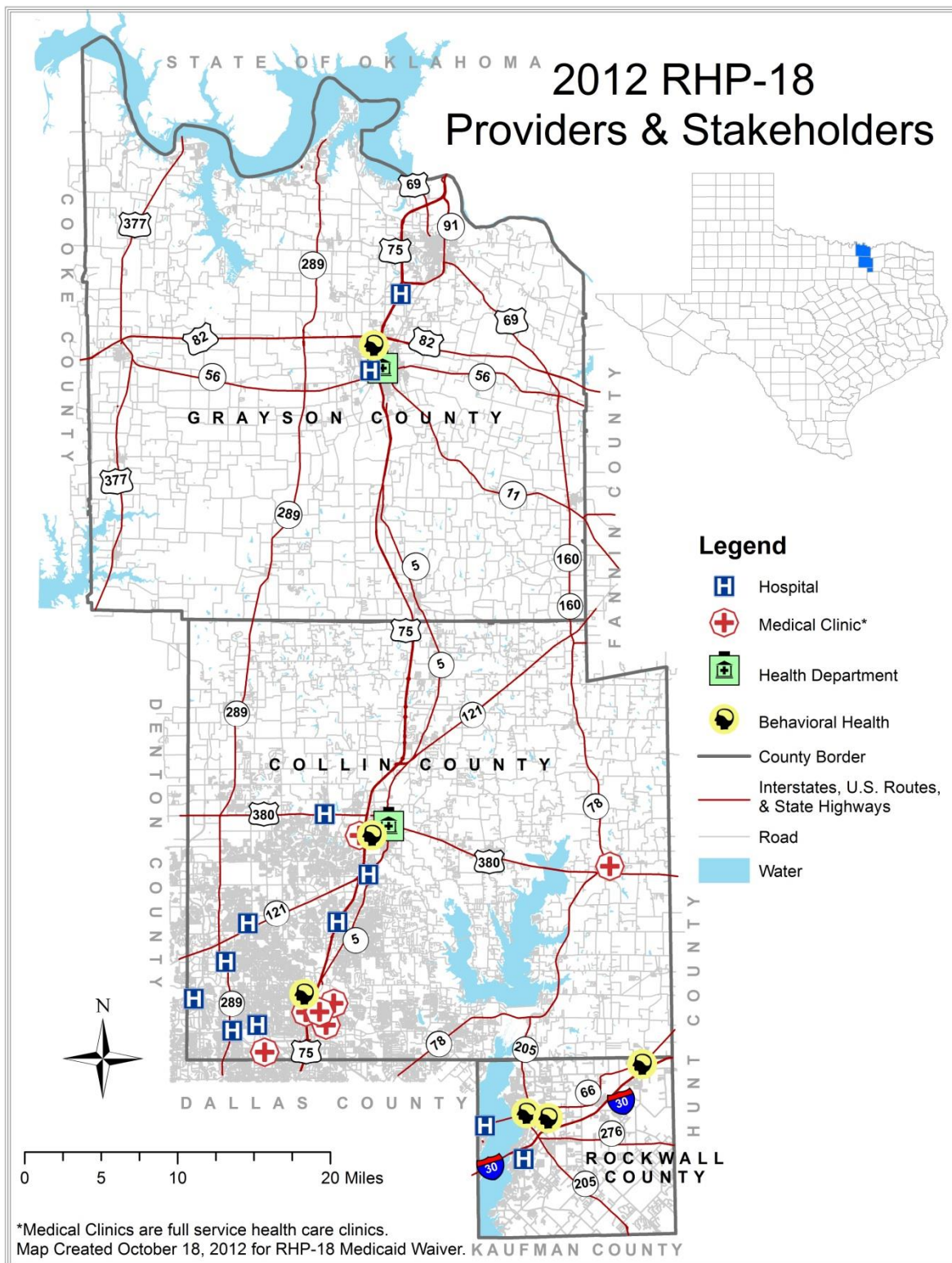
This Plan addresses these areas of need by expanding access to primary prevention and intervention in medical and behavioral health and increasing community education initiatives to prevent or avert and refer non-emergent cases presenting to emergency systems. New and expanded services will be dedicated to serving all ages and all racial and ethnic groups with innovative and collaborative evidence-based strategies. Innovation includes telemedicine, patient tracking systems, outreach and partnerships.

RHP-18 Delivery System Reform Incentive Payment (DSRIP) projects focus on expanding access to primary care for adults and children, establishing effective referral procedures, and monitoring systems. This includes addressing Potentially Preventable Admissions (PPAs) by increasing the number and type/mix of providers, expanding hours of operations, and installing follow up procedures, telephone consultations and case management activities. The medical home model for persons with chronic co-morbid physical and behavioral health conditions will be an important part of the plan. By enhancing culturally responsive programs, implementing disease registry systems, and increasing telehealth services, RHP-18 will reach out to a substantially heretofore underserved community.

### **Identification of regional areas, specifically listing counties covered under the partnership**

RHP-18 consists of three counties in north Texas (Collin, Grayson and Rockwall) that lie as a cluster directly north of Dallas County. In the southern borders of Collin County some metropolitan areas overlap, and may lie within with Dallas County. Geographic, socio-demographic and economic characteristics of RHP-18's counties, as they pertain to this transformation waiver plan, are discussed in Section III.

On the following page we have provided a map of the counties in RHP-18 illustrating the location of healthcare providers.



### *Summary of Categories 1-2 Projects*

<b>Project Title</b> Unique project ID for each project	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> Improvement Target (IT) identifier per RHP and outcome title	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
<b>Category 1: Infrastructure Development</b>			
<b>Category 1: PASS 1</b>			
Expand Pediatric Primary Care 138910807.1.1.1 <u>Children's Medical Center in Plano</u>	Expand the capacity of pediatric primary care in Collin County through one additional Children's Medical Center (CMC) primary care center so that children receive the right care at the right time; have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services.	OD-9 Right Care, Right Setting. IT-9.2 ED appropriate utilization. No separate narrative or table provided to date.	\$4,150,467
Expand Pediatric Primary Care 138910807.1.1.2 <u>Children's Medical Center in Plano</u>	Expand the capacity of pediatric primary care in Collin County through: (B) expanding primary clinic hours and (C) expanding primary care clinic staffing to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time; have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services.	OD-9 Right Care, Right Setting. IT-9.2 ED appropriate utilization.	\$3,779,890
Enhance Community Based settings where behavioral health services may be delivered in underserved areas 138910807.1.3 <u>Children's Medical Center in Plano</u>	Expand pediatric behavioral health capacity in CMC primary care settings in Collin County to align and coordinate care for behavioral and medical illnesses in an attempt to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services for care coordination of medical and behavioral health services.	OD-1 Primary Care and Chronic Disease Management IT-1.18 Follow-up After Hospitalization for Mental Illness.	\$3,582,248

<p>Enhance Community Based settings where behavioral health services may be delivered in underserved areas</p> <p>138910807.1.4</p> <p><u>Children's Medical Center in Plano</u></p>	<p>Expand pediatric behavioral health capacity in CMC primary care settings in Collin County to align and coordinate care for behavioral and medical illnesses to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services for care coordination of medical services and behavioral health services.</p>	<p>OD-1 Primary Care and Chronic Disease Management IT-1.18 Follow-up After Hospitalization for Mental Illness.</p>	<p>\$3,705,774</p>
<p>Expand Primary and Specialty Care Capacity</p> <p>126686802.1.1</p> <p><u>UT Southwestern</u></p>	<p>Projections targeting unique patients and patient visit volumes are still being developed.</p>	<p>As a Non-hospital Performing Provider, UT Southwestern is opting to indicate 'TBD' for both the improvement targets and their associated achievement levels in the initial plan submission. TBD represents the option to determine the characteristics of the patient population before selecting outcome measures for improvement.</p>	<p>\$4,704,220</p>
<p>Expand Primary and Specialty Care Capacity</p> <p>126686802.1.2</p> <p><u>UT Southwestern</u></p>	<p>Projections target approximately 4,500 unique patients and 12,750 visits in the first full year of operation. Clinics open in two phases: Family Medicine followed by OB/GYN. Internal Medicine by February 2013.</p>	<p>As a Non-hospital Performing Provider, UT Southwestern is opting to indicate 'TBD' for both the improvement targets and their associated achievement levels in the initial plan submission. TBD represents the option to determine the characteristics of the patient population before selecting outcome measures for improvement.</p>	<p>\$6,683,880</p>
<p>Establish more primary care clinics</p> <p>194997601.1.1</p> <p><u>Texoma Medical Center</u></p>	<p>Divert non-emergent patients away from the emergency departments at two local hospitals, and expand access to primary and urgent health care to indigent health patients, Medicaid patients, Medicaid-eligible patients, and the working poor (i.e. uninsured and underinsured residents).</p>	<p>TBD.</p>	<p>\$ 12,735,000</p>

Implement technology-assisted services (telehealth, telemonitoring, telementoring, and telemedicine)  084434201.1.1 <u>Texoma Community Center</u>	The project seeks to develop, enhance and promote telemedicine and telehealth protocols and practices to support, coordinate, or deliver behavioral health services, thereby improving access to care and expanding the population served.	OD-10: Quality of Life/Functional Status; IT-10.1 Quality of life (standalone measure).	\$ 353,840
Enhance Service Availability: Substance Abuse Services  084434201.1.2 <u>Texoma Community Center</u>	Expand treatment for substance abuse. The project seeks to develop and implement comprehensive outpatient substance abuse programs to expand access to care within the community and reduce unnecessary hospitalizations.	OD-10: Quality of Life/Functional Status; IT-10.1 Quality of life (standalone measure).	\$ 295,756
Enhance Service Availability: Counseling Services  084434201.1.3 <u>Texoma Community Center</u>	The project seeks to develop and expand counseling services within the community and expand access to unfunded and underserved individuals.	OD-10: Quality of Life/Functional Status; IT-10.1 Quality of life (standalone measure).	\$ 470,370
Enhance Performance Improvement and Reporting Capacity  084434201.1.4 <u>Texoma Community Center</u>	The project implements process improvement methodologies to enhance safety, quality and efficiency in overall health care service provision while maintaining excellent quality of care standards through continuing education and training and QI management processes.	IT-9.2 Right Care, Right Setting Outcome Domain	\$ 143,249
Telemedicine/Telehealth  121988304.1.1 <u>Lakes Regional MHMR Center</u>	1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region, including patient consultations and quality improvements using methods such as rapid cycle improvement.	IT-10 Quality of Life	\$ 965,797
<b>Category 1: PASS 2</b>			
Expand Behavioral Health Specialty Care Capacity  084001901.1.1 <u>LifePath Systems</u>	Accommodate high demand for behavioral health services for low income individuals by increasing the capacity for specialty behavioral healthcare services, including services that prevent unnecessary use of higher cost intensive treatment including hospitalization.	OD-1-Primary Care and Chronic Disease Management; IT-1.9 depression management.	\$17,263,705
Expand Primary Care  169553801.1.1 <u>Centennial Medical Center</u>	Expand services to address diabetes, women's wellness and HIV/AIDS	IT-1.10 Diabetes Care; IT-12.2 Cervical Cancer Screening	\$570, 528

Category 1: PASS 3			
Expand Behavioral Health: Trauma Counseling  121988304.1.2  <u>Lakes Regional MHMR Center</u>	1.12 Ensure persons not currently eligible for state supported services per diagnostic restrictions have access to trauma related services to prevent unnecessary use of emergency services and hospitalization.	OD-10 IT-10 Quality of Life and Functional Status	\$ 2,588,626

Category 2: Program Innovation and Redesign			
Category 2: PASS 1			
Enhance/Expand Medical Homes  138910807.2.1  <u>Children's Medical Center</u>	Institute a medical home team-based approach to care for pediatric patients across all locations including staff training, IT systems applications, and health promotion and education.	OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization.	\$4,199,877
Integrate Primary and Behavioral Health Care  084001901.2.1  <u>LifePath Systems</u>	Improve the physical health of individuals with chronic mental illnesses, and to improve the mental health of individuals with chronic physical illnesses.	OD- 10 Quality of Life/ Functional Status; IT 10.1 Quality of Life (Standalone measure)	\$6,427,984
Combine Primary and Behavioral Healthcare  08843201.2.1  <u>Texoma Community Center</u>	The project seeks to combine primary and behavioral health care for over-utilizers of local health care resources and those within the community who are underserved or poorly served.	OD-10 Quality of Life/Functional Status IT-10.1 Quality of life- (standalone measure)	\$ 441,259
Category 2: PASS 2			
Intervention for Targeted BH Population to Prevent Unnecessary Use of Higher LOC  084001901.2.2  <u>LifePath Systems</u>	Provide specialized services to forensic behavioral health clients to prevent unnecessary incarceration, including specialized assertive community intervention and support services at arrest, at release, and in the community, linking with community corrections programs, and other social support systems.	OD-9 Right Care, Right Setting; IT-9.1 Appropriate interventions to prevent unnecessary use of higher levels of care.	\$14,821,470



Interventions to prevent unnecessary use of higher level services.  08843201.2.2 <u>Texoma Community Center</u>	Interventions to prevent unnecessary use of higher level services including supportive housing, education for at-risk forensic populations, wellness and medication education, and continuous supportive therapies.	OD-9 Right Care, Right Setting; IT-9.1 Appropriate interventions to prevent unnecessary use of higher levels of care.	\$4,498,916
Interventions to prevent unnecessary use of higher level services.  121988304.2.1 <u>Lakes Regional MHMR Center</u>	Directly improve health, health literacy, and quality of life in ways that will reduce risks for preventable disease among persons with mental illnesses, targeting risk for obesity.	OD-6; IT-6.1 Patient Satisfaction.	\$ 863,421
<b>Category 2: PASS 3</b>			
Whole Health Peer Support Services  084001901.2.3 <u>LifePath Systems</u>	Respond to high need for health and wellness education for low income persons with chronic health problems at a peer level.	OD-10; IT10.1: Quality of Life and Functional Status.	\$3,104,409
Increase efficiencies in primary care clinic for persons with co-morbid behavioral health and medical conditions  08843201.2.3 <u>Texoma Community Center</u>	Innovation in combining behavioral health with medical care, with patient-centered scheduling model, assessment of visit compliance, interprofessional care.	OD-10; IT10.1: Quality of Life and Functional Status.	\$ 3,752,026
Day treatment for children with autism and behavioral health problems.  121988304.2.2 <u>Lakes Regional MHMR Center</u>	Prevent unnecessary hospitalizations for children with autism.	OD-10; IT10.1: Quality of Life and Functional Status.	\$ 3,882,940



## Section III. Community Needs Assessment

This section of the RHP-18 Plan provides information prescribed by HHSC. All data sources are identified.

### **Geographic, Socio-Demographic and Economic Characteristics**

The Regional Healthcare Partnership 18 (RHP-18) consists of three counties (Collin, Grayson and Rockwall) in North Texas, geographically located directly north of Dallas County. In the southern borders of Collin County metropolitan areas overlap with Dallas County. The overlap of city limits across county lines is an important consideration for the RHP-18 plan.

According to the U.S. Census Bureau, there are an estimated 1,014,935 residents in RHP-18, approximately 172,879 (17%) of whom are estimated to be uninsured. The Texas Department of State Health Services (DSHS) Medicaid website reports that in 2012, 64,288 (6.3%) individuals in RHP-18 were enrolled in Medicaid, reflecting increases over 2011, of 10% in Collin, 3% in Grayson, and 2% in Rockwall.

Collin and Rockwall counties are included in the Dallas-Fort Worth-Arlington Standard Metropolitan Statistical Area (SMSA) as defined by the U.S. Census Bureau. Grayson County is part of the Sherman-Denison SMSA. While none of these counties is classified as rural or small, large contiguous areas of each county are considered remote when considering access to health care. The urban population density in Collin County is 2,754 persons per square mile compared to Dallas' 3,401. Regarding rural populations, in Grayson County, 43% of the population lives in rural areas as defined by the U.S. Census Bureau, in Rockwall 16%, and in Collin, 5%. In Grayson County, the rural population density is 58 compared to Collin's 71, and Rockwall's 141. As a comparison, Dallas County's rural density is about 90.

Healthcare providers have historically been located close to the urban sectors of RHP-18, particularly in Collin County where eight acute care hospitals are located along the Southern-most border.

### **Health Status**

Table 2 displays 18 indicators for the three counties in RHP-18 that we believe to be germane to this community needs assessment, with comparison data for Texas and the Nation. The sources are noted below the table.

While these high-level indicators influence the overall approach to the plan for expanding and transforming Medicaid services, data reporting existing services and their utilization, population health status and changes, are proxies for estimates of need. The qualitative analyses of these data combined with the perspectives of the county government, the citizens, and the healthcare providers enable us to pinpoint specific issues/needs that have been subsequently addressed by the performing providers as parties to this plan. Thus this RHP-18 plan relied both on high level and local assessments to establish and guide the projects, milestones, metrics and outcomes selected for the proposed 2011-16, Delivery System Reform Incentive Payment (DSRIP) projects.

Each county in RHP-18 has distinguishing characteristics and some features in common. As shown in Table 1, these communities have relatively healthy economies, and the communities are predominantly comprised of White Non-Hispanic residents. The culture is continuously changing, however, and some demographic features indicate important areas for attention. A distinguishing feature of Collin County for example, is the presence of a large Asian population compared to the rest of Texas and the sizeable proportion of individuals who speak a language other than English at home.

Increases in non-farm employment, retail sales, median and per capita income indicate economic growth in Collin and Rockwall counties. Grayson County appears to have strong economic indicators, but faces a growing elderly population, decreased employment, and limited access to primary medical care.

**Table 1. RHP 18 County and State Indicators**

	<u><b>COLLIN</b></u>	<u><b>GRAYSON</b></u>	<u><b>ROCKWALL</b></u>	<u><b>TEXAS</b></u>
Land area in square miles, 2010	841	933	127	261,231.71
Persons per square mile, 2010	930	130	617	96
Population, 2011 estimate	812,226	121,419	81,290	25,674,681
Population change 4/1/10 - 7/1/11	4%	0.4%	4%	2%
Proportion of population enrolled in Medicaid	5%	13%	6%	13%
Persons under 18 years, percent, 2011	28%	24%	29%	27%
Persons under 18 enrolled in Medicaid	11%	28%	12%	32%
Persons 65 years and over, percent, 2011	8%	16%	10%	11%
Female persons, percent, 2011	51%	51%	51%	50%
Persons below poverty level, percent (2)	7%	14%	6%	17%
Percent population uninsured (ages 0 - 64)	17%	25%	19%	26%
Black	9%	6%	6%	12%
White	76%	89%	89%	81%
White non-Hispanic	62%	78%	73%	45%
Hispanic or Latino	15%	12%	17%	38%
Asian	12%	1%	3%	4%
Other racial ethnic groups	1.0%	2.0%	1.0%	1.0%
Foreign Born (2)	17%	6%	9%	16%
Over age 5: speak other language at home (2)	25%	10%	15%	34%
High school graduates over age 25 (2)	93%	85%	91%	80%
Bachelor's degree or higher over age 25 (2)	48%	19%	36%	26%
Veterans (2)	42,078	10,176	5,425	1,635,367
Housing units (3)	300,960	53,727	27,939	9,977,436
Households (2)	268,042	45,545	24,790	8,539,206
Per capita money in previous 12 months (2)	\$37,362	\$23,242	\$33,274	\$24,870
Median household income (2)	\$80,504	\$46,875	\$78,032	\$49,646
Private nonfarm employment change 2000-09	56%	-4%	74%	11%
Retail sales per capita, 2007	\$16,850	\$13,493	\$12,797	\$13,061

(1) 2011 estimates

(2) Averages for five years 2006-10

(3) for 2010

Table 2 displays key health indicators for each RHP-18 county. These data were obtained for each county at: <http://www.countyhealthrankings.org/#app/texas/2012/measures/factors/9/map>. Of particular note in this table are the rates of low birth weight infants that are only slightly lower than the average for all Texas counties, and higher than the national average. Also of note, RHP-18 counties overall have lower proportions of uninsured residents than the State as a whole but higher than the national estimates.

**Table 2. Health Outcomes and Health Facts (1)**

	Texas	Collin	Grayson	Rockwall	National
<b>Health Outcomes</b>		<b>1</b>	<b>125</b>	<b>3</b>	
<b>MORTALITY RANKING</b>		<b>2</b>	<b>138</b>	<b>3</b>	
<a href="#">Premature death</a>	7,186	4,038	8,901	4,584	5,466
<b>MORBIDITY RANKING</b>		<b>14</b>	<b>121</b>	<b>8</b>	
<a href="#">Poor or fair health</a>	19%	11%	19%	6%	10%
<a href="#">Poor physical health days</a>	3.6	2.7	3.7	2.9	2.6
<a href="#">Poor mental health days</a>	3.3	2.5	5.8	3.1	2.3
<a href="#">Low birthweight</a>	8.20%	7.60%	7.40%	7.00%	6%
<b>Health Factors</b>		<b>2</b>	<b>54</b>	<b>4</b>	
<b>HEALTH BEHAVIORS RANKING</b>		<b>1</b>	<b>52</b>	<b>5</b>	
<a href="#">Adult smoking</a>	19%	11%	24%	8%	14%
<a href="#">Adult obesity</a>	29%	25%	27%	27%	25%
<a href="#">Physical inactivity</a>	25%	22%	27%	27%	21%
<a href="#">Excessive drinking</a>	16%	13%	11%	missing	8%
<a href="#">Motor vehicle crash death rate</a>	17	9	25	11	12
<a href="#">Teen birth rate</a>	63	24	63	26	22
<b>CLINICAL CARE RANKING</b>		<b>2</b>	<b>45</b>	<b>17</b>	
<a href="#">Uninsured</a>	26%	17%	25%	19%	11%
<a href="#">Primary care physicians</a>	1,050:1	681:1	1,305:1	1,080:1	631:1
<a href="#">Preventable hospital stays</a>	73	66	73	82	49
<a href="#">Diabetic screening</a>	81%	85%	83%	85%	89%
<b>SOCIAL AND ECONOMIC RANKING</b>		<b>3</b>	<b>81</b>	<b>5</b>	
<a href="#">Unemployment</a>	8.20%	7.50%	8.40%	7.60%	5.40%
<a href="#">Children in poverty</a>	26%	10%	21%	9%	13%
<a href="#">Children in single-parent households</a>	32%	18%	33%	20%	20%

(1) University of Wisconsin Population Health Institute. County Health Rankings 2012. Accessible at [www.countyhealthrankings.org](http://www.countyhealthrankings.org).

Diabetic screening is the percent of Medicaid patients with diabetes who receive recommended annual screening

Rates of chronic disease vary slightly by source. The sources we used indicate that prevalence rates in RHP-18 for targeted conditions in this plan are equal to or lower than the State of Texas (%) for Asthma (8.2%), Diabetes (9.7%), overweight/obesity (66.7%), and Cardiovascular Disease (8.2%). More than a quarter of pregnant women in each county (28% in Collin, 42% in Grayson, and 31% in Rockwall) do not receive prenatal care within the first trimester. Higher proportions of White, compared to Black and Hispanic women, receive early prenatal care.

None of these counties has a public hospital. Local hospitals, public health departments, and publically funded clinics are the staples of the healthcare system in RHP-18. Table 3 displays total numbers from <http://www.healthindicators.gov/> the Health Indicators Warehouse website, for hospital and personnel resources in RHP-18. Regarding public health departments, Collin and Grayson counties have full service public health departments. Rockwall County, however, has a different structure inasmuch as this county utilizes a city office of code enforcement and cooperates with the Dallas County Health Department for other public health related functions.

While none of these counties is a Health Professions Shortage Area or a Medically Underserved Area according to Federal criteria, there are pockets of severely limited access to primary and preventive care leading to potentially preventable hospital admissions (PPAs).

There are currently two Federally Qualified Health Clinics in RHP-18. Although it is difficult to pinpoint precisely how many primary care physicians are available per/1,000 residents, and even more difficult to document the number of physicians who accept Medicaid or uninsured persons (if any), the below table reflects the best available data from the CDC, DSHS, and other few national websites that count healthcare workers at the county level.

**Table 3. Healthcare Resources**

<i>Hospital Resources</i>	<u>Collin</u>	<u>Grayson</u>	<u>Rockwall</u>	<b>Total RHP 18</b>
Acute care hospitals	10	3	2	15
Psychiatric care licensed beds	0	0	0	0
<i>Healthcare Personnel</i>				
Direct Care Physicians	1,483	245	113	1,841
Primary Care Physicians	691	86	60	837
Physician Assistants and Nurse Practitioners	357	55	36	448
EMS Personnel Per 100,000 population	187	447	323	Not Available

[http://www.dshs.state.tx.us/chs/hprc/tables/Emergency-Medical-Services-\(EMS\)-by-County-of-Residence---September,-2011/](http://www.dshs.state.tx.us/chs/hprc/tables/Emergency-Medical-Services-(EMS)-by-County-of-Residence---September,-2011/)

Collin ranked 223 for EMS personnel

Grayson ranked 53 for EMS personnel

Rockwall ranked 105 for EMS personnel

Texas ranks 42nd with 212/100,000 physicians

## **Key health challenges specific to region**

### ***Potentially Preventable Hospital Admissions and ED Utilization***

Tables 4, 5 and 6 present each county's data for each of the 10 conditions identified by DSHS as Potentially Preventable Hospital Admissions (PPAs) in Texas over a five year period of time (2006-10). We provide presented total admissions, average length of stay (ALOS), total charges in millions, average charge, percent of uninsured admissions, and the zip codes representing approximately half of the total admissions for that county per PPA. Some data were unavailable for Grayson and Rockwall counties (shaded).

### **Collin County**

Table 4 provides Collin County data. The county seat in Collin County is McKinney. The median age in Collin County is 34, and 8% of residents are over age 65 (Table 1). Seven percent of Collin County residents live in poverty. In FY 2009, Collin County reported \$669,300 spent for indigent health care.

In Collin County, two zip code areas (75070 and 75069) contributed the largest number of admissions for angina, bacterial pneumonia, congestive heart failure (CHF), dehydration, and hypertension. These factors may suggest that outreach to nursing homes may be important. The top three highest average charges were for pneumonia, CHF, and urinary tract infections (UTI), followed by chronic obstructive pulmonary disease (COPD), long-term diabetes problems, and asthma.

**Table 4. Collin County Potentially Preventable Admissions - Five Years: 2006 - 2010**

<b><u>PPA</u></b>	<b><u>Total (Per Year)</u></b>	<b><u>ALOS*</u></b>	<b><u>Total Charges</u></b>	<b><u>Ave. Charge</u></b>	<b><u>Percent Uninsured</u></b>	<b><u>Combining Zip Codes ≥ 50%**</u></b>
Angina	183 (37)	1.9	\$ 3.4	\$ 18,366	6.0%	070, 069, 098, 002, other
Asthma	1796 (359)	4.6	\$ 54.8	\$ 30,501	13.7%	069, 287, 075, other
Bacterial Pneumonia	5090 (1018)	5.6	\$ 189.1	\$ 37,157	6.5%	069, 070, 002, other
Congestive Heart Failure	4950 (990)	5.4	\$ 182.5	\$ 36,866	5.8%	069, 070, 023, other
COPD	2505 (410)	5.4	\$ 87.6	\$ 34,970	5.2%	069, 002, 098, other
Dehydration	1394 (279)	3.6	\$ 28.9	\$ 20,760	4.4%	070, 069, 023, 002, other
Diabetes - Short Term	819 (164)	3.8	\$ 22.4	\$ 27,950	26.0%	287, 034, 069, 098, 023, other
Diabetes - Long Term	1639 (328)	6.6	\$ 69.3	\$ 42,276	11.3%	069, 098, 025, 002, other
Hypertension	1016 (203)	2.8	\$ 23.1	\$ 22,715	18.5%	069, 287, 070, 074, other
UTI	3643 (729)	4.4	\$ 92.6	\$ 25,418	7.5%	069, 075, 023, 074, 002, other

## Grayson County

Table 5 provides Grayson County data. The county seat for Grayson County is Sherman, located near the Oklahoma border. The median age is 40, and 16% of the residents are over age 65 (Table 1). Fourteen percent of the population lives in poverty.

**Table 5. Grayson County Potentially Preventable Admissions - Five Years: 2006 - 2010**

<b>PPA</b>	<b>Total (Per Year)</b>	<b>ALOS*</b>	<b>Total Charges</b>	<b>Ave. Charge</b>	<b>Percent Uninsured</b>	<b>Combining Zip Codes ≥ 50%**</b>
Angina						
Asthma	519 (104)	4.1	\$ 9.7	\$ 18,640	13.9%	020, 090, 092
Bacterial Pneumonia	2322 (464)	5.3	\$ 51.6	\$ 22,229	5.1%	020, 090, 092
Congestive Heart Failure	1982 (396)	5.3	\$ 44.3	\$ 22,341	3.9%	020, 090, 092
COPD	1624 (325)	4.7	\$ 32.6	\$ 20,066	4.4%	020, 090
Dehydration	646 (129)	3.9	\$ 9.5	\$ 14,630	3.4%	020, 090
Diabetes - Short Term	306 (61)	3.8	\$ 5.3	\$ 17,242	22.5%	020, 090
Diabetes - Long Term	662 (132)	5.8	\$ 16.3	\$ 24,653	7.3%	090, 020
Hypertension	351 (70)	2.9	\$ 4.9	\$ 14,002	12.8%	020, 090, 092
UTI	1331 (266)	4.6	\$ 22.2	\$ 16,670	4.9%	020, 090, 092

In FY 2009, Grayson County reported \$1,711,234 spent for indigent health care. In Grayson County, two zip code areas (75020 and 090) contributed the largest number of admissions. The highest charges over this five-year period were for pneumonia, CHF, and COPD, followed by UTI and asthma. These data also suggest follow up with nursing home residents may be important. No data were available for angina.

## Rockwall County

Table 6 provides data for Rockwall County. The county seat for Rockwall County is Rockwall. The median age is 36, and 10% of the population is over age 65. In Rockwall County, 6.4% of the residents live in poverty (Table 1). In FY 2009, Rockwall County reported \$197,026 spent for indigent health care.

The greatest proportion of admissions for pneumonia, CHF, COPD, and UTI came from zip code 75087. PPAs with the highest charges were long-term complications of diabetes, pneumonia, and CHF. Data were not available for angina, asthma, or hypertension.

**Table 6. Rockwall County Potentially Preventable Admissions - Five Years: 2006 - 2010**

<b>PPA</b>	<b>Total (Per Year)</b>	<b>ALOS*</b>	<b>Total Charges</b>	<b>Ave. Charge</b>	<b>Percent Uninsured</b>	<b>Combining Zip Codes ≥ 50%**</b>
Angina						
Asthma						
Bacterial Pneumonia	727 (145)	4.9	\$ 19.8	\$ 27,289	4.1%	087
Congestive Heart Failure	506 (101)	4.5	\$ 12.8	\$ 25,265	3.8%	087
COPD	403 (80)	4.2	\$ 10.1	\$ 25,102	0.0%	087
Dehydration	203 (40)	3.1	\$ 3.3	\$ 16,384	4.9%	087, 032
Diabetes - Short Term						
Diabetes - Long Term	186 (37)	5.0	\$ 5.8	\$ 31,631	5.4%	189
Hypertension						
UTI	406 (81)	4.0	\$ 9.0	\$ 22,203	4.4%	087

In every county in RHP-18, the highest proportion of uninsured potentially preventable admissions (PPAs) is diabetes for long-term problems. In Collin and Grayson, asthma and hypertension admissions include a substantial proportion of uninsured events. Of note is the presence of a co-morbid psychiatric condition in between 25% to 50% of these PPAs.

### **Other issues in PPAs and ED use in contiguous counties**

Due to the close proximity and overlap between Collin and Dallas counties admissions to hospitals in Dallas County are of importance in planning the healthcare system. Admissions to Parkland Memorial Hospital (Parkland) for all RHP-18 counties are important, and admissions to all local RHP-18 hospitals are also critical data for planning.

Table 7 provides PPAs to hospitals located in Dallas County for Collin County residents for the past 15 months, by the total number of admissions, and the proportion of private insurance, public insurance, and uninsured events. Dallas County has a health and behavioral health care system of immense resources for Medicaid and uninsured populations, compared to RHP-18. Thus, it is an important aspect of the system when considering healthcare needs in RHP-18, in that patient flow to resources outside of RHP-18 provide an important opportunity to recognize limited or underdeveloped resources in these three counties that if expanded would reduce the burden on hospitals in Dallas particularly Parkland Memorial Hospital as the only major public hospital a large geographic area. RHP-18 also relies on private healthcare facilities in Dallas County for behavioral health emergencies.

**Table 7. Collin County PPA to All Dallas County Hospitals January 2011- march 2012**

Payment Source	Diabetes Short Term	Diabetes Long Term	Congestive Heart Failure	Bacterial Pneumonia	Dehydration	Hypertension	Angina (Not treated)	Adult Asthma	UTI	COP D	Totals
<b>Totals</b>	<b>126</b>	<b>83</b>	<b>168</b>	<b>252</b>	<b>72</b>	<b>48</b>	<b>6</b>	<b>33</b>	<b>164</b>	<b>91</b>	<b>1043</b>
<b>Insured &amp; Medicare</b>	71%	43%	38%	48%	58%	52%	50%	55%	38%	43%	48%
<b>Uninsured</b>	13%	48%	55%	47%	35%	31%	17%	30%	56%	53%	44%
	17%	8%	8%	4%	7%	17%	33%	15%	5%	4%	8%

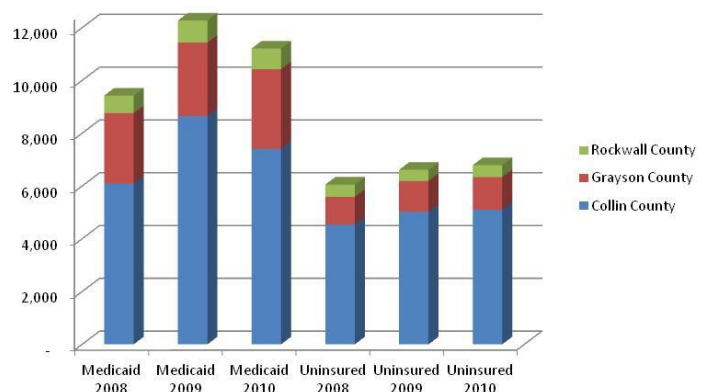
Tables 8 and 9 on the following pages provide information about the admissions from RHP-18 to all hospitals in these three counties and to Dallas County hospitals, combined, and admissions to Parkland Memorial Hospital. Interestingly, as shown in Table 8 and its accompanying graph, admissions were lower for Medicaid patients in 2010 compared to 2009, but higher for uninsured patients in 2010 compared to 2009. It is unclear if this is a trend or an anomaly.

In the first quarter of 2012 there were 14,035 Emergency Department (ED) visits reported for uninsured residents of RHP-18 to hospitals in RHP-18 and Dallas County hospitals combined (18.7% of all events), an increase of 15% over the previous year. Reported Medicaid and Medicare covered ED visits were 22,891, an increase of 23% over the same quarter in 2011. We also know from available data that an estimated 25% of these events are for individuals who are released without needing inpatient care. Between January 2011 and April 2012, Parkland Memorial Hospital (Parkland) discharged 577 uninsured admissions back to RHP-18, 4.3% of which were for PPAs. These individuals represent a population that will have access to expanded primary care services under the DSRIP projects proposed in this plan.

**Table 8: RHP 18 Admissions to All Hospitals**

Medicaid 2008	Medicaid 2009	Medicaid 2010	Uninsured 2008	Uninsured 2009	Uninsured 2010
6,085	8,643	7,408	4,537	5,022	5,100
2,677	2,791	3,020	1,050	1,170	1,239
668	839	785	468	421	451
9,430	12,273	11,213	6,055	6,613	6,790

Graph Table 8: RHP 18 Admissions to all hospitals serving these counties 2008 - 10



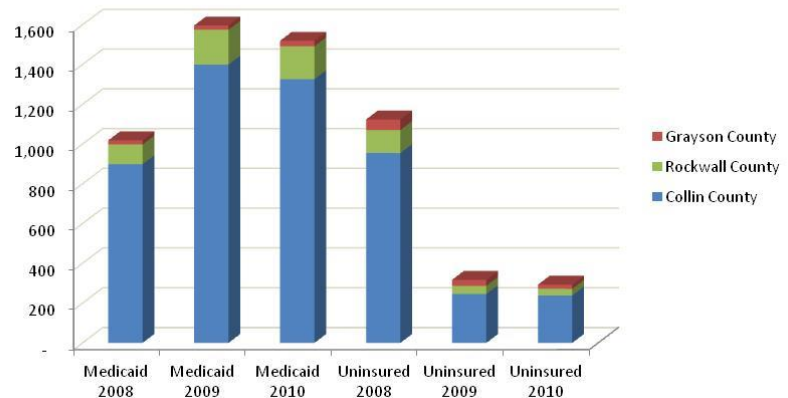


**Table 9. RHP 18 Admissions To Parkland Hospital 2008-10**

<b>Medicaid 2008</b>	<b>Medicaid 2009</b>	<b>Medicaid 2010</b>	<b>Uninsured 2008</b>	<b>Uninsured 2009</b>	<b>Uninsured 2010</b>
899	1,400	1,327	955	246	238
99	175	165	116	41	34
<u>21</u>	<u>22</u>	<u>28</u>	<u>53</u>	<u>30</u>	<u>21</u>
1,019	1,597	1,520	1,124	317	293

As shown in Table 9 and its accompanying graph above, RHP-18 admissions to Parkland Memorial have decreased in the total number of uninsured events. This may be a function of patient transfers among hospitals in the general metropolitan area or increasing enrollment in Medicaid.

Data in tables 7, 8 and 9 were obtained by request, from the Dallas-Fort Worth Hospital Council Foundation.

**Graph Table 9: Parkland Hospital Admissions from RHP 18**

The needs in RHP-18 regarding PPAs and ED visits are at the heart of our plan to expand primary care access and implement innovative community interventions.

### Children's Health

Compared to 2009, the number of children of Hispanic ethnicity is on the rise in Collin and Grayson counties and on the decline in Rockwall. In addition, there are increases in the number of Black children in all three counties. The Black population nearly doubled in Collin, and there were decreasing numbers of White non-Hispanic children in Collin and Rockwall counties. The infant mortality rate was 5.2 per 1,000 in Collin, 5.7 in Grayson, and 3.0 in Rockwall.

In Collin County, an estimated 26,798 children are uninsured, 8,039 of whom live in households earning 200% or less of the Federal Poverty Level (FPL). Grayson and Rockwall counties have 5,380 (1,264 ≤ 200% FPL) and 3,514 (1,118 ≤ 200% FPL) in that status, respectively. In 2011, rates of confirmed victims of child abuse per 1,000 were 5.4 in Collin, 10.2 in Grayson, and 3.3 in Rockwall counties.

Of the 14,035 reported uninsured ED events for RHP-18, 14.7% were for children under age 15. PPAs for children tend to involve asthma or respiratory illnesses and accidents. National statistics suggest that 1 out of 7 pre-school age children in low-income families is obese, and 17% of children age 2 to 19. White Hispanic boys, and Black, non-Hispanic girls are at higher risk for obesity than other race and ethnic groups.

Statistics for 2008 reflect that in Collin County, ~8% of all births were considered low birth weight babies, in Grayson County, 7%, and in Rockwall County 8.2%. Race, ethnicity, poverty, chronic diseases, health problems, and low birth weight babies are all factors associated with the need for expanded access to primary care for children.

A generally accepted national risk estimate for youth needing mental health and chemical dependency treatment is 9%. Youth are typically underserved because they do not come to the attention of schools or

families without a precipitating event usually violent. Many youth enter the public mental health system through the juvenile justice system. Family courts need more resources for referrals for troubled youth and families ordered for evaluation and possible counseling to avoid the child being removed from the home and placed in supervised living or foster care

### **Behavioral Health**

The greatest three needs in behavioral health (mental health and chemical dependency) are increased access to care, targeted resources to prevent relapse/re-hospitalization/higher cost care, and expanded diversity of evidence-based services such as jail diversion/mental health courts, peer-counseling, and integrated physical/behavioral care. Crisis response systems are limited, and access to public inpatient care is primarily on an emergency basis primarily utilizing local law enforcement and Dallas County based programs for homeless and crisis services. Estimates are that over half of the persons in community based behavioral healthcare programs are uninsured.

Collin and Rockwall counties participate in the NorthSTAR Behavioral Health System operated by Value Options, a private for-profit insurance corporation (3,793 persons received services in the third quarter of 2012). LifePath Systems serves Collin County, and Rockwall County residents are served by Lakes Regional MHMR Center that also serves fourteen other counties in North Texas. Individuals who need behavioral health services in the NorthSTAR area must meet the same clinical criteria used statewide but must also document stricter financial eligibility to gain access to care.

Under the principle of open access, Collin and Rockwall County residents have equal access to care throughout the geopolitical area covered by NorthSTAR. Collin and Rockwall County residents, particularly those in proximity to Dallas, can acquire behavioral health services anywhere in the seven counties by choice or as a consequence of insufficient locally available services. According to the DSHS “NorthSTAR Data Book: Summary Information on County Trends, FY06-FY11”, the NorthSTAR system spends less than one-half of the per client amount spent in the rest of Texas. NorthSTAR’s open access also has had an unintended consequence of certain services, such as jail diversion, veterans’ services, mobile crisis, supported housing, and after hours clinics being centralized in Dallas County rather than distributed more evenly in Collin and Rockwall counties.

Two major shifts in the NorthSTAR system for behavioral health occurred in 2010. Outpatient providers’ contract became a flat-rate contract resulting in limited access for new mental health clients with consequent referrals of some residents to other NorthSTAR providers in Dallas. In September of 2009, Value Options eliminated Supportive Outpatient Therapy for substance abuse treatment, requiring these consumers to meet the higher level of care criteria of Intensive Outpatient Treatment to access care.

Collin County has been perceived traditionally by the NorthSTAR system as having less demand for behavioral health services than its largest contiguous county, Dallas. Collin County’s behavioral health services needs however, are apparent from the direct and synthetic estimates of need and in the historical patterns of services utilization by Collin County residents documented in a published 2010 report. While the population in Collin County has grown 59% over the past 10 years, LifePath Systems has not expanded its capacity, and due to funding cuts has been forced to reduce services available by almost 50% from the baseline of 1999.

According to a study conducted by The Strategic Planning and Population Medicine Department of the Parkland Health & Hospital System, titled “Collin County Community Checkup 2008”, the arrest rate for all drug offenses increased from 180.1 per 100,000 persons in 2002 to 276.1 in 2006. Substance abuse (SA) related death rates increased from 33 per 100,000 persons in 2000 to 33.6 in 2004. These statistics reflect the increasing need for qualified chemical dependency provider, and the importance of early intervention services to prevent criminal justice involvement and SA related deaths. [http://www.dfwhc.org/documents/CollinCountyCommunityCheckup2008\\_000.pdf](http://www.dfwhc.org/documents/CollinCountyCommunityCheckup2008_000.pdf). Rockwall County has identified a critical need to improve jail diversion services. Family services to improve early intervention with juveniles to prevent criminal activities is also a critical need.

A large population not getting access to treatment is the working-poor not eligible for state-funded services, but unable to actually pay the full cost of behavioral health services. According to a 2012 Substance Abuse and Mental Health Services Administration (SAMHSA) approximately 20% of the population met the criteria for “Any Mental Illness” during a 12 month period, resulting in an estimated 155,685 Collin County individuals each year that should be receiving behavioral health services. <http://www.samhsa.gov/data/NSDUH/2k12Findings/CBHSQDataReviewC2MentalHealth2012.htm>

Physical and Behavioral Health services are also often not available or available in a timely manner to individuals with Intellectual and Developmental Disabilities (DD). Individuals with DD meet with access obstacles or long waiting periods for appointments, as there are too few providers who accept Medicaid. Few providers are experienced or trained in treating DD individuals with co-morbid psychiatric disorders.

RHP 18 has an estimated 2011 population of 1,014,935 (Census quick facts). The Center for Disease Control (CDC) estimated in 2012 that 1 in 88 individuals has an autism spectrum disorder (ASD). Studies also show that somewhere between one and 3 percent of Americans have DD. Thus approximately 20,289 individuals in RHP-18 may have DD. Using the CDC estimate, 11,533 individuals would have ASD. Approximately 55% of individuals with ASD also have an IQ under 70 (~6,343 individuals). People with ASD are at much higher risk (75%) of developing mental illness than people with IDD. People with IDD are estimated to experience mental illness at a rate of 33%. (Quintero and Flick, 2010)

Lakes Regional MHMR serves Rockwall County, as part of the NorthSTAR service system. Evidence suggests that an area of need is to expand access to services to segments of the community who have heretofore had limited access to care.

Texoma Community Center serves Grayson County. Evidence suggests that an area of need is to expand access to services to segments of the community that have heretofore had limited access to care.

Projected major changes in demographics, insurance coverage, and healthcare infrastructure expected to occur during the waiver period of FFY 2012 – FFY 2016

In the next five years, RHP-18 will increase in population at a rate of approximately 5.5% per year. Growth overall in RHP-18 is expected to be 25% over the 2010 census by the year 2020. The proportion of uninsured adults and children with household incomes ≤ 200% of FPL is likely to increase. There is a gap (100% vs. 200%) between the poverty eligibility criteria in RHP-18 counties and other healthcare systems.

The multi-cultural demographic character of the three counties will continue to become more complex. So much about the health of a community depends on the choices its citizens make and the values upheld by its community organizations, public and private. Economic conditions that drive health consumer choices will need to change to redirect health services utilization patterns away from higher-cost emergent care systems to lower cost effective and sustaining community support systems including health education, prevention, and long-term engagement with the healthcare consumer.

Local private and public providers need to become as easy to access as the ED, if we are going to influence healthcare consumer choices. Medical home models must provide wrap-around continuity of care programs for at-risk patients with co-morbid physical and mental challenges. Local clinics and hospitals must develop community-centered partnerships with efficient targeted patient registries, referral procedures, and follow up services to effectively engage families in a wellness model versus an illness model of care.

The DSRIP projects proposed by hospitals and community services providers are directed at these types of systems changes.

The suicide rate in Grayson County is ~15/100,000 compared to 8.5 for Collin, 10 for Dallas, and 13.8 for Rockwall counties. Counties contiguous with Grayson County have suicide rates similar to those in Grayson County. Evidence points to the need for expanded services and increased rapid access to care as well as continuity of information for patients across county borders. One way to do this in more rural areas is to enhance technical capabilities through telemedicine archiving and transmitting capabilities,

increasing the number of providers with more flexible policies regarding eligible populations, addressing substance abuse, and ensuring services for co-morbid medical and behavioral health conditions.

## Summary

RHP-18 subscribes collectively to the principles recommended by the Population Health Institute in the annual national health outcomes and health factors report. These are that healthy communities depend on and are derived from community members working together to assess needs and resources, focus on issues deemed by consensus to be the most important, and create effective policies and programs to favorably impact population health.

In addition to the community needs identified through national, state and local sources, RHP-18 also is attending to six of the 12 health indicators identified by the U.S. Center for Disease Control in **Healthy People 2020**. These six indicators have emerged as important areas of need in the planning process for the Texas Healthcare Transformation and Quality Improvement Program in Collin, Grayson, and Rockwall counties of Texas.

- Access to health services
- Clinical preventive services
- Injury and violence
- Maternal, Infant, and Child Health
- Nutrition, Physical Activity and Obesity
- Social Determinants of medical and behavioral health problems

Table 10 on the following page provides the list of 14 broadly defined community needs (CN) per HHSC protocol to which providers have linked DSRIP projects.

In addition to this needs assessment, in Section V of the plan, all performing providers have included narrative documentation and associated source references for discrete needs associated with each of their proposed projects and anticipated outcomes.

**Table 10.**

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Needs
CN.1	Primary care - adults	Request for Potentially Preventable Admissions (PPA) Data - Texas Department of State Health Services (DSHS) Warehouse
CN.2	Primary care - children	DSHS web site selected data: <a href="http://www.dshs.state.tx.us/wellness/data.shtm">http://www.dshs.state.tx.us/wellness/data.shtm</a>
CN.3	Prenatal care	DSHS web site selected data: <a href="http://www.dshs.state.tx.us/wellness/data.shtm">http://www.dshs.state.tx.us/wellness/data.shtm</a>
CN.4	Urgent and Emergency care	Emergency Department data DFW Hospital Council Foundation
CN.5	Co-morbid medical and behavioral health conditions - all ages	DSHS data request; NorthSTAR Dashboard
CN.6	Health professions shortage	Federal Government Health Indicators Warehouse website
CN.7	Preventable acute care admissions	DSHS provided based on data request
CN.8	Diabetes	DSHS PPA Data
CN.9	Cardiovascular Disease	2009 Texas Behavioral Risk Factors Surveillance System, Center for Health Statistics, DSHS: <a href="http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm">http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm</a> .
CN.10	Elderly at home, and Nursing Home patients	Extrapolated from DSHS PPA data
CN.11	Behavioral Health - all components - all ages	DSHS data website; Previously conducted studies and needs assessments available publicly
CN.12	Other special populations at-risk	DSHS data and surveillance reports
CN.13	Communicable Disease	Center for Disease Control
CN.14	Obesity and its co-morbid risk factors	<a href="http://www.window.state.tx.us/specialrpt/obesitycost/epidemic.php">http://www.window.state.tx.us/specialrpt/obesitycost/epidemic.php</a>

## **Section IV. Stakeholder Engagement**

### **A. RHP Participants Engagement**

RHP 18's project team was assembled in June 2012 and created a plan for identifying and communicating with stakeholders and Performing Providers over a four-month period (Phase 1). An additional plan was created to address stakeholder relations during the review process of November 2012 through June 2013 (Phase 2).

The stakeholder outreach initiative included the following steps:

- Research and identification of potential Performing Providers and stakeholders
- Individual outreach and interviews with potential Performing Providers
- Three workshops with potential Performing Providers and stakeholders

#### **Research and identification of potential Performing Providers and stakeholders**

The project team worked with county officials and health departments to identify a comprehensive list of stakeholders. The list includes appropriate representatives from hospitals, community clinics, Mental Health/Mental Retardation associations, county medical societies and public health officials. Addendum IV. A. provides the RHP 18 stakeholder list.

#### **Individual outreach with potential Performing Providers**

Project team members met with all primary stakeholders during the first month of the project and continued individual outreach efforts throughout the DSRIP-development process. Project team members also made themselves available for any on-call meetings requested by the Anchor entity and engaged in any opportunity to educate potential Performing Providers on the RHP process, DSRIP funding and UC funding. At critical milestones of the planning process, potential Performing Providers were encouraged to participate in HHSC weekly webinars, and submit questions directly to HHSC. Addendum IV. B. provides a listing of stakeholder meetings and presentations.

Throughout the process the RHP 18 project team facilitated discussions among possible IGT providers and potential Performing Providers at the request of the Anchor. These discussions resulted in fostering better understanding of the Waiver 1115 funding mechanisms, and in some cases resulted in innovative cooperation to provide additional IGT dollars directed toward potential DSRIP projects.

#### **Three workshops with potential Performing Providers and stakeholders**

RHP-18 conducted stakeholder outreach workshops on July 17, 2012, July 31, 2012, and September 14, 2012. Approximately 50 people (including potential performing providers) attended the first workshop that included the following activities.

- A review of the 1115 Waiver Program
- Roles and responsibilities of RHP-18
- Questions & answers with a representative from HHSC
- Breakout sessions, per county, to discuss potential DSRIP projects

Approximately 25 people attended the second workshop in which the project team reviewed potential DSRIP narrative and menu details. A representative from HHSC provided additional time (via conference call) to answer stakeholder questions. Approximately 25 individuals attended the third workshop where the project team reviewed the draft RHP 18 Community Needs Assessment.

RHP-18 provided stakeholders with a draft of the Community Needs Assessment on Sept. 12, 2012. This provided the stakeholders with two days to review the document prior the group review workshop on September 14, 2012. During this workshop, the project team sought feedback regarding the Community Needs Assessment, discussed the overall RHP vision, and identified DSRIP projects. In addition, the project team provided updates regarding the HHSC schedule and updates to the RHP plan requirements. RHP-18 project team members were available to answer questions and provide assistance to performing providers expected to submit Pass 1 DSRIP projects. Addendum IV. C. provides agendas for three workshops.

***Pass 2 and Pass 3 procedures engaged stakeholders in face-to-face meetings, teleconferences and email communications. These activities involved technical assistance, project consultation, plan document development guidance, and policy communications from HHSC and Anchor teleconferences.***

### **Future stakeholder outreach**

The complete stakeholder group will be assembled approximately four times, at minimum once per quarter to review the selected DSRIP projects as they progress. Meetings will tentatively be scheduled for January, April and June 2013. This will serve as the Learning Collaborative for RHP 18 performing providers at which plan implementation and success strategies will be discussed.

## **B. Public Engagement**

The RHP 18 project team conducted proactive public engagement initiatives through four primary initiatives:

- Website updates
- Engagement with non-participating Providers and non-Performing Providers such as Medical Societies
- An open planning meeting with potential Performing Providers and stakeholders
- Public Hearings to obtain stakeholder feedback on Sections I, II, III and IV of the Plan with a focus on *each and every "passes"* DSRIP projects.
- 

### **Website updates**

The project team provided Collin, Grayson and Rockwall counties with materials regarding the 1115 Waiver program, efforts conducted within the RHP-18 region and notice for the public hearings. These items were posted on county websites for public viewing. In addition, the Anchor entity directed the RHP project team to follow up on email and phone correspondence received by interested parties and the general public.

Upon request, the RHP project team members provided briefings at County Commissioner's Court sessions and answered questions from county officials in an open forum. These briefings were documented as part of an official public record.

### **Engagement with non-participating Providers and non-Performing Providers**

The RHP Anchor and project team conducted public engagement with non-participating Providers and non-Performing Providers such as medical society representatives to inform them of the RHP process and solicit their feedback and/or endorsement of the proposed DSRIP projects. Non-participating providers who were eligible to submit transformative projects and chose to opt out were kept informed of all

meetings and the project team shared information regarding the ability to submit DSRIP projects at a later date for potential Pass 2 funding opportunities. Non-participating providers provided input throughout the workshop opportunities, received email updates through the list serve and had opportunities to attend and participate in the public hearings.

### **Open planning meeting with potential Performing Providers, stakeholders, and the general public**

The RHP-18 held a daylong open planning meeting on October 16, 2012. This open planning meeting was held at the Collin County Administration Building from 9:30 AM to 5:00 PM. The open planning meeting format was intentionally held in Collin County, the location of the Anchor. The meeting was designed to demonstrate in real-time how the RHP project team assembled the RHP Plan in its final format, prior to plan approval. The documents were projected onto a large screen whereby stakeholders and passersby could come and go, observe, ask questions and provide verbal input throughout the day as the team worked and discussed Sections I, II, III, and IV of the plan. This open process was meant to both educate and involve potential Performing Providers and stakeholders.

### **Public Hearings**

Three Pass 1 public hearings were conducted – one in each county (Collin, Grayson, Rockwall) – in October 2012. At each of the public hearings held on October 22 and 23, the RHP project team provided an overview of Sections I, II, III, and IV of the RHP-18 Plan to include Pass 1 DSRIP projects. In preparation for these public hearings, public hearing notices were generated, and each partner county posted information in accordance with the Texas Open Meetings Act. In addition to conducting the public hearings, the RHP project team submitted draft RHP Plan information for posting on the county websites for no less than a five-day period, Oct. 22-26. The public had an opportunity to provide written or verbal comments following the Public Hearings. Addendum IV. D. provides the public hearing notices.

A total of six stakeholders presented public comments during the public hearings and one person submitted a written question during the process. The person who submitted the question was directed to the state insurance office. All comments were of a positive, supportive nature of the communications process.

The RHP 18 project team conducted one public hearing for Pass 2 and Pass 3 projects on December 10, 2012.

### **Future Public Engagement**

The RHP 18 project team will continue to provide updates to each county for posting and distribution to the public. The project team will respond to requests for meetings and correspondence with the public as required.



## Section V. DSRIP Projects

### A. RHP Plan Development

#### Assigned RHP Tier-4 process used to implement list of projects

RHP-18 (Collin, Grayson and Rockwall counties) is a Tier 4 region and is required to have a minimum of four (4) projects from Category 1 and Category 2. Two projects must come from Category 2.

The RHP 18 team contacted potential providers in the original four counties (Collin, Grayson, Rockwall and Denton) and invited them to a workshop to introduce and discuss the Texas Healthcare Transformation and Quality Improvement Program. Following the meeting, a call for potential DSRIP projects from Categories 1 and 2 went out to the potential participating providers who attended the meeting. The RHP-18 team provided technical assistance with guidance from the information provided by HHSC. The following table lists projects considered in Pass 1.

<b>DSRIP Projects Considered for Pass 1</b>
<b>Category 1</b>
Expand Pediatric Primary Care: Children's Medical Center
Expand Pediatric Primary Care: Children's Medical Center
Enhance Community based settings where behavioral health services may be delivered in underserved areas: Children's Medical Center
Enhance Community based settings where behavioral health services may be delivered in underserved areas: Children's Medical Center
Expand Primary and Specialty Care Clinics: UT Southwestern
Expand Primary and Specialty Care Clinics: UT Southwestern
Establish more primary care clinics: Texoma Medical Center
Enhance Performance Improvement and Reporting Capacity: Texoma Community Center
Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers(Telemedicine projects): Texoma Community Center
Enhance service availability of appropriate levels of behavioral health care (expand treatment for chemical dependency): Texoma Community Center
Enhance service availability of appropriate levels of behavioral health care (increase access in underserved areas): Texoma Community Center
Introduce, Expand or Enhance Telemedicine/Telehealth: Lakes Regional MHMR Center

<b>Category 2</b>
Enhance and expand medical homes: Children's Medical Center
Integrate Primary and Behavioral Health Care: LifePath Systems
Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals: Texoma Community Center

#### RHP goals - Regional approach to address needs/goals

Based on the community needs assessment data, the goal to improve the health of those living in RHP-18 is focused on six of the 12 health indicators defined by the U.S. Center for Disease Control in Healthy

People 2020. These six have emerged as important areas of need in the planning process for the Texas Healthcare Transformation and Quality Improvement Program in Collin, Grayson, and Rockwall counties of Texas.

- Access to health services
- Clinical preventive services
- Injury and violence
- Maternal, Infant, and Child Health
- Nutrition, Physical Activity and Obesity
- Social Determinants

Fourteen specific areas of needs were identified by the community assessment and were distributed to the RHP-18 stakeholders. While addressing specific identified needs in RHP-18, selected DSRIP projects will address these broad areas to transform care in the region and ultimately affect the health of all populations within the counties.

### **Process for evaluating & selecting projects**

RHP-18 potential providers were asked to submit DSRIP narratives and milestone and metrics tables to be reviewed by the RHP-18 project team. During the review process, care was taken to assure that they met the expectations and requirements set forth in the Funding and Mechanics protocol. Selections of the Pass 1 projects were based on the ability to address the needs of the population, suitability to population regional impact and available IGT. The following pages list narratives from each project provider.

### ***B. Project Valuation***

RHP-18 considered valuation methodologies used by other regions with similar characteristics. Ultimately we selected a methodology utilized by RHP-6, in which specific program attributes are assigned numeric rankings on a scale of 1 to 5. Each RHP-18 provider was free to utilize individual valuation methodologies so long as they referenced the source and rationale.

Once IGT was identified/verified and after potential providers submitted DSRIP projects, the project team assembled the projects into a spreadsheet (Addendum V.B.1.). The spreadsheet was also provided to potential providers to complete if they did not have their own valuation mechanisms. The project team submitted rankings with the potential provider rankings. The final information was submitted to the Anchor. The Collin County Commissioners Court, serving as the RHP-18 Anchor, approved the DSRIP projects as part of the RHP Plan. The project valuation methodology was provided to stakeholders on Oct. 3, 2012, in advance of the Oct. 5 Pass 1 project submission deadline.

General criteria for valuing projects are reflected in the following table, except for those who utilized other methods.

<b>Criteria</b>	<b>Description</b>
<b>Achieves Waiver Goals</b>	<p>The project:</p> <ul style="list-style-type: none"> <li>-Assures patients receive high-quality and patient-centered care, in the most cost effective ways</li> <li>-Improves the health care infrastructure to better serve the Medicaid and uninsured residents of our counties</li> <li>-Further develops and maintain a coordinated care delivery system</li> <li>-Improves outcomes while containing cost growth</li> <li>-Does the project primarily impact Medicaid and/or uninsured residents?</li> <li>-How significant is the expected impact? To what extent will it “move the dial”?</li> <li>-Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?</li> </ul>

<b>Addresses Community Needs</b>	-Will the project address one or more community needs outlined in the RHP-18 Plan? -How significant is the expected impact? To what extent will it “move the dial”? -Is there strong evidence, as shown by literature review, best practices, and/or past experience, that the proposed project will be effective in its impact?
<b>Project Scope</b>	-How “big” is the project? Consideration is given to the following: -Outreach to the targeted population -Patient visits/encounters Providers recruited/trained -Savings estimated from avoiding/preventing unnecessary ER visits or hospitalizations
<b>Project Investment</b>	-How large is the expected investment to successfully implement this project and achieve milestones and metrics? Consideration is given to the following: Human resources, equipment purchase and maintenance, legal and professional fees, time to implement Risk Assessment, organizational priorities
<b>1 to 5 scale: 1=minimal achievement of criteria; 5=maximum achievement of criteria</b>	

An example of the template and scoring is below.

<b>Project Description</b>	<b>Category</b>	<b>Project Area</b>	<b>Project Option</b>	<b>Meets Waiver Goals (1 to 5)</b>	<b>Addresses Community Needs (1 to 5)</b>	<b>Project Scope (1 to 5)</b>	<b>Project Investment (1 to 5)</b>	<b>Value Weight of Project</b>
Hospital ABC – Open a Clinic	1.1.1	Expand Primary Care Capacity	Establish more primary care clinics	5	5	4	4	18

For each proposed project, each criterion score was added to produce a total score, that is the value weight of the project. In addition, the template calculates initial project values for the selected projects based on the provider’s allocation of funds and project scores. The next table displays the total DSRIP allocation for RHP-18.

<b>Total DSRIP Entitlement</b>					
<b>DY1</b>	<b>DY2</b>	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>DSRIP Total</b>
	\$28,037,958	\$32,499,651	\$34,767,068	\$37,790,292	\$133,094,969

The example is continued with the cost valuation summary.

<b>Project Description</b>	<b>Value Weight of Project</b>	<b>Value for DY 2</b>	<b>Value for DY 3</b>	<b>Value for DY 4</b>	<b>Value for DY 5</b>	<b>Total Value DY 2-5</b>
Hospital ABC – Open a Clinic	18	\$650,000	\$710,000	\$750,000	\$790,000	\$2.9 million

It is important to note that these are gross estimates, and IGT will be required to pull down the full payment. This methodology is based on valuation models in RHP-6.

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

In the following Section C of the RHP 18 Plan we have presented 15 projects in Category 1, each pass separated by a cover page listing the number of projects by provider.

**Each project includes a one-page abstract per instructions of the Texas HHSC 11-2012.**

Provider: Brief description of the provider organization

Hospital ABC is a 40-bed hospital in CDF Town serving a 25 square mile area and a population of approximately 21,000.

Intervention(s): This project will implement telemedicine to provide patient consultations by a pharmacist after hours and on weekends to reduce medication errors.

Need for the project: We currently only have a pharmacist onsite 40 hours per week and have noticed an increase in inpatient admissions, many of which are related to medication errors.

Target population: The target population is our patients that need medication consults after hours.

Approximately 50% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the consults.

Category 1 or 2 expected patient benefits: The project seeks to provide 200 telemedicine consults in DY4 and 400 in DY5.

Category 3 outcomes: IT-X.X Our goal is to reduce the 30-day potentially preventable all-cause readmission rate from X% currently to X% by DY5. *(If more than one outcome, use sub-bullets.)*

***Major needs addressed by Category 1 projects include expanding access to needed services to prevent unnecessary use of emergency and inpatient care:***

***Primary Care for adults and for children***

***Specialty care clinics to prevent unnecessary use of ER and hospital services***

***Health professions shortages***

***Pre-natal care and behavioral health care***

***Blended services for co-morbid conditions***

***Remote access through telemedicine services***

***Patient education for improved health behaviors and appropriate services use***

***Primary metrics for projects in Category 1 include monitoring the services utilization and referral patterns, the impact on hospitalization and ER use, the maximum utilization of provided capacities in new programs, and patient satisfaction measures.***

# **CATEGORY 1**

## **PASS 1**

**In Pass 1 there are 12 Projects**

- Four from Children's Medical Center in Plano,
- Two from the University of Texas Southwestern (UTSW),
- One from Texoma Medical Center,
- Four from Texoma Community Center,
- One from Lakes Regional MHMR.

**For Pass 2, two providers have submitted Category 1 projects:**

- One by LifePath Systems
- One by Tenet Centennial Medical Center of Frisco

**In Pass three, we added one Category 1 project by Lakes Regional MHMR**

## **SUMMARY PAGE: CHILDREN'S MEDICAL CENTER: Pass 1 Category 1 Project/138910807.1.1**

Expand Pediatric Primary Care – Children’s Medical Center

**Provider:** Children’s has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children’s has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children’s also has a system of primary care centers, MyChildren’s, which focuses on providing primary care to children covered by Medicaid and CHIP. Children’s has approximately 600,000 patient contacts a year.

Children’s has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

**Intervention(s):** Expand the capacity of pediatric primary care in Collin County with an additional Children’s Medical Center (CMC) primary care center integrated with critical support services across a continuum of care to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time, have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services.

Children’s Medical Center is the safety net hospital for children in Dallas County, providing the majority of ED, specialty and inpatient care to Medicaid and safety net patients/families.

**Need for the project:** There are very limited options for children covered by Medicaid and CHIP to receive care in a primary care setting.

**Target population:** The target population is children in RHP 18 covered by Medicaid and CHIP.

**Category 1 or 2 expected patient benefits:** This project will improve access to care to children covered by Medicaid and CHIP.

**Category 3 outcomes:** OD-9 Preventive and Primary Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure) This measure was selected because the project is designed to support appropriate utilization of ED services and reduce the inappropriate use of ED services. *This project will increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day “sick” visits, reduce the inappropriate use of the emergency department and reduce overall cost of health care for children in Collin County. Specifically this project will decrease or stabilize the number of patients in the ER or UR settings and increase use of primary care, as well as decrease the repeated use of the ER. It will align care intensity with the requirements of the clinical presentation and provide evidence of change in patient flow to the PC clinics.*

**Title of Project:** Expand Pediatric Primary Care

**Unique RHP project identification number:** 138910807.1.1

**Performing Provider Name:** Children's Medical Center/138910807

### **Project Description**

Expand the capacity of pediatric primary care in Collin County through one additional Children's Medical Center (CMC) primary care center so that children receive the right care at the right time; have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services. The additional capacity will be integrated with all other community-based providers across a continuum of care to establish a "virtual safety net" for children's health care.

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

The goals of the project are to increase the availability of pediatric primary care services in Collin County and ensure the appropriate use of such services by the population through support systems and electronic technology. Incremental increase in local pediatric primary care clinics with after-hours availability and the use of telemedicine to link primary care providers with pediatric specialists will ensure both the availability and use of cost-effective, high-quality pediatric care and health advice and reduce unnecessary use of emergency department services.

This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complication, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

### **Challenges**

A major challenge will be changing the behaviors of families who have used emergency services for low complexity care. This challenge will be addressed through the use of health literacy principles, language and culturally appropriate approaches through the use of community health workers who reside in the community and understand the customs and speak the language. Behavior changes are projected based on the reduction in inappropriate emergency department utilization in a targeted zip code after a new MyChildren's primary care office opened in that zip code. Another challenge will be recruiting sufficient numbers of staff who are bilingual and multicultural. Children's is the pediatric training site for many student healthcare training programs. Bilingual and culturally diverse students will be identified through the relationships developed during the training at Children's and then recruited after the student training is completed.

### **Five-year Expected Outcomes**

The five-year expected outcomes of the project include increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day "sick" visits, reduction in the inappropriate emergency department use and reduction in overall cost of health care for children in Collin County.

### **Starting point/baseline**

The baseline for this project is the number of MyChildren's locations at the beginning of DY1.

### **Rationale**

Children's Medical Center's (CMC) emergency department treats approximately 50,000 Level 4 and Level 5 visits annually (36% of total emergency department visits) for children with low-acuity illnesses and acute care symptoms, which can be more cost-effectively addressed in community-based primary care clinics. The days and times of the day for the Level 4 and Level 5 visits include normal workday hours,

evening weekday hours and weekend hours. Children's Medical Center mapped the ZIP codes where the largest percentage of the families reside whose children were presenting themselves at the CMC emergency department for Level 4 and Level 5 visits. CMC then determined which of the identified ZIP codes lacked available and accessible primary care, located a suitable lease opportunity in the identified ZIP code for a CMC primary care center.

As concluded in the Regional Health Partnership 18 Community Needs Assessment Report, the demand for pediatric primary care services, which are both accessible and convenient for patient families, exceeds the available capacity, thus limiting health care access for many low-level acute care management or chronic conditions. Emergency departments are treating high volumes of pediatric patients with preventable conditions or conditions that are suitable to be addressed in a primary care setting. Additionally, many pediatric primary care physicians accept a limited number of the Medicaid/CHIP/uninsured population and may have limited or no extended hours, ultimately even further restraining the capacity of many families to access important primary care services. Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. About 40% of the children in the North Texas Corridor have no or limited access to health insurance.

### **Project Components**

Project 1.1 "Establish more primary care clinics" does not contain core project components. Milestones and metrics are based on relevancy to the RHP 18's pediatric population, the community needs for additional pediatric primary care and the baseline data of non-emergent emergency department use by children.

### **Community Needs Addressed**

- CN 2 Primary care – children
- CN 7 Preventable acute care admissions
- CN 4 Urgent and emergency care

### **Project Enhances an Existing Delivery System**

The project will enhance the current supply of pediatric primary care and lessen the burden of care in current Federally Qualified Healthcare Centers and centers who serve children on Medicaid and CHIP in Collin County.

### **Related Category 3 Outcome Measure and Rationale for Selecting Outcome Measure**

OD-9 Primary and Preventive Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure)

This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children.

### **Relationship to other projects**

- 1.2 Expand Primary Care Hours
- 1.3 Implement Disease Management
- 1.4 Expand Pediatric Behavioral Health
- 2.1 Expand/Enhance Medical Homes
- RD-1 Potentially Preventable Admissions
- RD-2 30-day readmissions
- RD-3 Potentially Preventable Complications
- RD-4 Patient-centered Healthcare
- RD-5 Emergency Department
- RD-6 Initial Core Set Health Care Quality Measure



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

Activities undertaken by Children's Medical Center will have relationships with other transformation projects. Among these are those undertaken by UT Southwestern in the Primary and Specialty Care Capacity, Texoma Medical Center's Grayson County Health Clinic in Primary Care Clinics, Texoma Community Center, LifePath Systems, and potentially Lakes Regional MHMR Center in the integration initiatives for persons with co-morbid medical and behavioral health conditions.

**Plan for Learning Collaborative:**

*The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.*

**Project Valuation:**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

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<i>138910807.1.1</i>	<i>1.1.1</i>	<i>NO COMPONENTS]</i>	<i>EXPAND PEDIATRIC PRIMARY CARE</i>	
<i>Children's Medical Center</i>			<i>138910807</i>	
<i>OD 9</i>	<i>IT-3.9.2</i>	<i>P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1</i>	<i>Preventive and Primary Care</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p><b>P-1. Milestone:</b> Establish additional/expand existing/relocate primary care clinics</p> <p><b>P-1.1. Metric:</b> Number of additional clinics or expanded hours or space Documentation of detailed expansion plans</p> <p><b>Data Source:</b> New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.</p> <p><b>Rationale/Evidence:</b> 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</p>	<p><b>P-5. Milestone:</b> Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers</p> <p><b>P-5.1. Metric:</b> Documentation of increased number of providers and staff and/or clinic sites.</p> <p><b>Data Source:</b> Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation</p> <p><b>Rationale:</b> Additional staff members and providers may be necessary to increase capacity to deliver care.</p>	<p><b>I-12. Milestone:</b> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</p> <p><b>I-12.2. Metric:</b> Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Total number of unique patients encountered in the clinic for reporting period.</p> <p><b>Data Source:</b> Registry, EHR, claims or other Performing Provider source</p> <p><b>Rationale/Evidence:</b> This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase</p>	<p><b>I-13. Milestone:</b> Enhanced capacity to provide urgent care services in the primary care setting.</p> <p><b>I-13.1. Metric:</b> Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates</p> <p><b>Numerator:</b> number of patients receiving urgent care appointment within 2 days of request</p> <p><b>Denominator:</b> number of patients requesting urgent care appointment. Data source: Registry, EHR, claims or other Performing</p>	

138910807.1.1	1.1.1	NO COMPONENTS]	EXPAND PEDIATRIC PRIMARY CARE	
Children's Medical Center			138910807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)	
individuals and families healthy and therefore avoid more costly ER and inpatient 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.  Goal: One additional clinic open on or before 9/30/13  Milestone P1 Estimated Incentive Payment: \$ 1,072,890	Goal: Training completed by for 7 new staff by 9/30/14 Milestone P5 Estimated  Incentive Payment: \$1,097,312	capacity to provide care. Increase over baseline determined in DY2  Milestone I 12 Estimated Incentive Payment: \$1,095,611	Provider scheduling source Rationale: Identifying patient flow as it relates to urgent care needs allow Performing Providers to tailor staffing, triage protocols and service hours to best address patient needs and increase capacity to accommodate both urgent and non-urgent appointments.  Goal: Increase over baseline established in DY2  Milestone I 13 Estimated Incentive Payment: \$884,654	
Year2 Estimated Milestone Bundle Amount: \$1,072,890	Year3 Estimated Milestone Bundle Amount: \$1,097,312	Year4 Estimated Milestone Bundle Amount: \$1,095,611	Year5 Estimated Milestone Bundle Amount: \$884,654	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$4,150,467				

## **SUMMARY PAGE: CHILDREN'S MEDICAL CENTER: Pass 1 Category 1 Project/138910807.1.2**

### Expand Pediatric Primary Care

**Provider:** Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Children's has approximately 600,000 patient contacts a year.

Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

**Intervention(s):** The purpose of this project is to expand the hours of operation to include nights and weekends at the MyChildren's locations and to establish a 24 hour RN triage telephone.

**Need for the project:** There are very limited options for children covered by Medicaid and CHIP to receive care on evenings and weekends except at hospital emergency departments.

**Target population:** The target population is children in RHP 18 covered by Medicaid and CHIP.

**Category 1 or 2 expected patient benefits:** This project will improve access to care to children covered by Medicaid and CHIP.

**Category 3 outcomes:** OD-9 Preventive and Primary Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure) This measure was selected because the project is designed to support appropriate utilization of ED services and reduce the inappropriate use of ED services. *Evidence of effectiveness will include metrics regarding the full utilization of the 24 hour RN triage service, with patient satisfaction with follow-up care and management.*

**Title of Project:** Expand Pediatric Primary Care

**Unique RHP project identification number:** 138910807.1.2

**Performing Provider Name:** Children's Medical Center/13890807

### **Project Description**

Expand the capacity of pediatric primary care in Collin County through: (B) expanding primary clinic hours and (C) expanding primary care clinic staffing to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time; have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services. No additional primary care clinic space (component A) is anticipated as additional capacity can be achieved in the current space by increasing hours open and adding staff. This project will also establish a 24/7 pediatric nurse/physician advice line and outreach call capability. The additional capacity will be integrated with all other community-based providers across a continuum of care to establish a "virtual safety net" for children's health care.

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

The goals of the project are to increase the availability of pediatric primary care services in Collin County and ensure the appropriate use of such services by the population through support systems and electronic technology. Incremental increase in local pediatric primary care clinics with after-hours availability, coupled with a 24/7 pediatric nurse/physician advice line and outreach call capability will ensure both the availability and use of cost-effective, high-quality pediatric care and health advice and reduce unnecessary use of emergency department services.

This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complication, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

### **Challenges**

A major challenge will be changing the behaviors of families who have used emergency services for low complexity care. This challenge will be addressed through the use of health literacy principles, language and culturally appropriate approaches through the use of community health workers who reside in the community and understand the customs and speak the language. Behavior changes are projected based on the reduction in inappropriate emergency department utilization in a targeted zip code after a new MyChildren's primary care office opened in that zip code. A second challenge will be recruiting sufficient numbers of staff who are bilingual and multicultural. Children's is the pediatric training site for many student health care training programs. Bilingual and culturally diverse students will be identified through the relationships developed during the training at Children's and then recruited after the student training is completed.

The five-year expected outcomes of the project include increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day "sick" visits, reduction in the inappropriate emergency department use and reduction in overall cost of health care for children in Collin County.

## **Starting point/baseline**

The baseline for this project is the hours of operations of MyChildren's locations in Collin County at the beginning on DY1.

## **Rationale**

Children's Medical Center's (CMC) emergency department treats approximately 50,000 Level 4 and Level 5 visits annually (36% of total emergency department visits) for children with low-acuity illnesses and acute care symptoms, which can be more cost-effectively addressed in community-based primary care clinics. The days and times of the day for the Level 4 and Level 5 visits include normal workday hours, evening weekday hours and weekend hours. Children's Medical Center mapped the ZIP codes where the largest percentage of the families reside whose children were presenting themselves at the CMC emergency department for Level 4 and Level 5 visits. CMC then selected one of the identified ZIP codes lacked available and accessible primary care and located suitable lease opportunities in the identified ZIP codes for CMC primary care centers.

As concluded in the Regional Health Partnership 18 Community Needs Assessment Report, the demand for pediatric primary care services for children on Medicaid and CHIP, which are both accessible and convenient for patient families, exceeds the available capacity, thus limiting health care access for many low-level acute care management or chronic conditions. Emergency departments are treating high volumes of pediatric patients with preventable conditions or conditions that are suitable to be addressed in a primary care setting. Additionally, many pediatric primary care physicians accept a limited number of the Medicaid/CHIP/uninsured population and may have limited or no extended hours, ultimately even further restraining the capacity of many families to access important primary care services. Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. In the North Texas Corridor, almost 40% of children either have no health insurance or insurance with limited access (Medicaid and CHIP).

## **Project Components**

Project 1.2 "Establish more primary care clinics" does contain core project components. As noted above, we will not be using component (A), expand clinic space but will increase capacity through components (B) expand clinic hours and (C) expand primary care staffing. Milestones and metrics are based on relevancy to the RHP 18's pediatric population, the community needs for additional pediatric primary care and the baseline data of non-emergent emergency department use by children.

## **Community Needs Addressed**

- CN 2. Primary care - children
- CN 4. Urgent and emergency care
- CN 7. Preventable acute care admissions

## **Project Enhances an Existing Delivery System**

The project will enhance the current supply of pediatric primary care and lessen the burden of care in current Federally Qualified Healthcare Centers and other centers which serve children covered by Medicaid and CHIP.

## **Related Category 3 Outcome Measure and Rationale for Selection**

OD-9 Preventive and Primary Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure)

This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children.

**Relationship to other projects:**

- 1.1 Establish more primary care clinics
- 1.3 Implement Disease Management
- 1.4 Expand Pediatric Behavioral Health
- 2.1 Expand/Enhance Medical Homes
- RD-1 Potentially Preventable Admissions
- RD-2 30-day readmissions
- RD-3 Potentially Preventable Complications
- RD-4 Patient-centered Healthcare
- RD-5 Emergency Department
- RD-6 Initial Core Set of Health Care Quality Measures

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

Activities undertaken by Children's Medical Center will have relationships with other transformation projects. Among these are those undertaken by UT Southwestern in the Primary and Specialty Care Capacity, Texoma Medical Center's Grayson County Health Clinic in Primary Care Clinics, Texoma Community Center, LifePath Systems, and potentially Lakes Regional MHMR Center in the integration initiatives for persons with co-morbid medical and behavioral health conditions.

Healthcare transformation projects in RHP 18 are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, the needs span the region, and healthcare consumers may move across geo-political boundaries in this mixed urban and rural area of the state. Participating providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region.

**Plan for Learning Collaborative:**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

**Project Valuation**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment



- Value Weight of the Project

## References

- Halfon N, Newacheck PW, Wood DL, St Peter, RF. Routine emergency department use for sick child care by children in the United States . *Pediatrics*. 1996; 98: 28-34
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138910807.1.2	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE	
Children's Medical Center of Dallas			138910807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary Care	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>P-4. Milestone:</b> Expand the hours of a primary care clinic, including evening and/or weekend hours</p> <p><b>P-4.1. Metric:</b> Increased number of hours at primary care clinic over baseline</p> <p>Data Source: Clinic documentation</p> <p>Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients.</p> <p>Goal: Expanded hours offered by 9/30/13.</p> <p><b>Milestone P4 Estimated Incentive Payment (maximum amount): \$488,548</b></p>	<p><b>P-7. Milestone:</b> Establish a nurse advice line and/or primary care patient appointment unit.</p> <p><b>P-7.1. Metric:</b> Documentation of nurse advice line and/or primary care patient appointment unit.</p> <p>Data Source: Documentation of advice line and appointment unit implementation, operating hours and triage policies. Advise line system logs, triage algorithms and appointment unit operations/ policies.</p> <p>Rationale: In many cases patients are unaware of the appropriate location and timing to seek care for urgent and chronic conditions. Implementation of a nurse advice line allows for primary</p>	<p><b>I-12. Milestone:</b> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</p> <p><b>I-12.1. Metric:</b> Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Total number of visits for reporting period</p> <p>Data Source: Registry, EHR, claims or other Performing Provider source</p> <p>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.</p> <p>Goal: X% increase to be</p>	<p><b>I-13. Milestone:</b> Enhanced capacity to provide urgent care services in the primary care setting.</p> <p><b>I-13.1. Metric:</b> Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates</p> <p>Numerator: number of patients receiving urgent care appointment within 2 days of request</p> <p>Denominator: number of patients requesting urgent care appointment.</p> <p>Data source: Registry, EHR, claims or other Performing Provider scheduling source</p>	

138910807.1.2	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE	
Children's Medical Center of Dallas			138910807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary Care	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>P-5. Milestone:</b> Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers</p> <p><b>P-5.1. Metric:</b> Documentation of increased number of providers and staff and/or clinic sites.</p> <p>Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation</p> <p>Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care.</p>	<p>care to be the first point of contact and offer clinical guidance around how to mitigate symptoms, enhance patient knowledge about certain conditions and seek timely care services.</p> <p>Goal: RN advice line implemented by 9/30/14</p> <p><b>Milestone P7 Estimated Incentive Payment (<i>maximum amount</i>): \$999,338</b></p>	<p>determined in DY2. X% increase by 9/30/15</p> <p><b>Milestone I 12 Estimated Incentive Payment (<i>maximum amount</i>): \$997,788</b></p>	<p>Rationale: Identifying patient flow as it relates to urgent care needs allow Performing Providers to tailor staffing, triage protocols and service hours to best address patient needs and increase capacity to accommodate both urgent and non-urgent appointments.</p> <p>Goal: X% increase to be determined in DY2. X% increase by 9/30/16</p> <p><b>Milestone I-13 Estimated Incentive Payment (<i>maximum amount</i>): \$402,834</b></p> <p><b>I-14. Milestone:</b> Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior</p>	

138910807.1.2	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE	
Children's Medical Center of Dallas			138910807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)	
Goal: 2 new staff trained by 9/30/13  <b>Milestone P5 Estimated Incentive Payment (<i>maximum amount</i>): \$488,548</b>			reporting period.  <b>I-14.1. Metric:</b> Number of patients served by the nurse advice line. Demonstrate improvement over baseline rates. Numerator: number of unique records created from calls received to the nurse advice line. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered).  Data Source: Automated data from call center  Rationale/Evidence: This measure will indicate how many calls are addressed successfully as well as an overall call abandonment rate.	

138910807.1.2	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE	
Children’s Medical Center of Dallas			138910807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)
				Abandonment rate is the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person. It is related to the management of emergency calls. This metric speaks to the capacity of the nurse advice line.  Goal: X% increase to be determined in DY2. X% increase by 9/30/16  <b>Milestone I14 Estimated Incentive Payment (<i>maximum amount</i>): \$402,834</b>
Year 2 Estimated Milestone Bundle Amount: \$ 977,097		Year 3 Estimated Milestone Bundle Amount: \$999,338	Year 4 Estimated Milestone Bundle Amount: \$997,788	Year 5 Estimated Milestone Bundle Amount: \$805,667
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$3,779,890				

## **SUMMARY PAGE: CHILDREN'S MEDICAL CENTER: Pass 1 Category 1 Project/138910807.1.3**

### Expand Pediatric Primary Care

**Provider:** Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Children's has approximately 600,000 patient contacts a year.

Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

**Intervention(s):** The purpose of this project is to implement a disease management program at the MyChildren's locations. By providing disease management to children with chronic diseases, children with chronic diseases receive the best management of chronic disease with the least cost and minimal disruption of daily life for these children and their families.

**Need for the project:** Lack of effective chronic disease management was identified a community need in the needs assessment.

**Target population:** The target population is children in RHP 18 covered by Medicaid and CHIP.

**Category 1 or 2 expected patient benefits:** This project will improve management of chronic diseases for children covered by Medicaid and CHIP.

**Category 3 outcomes:** OD-9 Preventive and Primary Care. IT-3.9.3 Pediatric/Young Adult Asthma Emergency Department Visits. (Stand alone measure) This measure was selected because the project is designed to support appropriate management of asthma and reduce the use of ED services for asthma management. *Improved understanding by the patients and caregivers (parents, etc.) of the medical condition and preventive care, to reduce risk for exacerbation leading to preventable ER or UR visits. Assessment of patient and family awareness, attitudes and health behaviors will be included.*

## **Title of Project: Implement and Utilize Pediatric-Specific Disease Management System Functionality**

**Unique RHP project identification number:** 138910807.1.3,  
Children's Medical Center/13890807

### **Project Description:**

Expand the implementation of Children's Medical Center's (CMC's) disease management programs into CMC's primary care settings in RHP 18.

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

Children's Medical Center (CMC) has seven (7) Joint Commission Disease-Specific Certified disease management programs, however, resources, infrastructure and technology have been severely limited, and therefore, CMC is only able to care for a very small percentage (<1%) of chronic disease management patients in Collin County. The goal of this project is to expand the CMC-certified disease management programs capacity to treat more patients and to provide the infrastructure and support needed to accomplish standardized, evidence-based chronic illness management in the primary care setting and implement the infrastructure that supports the regional goals of patient population health, panel management and coordination of care.

In order to do this, we propose to:

- Expand the CMC certified disease management programs in the community ambulatory settings
- Design care coordination strategies that are designed to optimize care across a continuum, including home, school and community settings
- Design culturally appropriate patient/family self-management programs for chronic illness management
- Incorporate electronic registries, predictive modeling, decision support and social awareness systems that are pediatric-specific and family focused into team-based practice settings
- Incorporate and maintain evidence-based standards in the pediatric disease management programs
- Design and implement pediatric community-based resource centers for joint patient/family education and behavior change programs, opportunities for patients/families to learn from each other and the creation of support networks for providers, patients and families

### **Challenges:**

A major challenge will be changing patient/family behaviors to improve and maintain the health of children with chronic illnesses. Training patients/families in self-management of their own health is a challenge for any population of chronically ill patients. Another challenge will be the ability to risk-adjust the population and tailor the interventions to achieve the best outcomes with limited resources. These challenges will be addressed by using behavior change science, health literacy principles, language and culturally appropriate approaches and the use of community health workers who reside in the community, understand the customs and speak the language. State-of-the-art, evidence-based software will be used for risk-adjusting the population and identifying the children who are appropriate for enrollment in disease management programs and identifying the children who are at highest risk.

### **Five-year Expected Outcome for Provider and Patients:**

Implementing and utilizing pediatric-specific disease management system functionality is a prerequisite for many of the improvements targeted by pediatric medical home initiatives to prevent disease, minimize

unnecessary exacerbation of chronic illness, train patients/families in effective behavior change and self-management techniques and maintain a higher state of well-being across the family. Additionally, pediatric-specific disease management programs that are electronically supported and integrated consistently across the continuum of care can keep children out of the emergency department, specialist clinics and inpatient beds. The expected result will be decreased ED visits, decreased specialty clinic visits and decreased preventable admissions/readmissions/complications (PPAs, PPRs and PPCs).

### **Starting point/baseline**

Baseline will be number of patients enrolled in program during DY1.

### **Rationale**

Effective and accessible pediatric-specific chronic disease management programs have been shown to have a measurable impact on quality of life, reducing the risk and consequences of worsening health conditions, reducing the need for unnecessary ED visits, specialist visits and inpatient admissions/length of stay (LOS).

In 2006, at the Public Health Forum, held in Austin, it was reported that one in three children in Texas can be considered overweight or obese. Additionally, the racial disparity of higher diabetic-related deaths in African Americans demonstrated in the adult population is also present among children. According to the Dallas Morning News, “those of Mexican ancestry, for example, are nearly twice as likely to have diabetes as non-Hispanic whites.” With the association of diabetes and obesity there is also concern of the future trajectory as low income preschool obesity within the Dallas Metropolitan Statistical Area was 17.2% in 2009, placing many young children at higher risk of developing diabetes in later years. Finally, the Community Needs Assessment Report documented increasing rates of many chronic diseases, including but not limited to asthma and diabetes.

According to Children’s Medical Center data, between 2000 and 2010, the number of Children’s Medical Center admissions of youth with a primary or secondary diagnosis of asthma increased by 15%.

### **Project Components:**

The project components will include:

- a. Enter patient data into unique chronic disease registry
- b. Use registry data to proactively identify, contact, educate and track patients by disease status, risk status, self-management status, self-management status, community and family need
- c. Use registry to develop and implement targeted QI plan
- d. Conduct quality improvement or 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 the expansion of the project, including special considerations for safety-net populations.

### **Community Needs Addressed:**

- CN 2 Primary Care Children
- CN 4 Urgent and Emergency Care
- CN 5 Co-morbid and Behavioral Health Conditions – All Ages
- CN 8 Diabetes
- CN 14 Obesity and its co-morbid risk factors



**Related Category 3 Outcome Measure and Rationale for Selection:**

OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization. (Stand alone measure)

This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children.

**Relationship to other projects:**

- 1.1 Expand Primary Care Clinics
- 1.2 Expand Primary Care hours
- 1.3 Expand Behavioral Health
- 1.4 Expand Medical Homes

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

Comprehensive Chronic Disease Management and Wellness Program (Baylor), Diabetes Management interventions (Methodist), Self Management and Wellness Program (THR), Outpatient Delivery System: Coordinate Care for Diabetic Patients

*Healthcare transformation projects in RHP 18 are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, the needs span the region, and healthcare consumers may move across geo-political boundaries in this mixed urban and rural area of the state. Participating providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region.*

**Plan for Learning Collaborative:**

*The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.*

**Project Valuation:**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

**References:**

Goetz RZ, Ozminkowski RJ, Villagra VG, Duffy J. Return on investment in disease management: a review. *HealthCare Financing Review*, 2005; 26: 1-19

Joni K. Beck, PharmD, CDE, Kathy J. Logan, RN, MS, RD/LD, CDE, Robert M. Hamm, PhD, Scott M. Sproat, MHA, Kathleen M. Musser, MD, Patricia D. Everhart, Harrold M. McDermott, MBA, CPA,

Kenneth C. Copeland, MD. Reimbursement for Pediatric Diabetes Intensive Case Management: A Model for Chronic Diseases? *Pediatrics* Vol. 113 No. 1 January 1, 2004 pp. e47 -e50.

Tracy A Lieu, Charles P Quesenberry, Michael E Sorel, Guillermo R Mendoza and Albin B Leong. Prediction Models to Support Cost-Effective Disease Management of Pediatric Asthma. *Pediatric Research* (1997) 41, 78–78; doi:10.1203/00006450-199704001-00471

Smith, JL. A Roadmap to the Disease Specific Care Certification Process. *Orthopaedic Nursing*, 2008; 27: 218-222

13890807.1.3	1.3.1	1.3.1 A, B, C, D	Implement and Utilize Pediatric-Specific Disease Management System Functionality	
Children's Medical Center			13890807	
OD 9	IT-3.9.3	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary Care	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p>P-1. Milestone: Identify one or more target patient populations diagnosed with selected chronic disease(s) (e.g. diabetes, CHF, COBP, etc) or with Multiple Chronic Conditions (MCCs). P-1.1. Metric: Documentation of patients to be entered into the registry a. Numerator: Number of patients entered into the registry with target condition; b. Denominator: Total number of patients with the target condition; c. Data source: performing providers records/documentation; d. Rationale/Evidence: Condition specific registries allow providers to focus on quality improvements around clinical outcomes and processes for targeted patients. e. Goal: 20% of patient entered into registry by 9/30/12 <b>Milestone P1 Estimated Incentive Payment (maximum amount): \$463,003</b></p>	<p>P-4. Milestone: Implement/expand a functional disease management registry. P-4.1. Metric: Registry functionality is available in X% of the Performing Provider's sites and includes an expanded number of targeted diseases or clinical conditions. a. Numerator: Number of sites with registry functionality b. Denominator: Total number of sites c. Data Source: Documentation of adoption, installation, upgrade, interface or similar documentation d. Rationale/Evidence: 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. Having the functionality in as many sites as possible will enable care coordination for patients as</p>	<p>I-16. Milestone: Increase the number of patient contacts recorded in the registry relative to baseline rate. I-16.1. Metric: Total number of in-person and virtual (including email, phone and web based) visits, either absolute or divided by denominator. a. Numerator: Number of patient contacts recorded in the registry b. Denominator: Number of targeted patients in the registry ("targeted" as defined by Performing Provider) c. Data source: Internal clinic or hospital records/documentation d. Rationale/evidence: help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care. Goal: 15% of eligible patients receive contact by 9/30/15 <b>Milestone I-16 Estimated Incentive Payment (maximum</b></p>	<p>I-18. Milestone: Perform routine follow-up monitoring to ensure adherence to the disease management program I-18.1. Metric: As measured by the # of patients adhering to the recommended program regimen compared to the total number of patients following a program regimen – using the patient registry a. Numerator: Number of patients of a certain target group involved in disease management programs. b. Denominator: Total number of patients in the target group or the clinic. c. Data Source: Internal clinic or hospital records/documentation d. Rationale/Evidence: Improve effective management of chronic conditions and ultimately improve patient clinical indicators, health outcomes and quality, and reduce unnecessary acute and emergency care utilization. Goal: 25% of eligible patients participating in program by 9/30/16</p>	

13890807.1.3	1.3.1	1.3.1 A, B, C, D	Implement and Utilize Pediatric-Specific Disease Management System Functionality	
Children's Medical Center			13890807	
OD 9	IT-3.9.3	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary Care	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p>P-2. Milestone: Review current registry capability and assess future needs.</p> <p>P-2.1. Metric: Documentation of review of current registry capability and assessment of future registry needs.</p> <p>a. Numerator: number entered into the registry; 0 if documentation is not provided, 1 if it is provided;</p> <p>b. Denominator: total patients with the target condition;</p> <p>c. Data source: EHR systems and/or other performing provider documentation.</p> <p>d. Rationale/Evidence: Used to determine if the necessary elements for a chronic disease registry are in place for optimal care management. Necessary elements may include inpatient admissions, emergency department visits, test results, medications, weight, activity level changes and/or diet changes.</p> <p>e. Goal: Review complete by 9/30/13</p> <p><b>Milestone P-2 Estimated</b></p>		<p>they access various services throughout a Performing Provider's facilities. Registry use can be targeted to clinical conditions/diseases most pertinent to the patient population (e.g., diabetes, hypertension, chronic heart failure).</p> <p>e. Goal: 50% of sites with functionality by 9/30/14</p> <p><b>Milestone P-4 Estimated Incentive Payment (maximum amount): \$473,542</b></p> <p>P-5. Milestone: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status</p> <p>P-5.1. Metric: Documentation of registry automated report</p> <p>a. Numerator: number of patients with required information entered in the registry</p> <p>b. Denominator: total number of</p>	<p><b>amount): \$472,808</b></p> <p>I-17. Milestone: Use the registry to identify patients and families that would benefit from targeted patient education services. Develop and implement patient and family training programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management, nurse and/or therapist-based education in primary care sites, group classes or patients' homes and standardized teaching materials available across the care continuum.</p> <p>I-17.2. Metric: Development of tool for documenting the existence of patient's self management goals in patient record for patients with chronic disease(s) at defined pilot sites(s).</p> <p>Goal: Tool developed by 9/30/15</p>	<p><b>Milestone I-18 Estimated Incentive Payment (maximum amount): \$763,541</b></p>

13890807.1.3	1.3.1	1.3.1 A, B, C, D	Implement and Utilize Pediatric-Specific Disease Management System Functionality	
Children’s Medical Center			13890807	
OD 9	IT-3.9.3	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)
Incentive Payment ( <i>maximum amount</i> ): \$463,003		patients with target condition c. Data Source: Registry d. Rationale/Evidence: To be meaningful for panel management and potentially for population health purposes, registry functionality should be able to produce reports for groups or populations of patients that identify clinical indicators. e. Goal: 20% of patients with target condition entered by 9/30/14 Milestone P-5 Estimated Incentive Payment ( <i>maximum amount</i> ): \$473,542	Milestone I-17 Estimated Incentive Payment ( <i>maximum amount</i> ): \$472,808	
Year 2 Estimated Milestone Bundle Amount: \$926,007		Year 3 Estimated Milestone Bundle Amount:\$947,085	Year 4 Estimated Milestone Bundle Amount: \$945,616	Year 5 Estimated Milestone Bundle Amount: \$763,541
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD \$3,582,248				

## **SUMMARY PAGE: CHILDREN'S MEDICAL CENTER: Pass 1 Category 1 Project/138910807.1.4**

Expand Pediatric Primary Care to expand services for co-morbid behavioral health conditions

**Provider:** Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Children's has approximately 600,000 patient contacts a year.

Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

**Intervention(s):** The purpose of this project is to bring behavioral health services into the primary care setting through the MyChildren's offices in Region 18.

**Need for the project:** Behavioral health care and medical health care are very disjointed resulting in poorly coordinated services for children covered by Medicaid and CHIP who need behavioral health services.

**Target population:** The target population is children in RHP 18 covered by Medicaid and CHIP.

**Category 1 or 2 expected patient benefits:** This project will improve coordination of behavioral and medical care for children covered by Medicaid and CHIP.

**Category 3 outcomes:** OD-1 Primary Care and Chronic Disease Management IT-1.18 Follow-up after Hospitalization for Mental Illness. (Stand alone measure) This measure was selected based on its relevance to the project and its goals. Providing outpatient follow-up after an inpatient hospitalization for mental illness will be a vital step in the developing and maintaining the continuum of care for behavioral health and avoiding additional high-cost inpatient stays. *Measures include reduced duplication of services between BH and Medical care providers, record keeping and a consistent approach to comorbid conditions, especially conditions associated with poor health status. Enhanced care at an early age to prevent juvenile and adult exacerbation, and increased referrals from BH and PC physicians.*

**Title of Project:** Enhance Community-Based settings Where Behavioral Health Services May Be Delivered in Underserved Areas

**Unique RHP project identification number:** 138910807.1.4

**Performing Provider Name:** Children's Medical Center/13890807

### **Project Description**

Expand pediatric behavioral health capacity in CMC primary care settings in Collin County to align and coordinate care for behavioral and medical illnesses in an attempt to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services and other behavioral health care providers for coordination of care between medical services and behavioral health services.

### **Goals**

The following goals address regional needs of better coordination of care between behavioral health and medical providers and increasing access to behavioral health services.

1. Build clinical protocols with primary care physicians and psychiatrists
2. Place pediatric behavioral health capacity (social workers and psychologists) in primary care settings
3. Integrate behavioral health and medical health treatment plans into a family-focused, comprehensive and culturally appropriate approach, using a care team approach
4. Improve coordination of care between behavioral health and medical providers

### **Challenges**

A major challenge will be to identify, recruit and retain pediatric behavior health staff. Second, another challenge will be the development of processes and protocols to integrate behavioral health services into the primary care setting and align/integrate behavioral health and medical services. We will be working with Timberlawn Psychiatric Services, which currently provides inpatient and outpatient behavioral health services to children and adolescents in RHP 18, to assist us in overcoming the challenges noted. We will also collaborate with other behavioral health care providers in RHP 18.

### **Five-year expected outcomes to Provider and Patients**

This project is related to the regional goal of increasing access to behavioral health services and addressing co-morbid medical and behavioral health conditions.

- Increase behavioral health visits in primary care center
- Transition appropriate patients from specialty mental health care to primary care
- Implement primary care-initiated behavioral health visits in primary care clinic

### **Starting point/baseline**

In 2011, there were no behavioral health services available in the MyChildren's locations. As a result, medical professionals and behavioral health professionals were treating the same children without common evidence-based protocols and without an integrated family-focused, comprehensive and culturally appropriate care team approach.

### **Rationale**

According to Regional Health Partnership 18 Community Needs Assessment Report, the behavioral health (mental health and substance abuse) system in Collin County is delivered via the NorthSTAR program, instead of a traditional local mental health authority system. Since the program's inception, the growth in enrollment has outpaced funding such that the funding per person is 30% less today than when

the program started in 1999. Texas ranks 50<sup>th</sup> nationally in mental health funding. Despite the strong relationship between behavioral health and medical illness related outcomes and costs, the percentage of the 200% FPL population receiving behavioral health care to primary care settings is below the national average in Texas. Children's Medical Center, one of the larger providers of primary care to low income populations in Collin County, is not a NorthSTAR provider, and consequently, children who may be successfully served in primary care settings are referred to NorthSTAR. This results in dilution of limited NorthSTAR funds, inadequate services available to children, and coordination of care issues.

According to Beyond ABC, Growing Up in the North Texas Corridor, the number children in Collin County children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 9,304 in 2010 children. According to 2005 research conducted by the National Institute of Mental health, half of all lifetime cases of mental illness begin by age 14. Services in the health care community frequently do not include the family-focused and comprehensive approach needed to adequately address these mental health issues. Rather, nearly all of the intensive service availability, including evidence-based programs such as multi-systemic therapy, is provided through the Juvenile Justice System. Furthermore, the number of youth served in the juvenile justice system is increasing, as evidenced by a 17% increase in the number of children receiving psychotropic medications in juvenile detention from 2010 to 2011.

Expanded pediatric behavioral health capacity and integration with medical care in the primary care setting in a family-focused, comprehensive and culturally appropriate manner will improve access for children to behavioral health services, prevent unnecessary exacerbation of chronic illnesses, improve patient/family self-management and improve cost and quality outcomes. The result will be reduced ED visits, specialty care visits and preventable admissions/readmissions for the identified population.

The milestones and metrics for this project are based on the relevancy to RHP 18 population, the community need, RHP priority and the starting point.

### **Project Components:**

There are no project components for this project.

### **Community Needs Addressed:**

- CN 2: Primary Care and Children
- CN 4: Urgent and Emergency Care
- CN 5: Co-morbid and Behavioral Health Conditions – all ages
- CN 11: Behavioral Health – All Components, All Ages

### **Project Represents a New Initiative**

This project represents a new initiative to bring behavioral health services into MyChildren's Medical Home Practices.

### **Related Category 3 Outcome Measure and Rationale for Selection**

OD-1 Primary Care and Chronic Disease Management

IT-1.18 Follow-up after Hospitalization for Mental Illness. (Stand alone measure)



This measure was selected based on its relevance to the project and its goals. Providing outpatient follow-up after an inpatient hospitalization for mental illness will be a vital step in the developing and maintaining the continuum of care for behavioral health.

**Relationship to other projects:**

- 1.1 Establish more primary care clinics
- 1.2 Establish extended hours for pediatric primary care
- 1.3 Implement Disease Management
- 2.1 Expand/Enhance Medical Homes
- RD-1 Potentially Preventable Admissions
- RD-2 30-day readmissions
- RD-3 Potentially Preventable Complications
- RD-4 Patient-centered Healthcare
- RD-5 Emergency Department
- RD-6 Initial Core Set of Health Care Quality Measures

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

Creation of Behavioral Health Programs (Baylor), Primary Care Integration with Behavioral Health (Metrocare), Family Preservation Program (Metrocare). Healthcare transformation projects in RHP 18 are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, the needs span the region, and healthcare consumers may move across geopolitical boundaries in this mixed urban and rural area of the state. Participating providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region.

**Plan for Learning Collaborative:**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

**Project Valuation**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

**References:**

James P. Smith, Gillian C. Smith Long-term Economic Costs of Psychological Problems During Childhood *Social Science & Medicine*, v. 71, no. 1, July 2010, p. 110-115.

Aalsma MC, Blythe MJ, Tong Y, Harezlak J, Rosenman MB. Insurance Status of Urban Detained Adolescents. *Journal of Correct Health Care*. 2012 Aug 23. [Epub ahead of print]

Dumont IP, Olson AL, Primary care, depression, and anxiety: exploring somatic and emotional predictors of mental health status in adolescents. *J Am Board Fam Med* 2012 May-Jun;25(3):291-9.

Jacob MK, Larson JC, Craighead WE Establishing a Telepsychiatry Consultation Practice in Rural Georgia for Primary Care Physicians: A Feasibility Report. *Clin Pediatr (Phila)*. 2012 Apr 20.

13890807.1.4	1.12.2	NO COMPONENTS	Expand Behavioral Healthcare Capacity	
Children's Medical Center			13890807	
OD 1	IT-3.1.18	P-1, I-1, I-2; P-2, I-1, I-2; P-3, I-1, I-2; P-4, I-1, I-2; P-5, I-1, I-2	Primary Care and Disease Management	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p><b>P-2. Milestone:</b> Identify licenses, equipment requirements and other components needed to implement and operate options selected.</p> <p>P-2.1. Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components</p> <p>Research existing regulations pertaining to the licensure requirements of psychiatric clinics in general to determine what requirements must be met. When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate.</p> <p>Data Source: Project Plan</p> <p>Goal: Project plan completed by 9/30/13</p>		<p><b>P-3. Milestone:</b> Develop administrative protocols and clinical guidelines for projects selected.</p> <p>P-3.1. Metric: Manual of operations for the project detailing administrative protocols and clinical guidelines</p> <p>Data Source: Administrative protocols; Clinical guidelines</p> <p>Goal: Protocols and Guidelines developed by 9/30/13</p> <p><b>Milestone P.3 Estimated Incentive Payment (<i>maximum amount</i>): \$489,871</b></p> <p><b>P-6. Milestone:</b> Establish behavioral health services in new community-based settings in underserved (targeted) areas.</p> <p>P-6.1. Metric: Number of new community-based settings where behavioral health</p>	<p><b>I-11 Milestone:</b> Increase utilization of community behavioral healthcare</p> <p>I-11.1 Metric Percent utilization of community behavioral healthcare services.</p> <p>Numerator: Number receiving community behavioral healthcare after access expansion.</p> <p>Denominator: Number of people eligible for receiving community behavioral health services after access expansion.</p> <p>Data source: Claims data and encounter data</p> <p>Goal: 25% patients referred receive the service.</p> <p><b>I.131Estimated Incentive Payment (<i>maximum amount</i>): \$978,224</b></p>	<p><b>I-12. Milestone:</b> Use of Emergency Department Care by individuals with mental illness or substance use disorders.</p> <p>I-12.1. Metric: X% decrease in inappropriate utilization of Emergency Department.</p> <p>Numerator: total number of individuals receiving services through expanded access sites who inappropriately use emergency department.</p> <p>Denominator: total number of individuals receiving services through expanded access sites</p> <p>Data Source; Claims data and encounter data from ED and expanded access sites</p> <p>Rationale: see project description.</p> <p>Goal: Percentage decrease to be determined in DY2</p>

13890807.1.4	1.12.2	NO COMPONENTS	Expand Behavioral Healthcare Capacity	
Children's Medical Center			13890807	
OD 1	IT-3.1.18	P-1, I-1, I-2; P-2, I-1, I-2; P-3, I-1, I-2; P-4, I-1, I-2; P-5, I-1, I-2	Primary Care and Disease Management	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<b>Milestone P.2 Estimated Incentive Payment (<i>maximum amount</i>): \$478,969</b>  P-4. Milestone: Hire and train staff to operate and manage projects selected. P-4.1. Metric: Number of staff secured and trained a. Data Source: Project records; Training curricula as develop in P-2  B. 3 staff hired and trained for the MyChildren's System by 9/30/13 <b>Milestone P. 4 Estimated Incentive Payment (<i>maximum amount</i>): \$478,969</b>		services are delivered Number of patients served at these new community-based sites Goal: 2 new settings <b>Milestone P.6 Estimated Incentive Payment (<i>maximum amount</i>): \$489,871</b>		<b>Milestone I.12 Estimated Incentive Payment (<i>maximum amount</i>): \$789,870</b>
<b>Year 2 Estimated Milestone Bundle Amount: \$ 957,938</b>		<b>Year 3 Estimated Milestone Bundle Amount: \$979,743</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$978,224</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$789,870</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$3,705,774</b>				

## **SUMMARY PAGE: UTSW: Pass 1 Category 1 Project/126686802.1.1**

**Project Title:** *UT Southwestern Clinical Center at Richardson/Plano: Establishing a New Primary Care Community Outreach Center*

**Provider:** University of Texas Southwestern Medical Center (“UTSW” or “UT Southwestern”) operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. The physician faculty of UTSW provide patient care at UTSW University Hospitals & Clinics, Parkland Health & Hospital System, Children’s Medical Center Dallas, Texas Scottish Rite Hospital, VA North Texas Health Care System, and other affiliated hospitals and clinics in Dallas, Fort Worth and North Texas communities. Its Faculty physicians, residents and health care professionals at UTSW provide almost \$144 million in uncompensated clinical services annually.

**Intervention(s):** UTSW will establish a new Primary Care Clinic that will be staffed by Family Medicine, Internal Medicine and Obstetrics/Gynecology faculty physicians. As volume and demand warrants it, evening and weekend hours are planned to improve access and capacity. Imaging and laboratory services will also be available once volume justifies the additional services.

**Need for the project:** The Community Needs Assessment for RHP 18 identifies CN.1 – Primary Care for Adults and CN.6 – Health Professions Shortage as high priorities. This is particularly true for the area served by the new clinic.

**Target population:** The target population includes people living and working within an approximately 5 mile radius of the new clinic. Collin County has a diverse population that includes 5% Medicaid enrollees and 12% Uninsured.

**Category 1 or 2 expected patient benefits:** The new clinic will require UT Southwestern to recruit additional physicians to the Faculty Practice Plan, which in turn will increase the capacity of the Health System to see more patients. The Primary Care Clinic is planned to grow to 5 physicians and 17 support staff including nurses, medical office assistants and other support staff. Projections target approximately 2,500 unique patients and 7500 visits in the first year of full operations. Five-year projections estimate that the Primary Care Clinic will have approximately 7,000 unique patients and 17,000 patient visits annually.

### **Category 3 outcomes:**

- **Measure IT-1.10: Diabetes Care: Hb1Ac poor control (>9.0%)** – The incidence of Diabetes is well above the national average in the Dallas/Fort Worth area. Our goal is to help our patient improve control of this chronic disease condition.
- **Measure IT-1.11: Blood Pressure Control (<140/80mm Hg)** – Hypertension is one of the most common problems associated with diabetes and obesity, which also has an incidence rate well above state and national averages. Our goal is to help patient control their high blood pressure as part of a larger chronic disease management strategy.
- *Evidence will be trends in normalization of health indicators and reduced risk for higher levels of care.*

**Title of Project:** Establishing a New Primary Care Community Outreach Center

**Unique RHP project identification number:** 126686802.1.1

**Performing Provider Name:** UT Southwestern/126686802

## **Project Description**

UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Southern Collin County that is comprised of both Primary Care and Specialty Care Services. This proposal addresses *solely* the **Primary Care Clinic Services**. The Primary Care Clinical areas are distinct from the Specialty Care Clinical areas. The Primary Care Clinic components will provide Family Medicine, Internal Medicine, and Obstetrics & Gynecology. The Primary Care Clinic will be 12,759 square feet and will eventually include ultrasound, laboratory testing, and access to x-rays, CT Scanning, and mammography, and a pharmacy. MRI access may be added depending on volume and need. In addition, the new clinic will have an electronic medical record that immediately will be integrated into the main UT Southwestern Medical Center electronic medical record system. Parking at the new location is free and easily accessible to patients.

The new clinic will require UT Southwestern Medical Center to recruit additional physicians to the Faculty Practice Plan, which in turn will increase the capacity of the Health System to see more patients. The Primary Care Clinic is currently planned to have 5 physicians and 17 support staff including nurses, medical office assistants and other support staff. Newly recruited physicians and support staff will undergo orientation and training on the UT Southwestern main campus. A key element of that training will be in how to use Epic, the UTSW electronic medical record and how to make and track referrals within and outside of UT Southwestern Medical Center.

Projections target approximately 2,500 unique patients and 7500 visits in the first year of full operations. Five-year projections estimate that the Primary Care Clinic will have approximately 7,000 unique patients and 17,000 patient visits annually.

The new location will make it easier for patients to access the new providers and services. In addition, once the new clinic reaches certain growth projections, evening and weekend hours are planned to further improve access to services.

## **Goals and Relations to Regional Goals**

The overarching goal of the project is to expand Primary Care capacity and access to patients needing primary and preventive care services through increased primary care clinic visits. The specific goals in support of this project's overarching goal are as follows:

- Establish a new primary care clinic location;
- Expand the hours of this primary care clinic; and
- Train/Hire additional primary care providers and staff.

This project is also related to the regional goal of providing seamless and timely access to a range of evidence-based health and medical services of such quantity and quality that will promote optimum outcomes for RHP 18 residents.

## **Challenges**

Historically, patients from RHP 18 have had to travel long distances to reach the UT Southwestern campus. Once there, they often found the campus difficult to navigate and had limited parking

availability. Primary Care resources were also limited due to the tradition of providing specialty care services for complex cases. Furthermore, UT Southwestern is challenged to expand primary care services on its current campus due to facility limitations. The new clinic addresses these challenges by locating in an area that is closer to a large population that is known to desire improved access. The new clinic is located near major highways and roads, making it easy to find. Parking is plentiful and free. In addition, a new DART Train station will be located within walking distance of the new clinic within the next few years.

### **Five year Expected Outcomes**

The clinic will have noteworthy impacts on the priorities of the region with the following data being highlighted:

- 5 new Primary Care providers will be accessible in the community
- 17 additional health professionals supporting the physicians
- 7,000 patients in the community will have a nearby PCP
- 17,000 patient visits will be provided in the community

### **Starting Point/Baseline**

The new UTSW Clinical Center at Richardson/Plano is in the fast-track design-build process. The first phase of the new clinic opened on October 1, 2012 with a Family Medicine physician and support staff. The next phase is scheduled to open in mid-October with two Obstetrics & Gynecology physicians, with another physician joining the practice by December. An Internal Medicine physician is planned to be added by February 2013. As a new clinic in a new location, the baseline is zero for the number of patient visits and number of unique patients seen, by the project.

The Primary Care Clinic is currently planned to add 5 physicians and 17 support staff including nurses, medical office assistants and other support staff. Newly recruited physicians and support staff will undergo orientation and training on the UT Southwestern main campus. A key element of that training will be in how to use Epic, the UTSW electronic medical record and how to make and track referrals within and outside of the UT Southwestern Health System.

The establishment of the clinic will require UT Southwestern to recruit new physicians in Family Medicine, Internal Medicine, Obstetrics & Gynecology, and selected other specialties depending upon demand. While we do not contemplate training residents at the new location during the first year, the clinic would provide an ideal setting to train medical students and residents in how to practice in a traditional community setting.

### **Rationale**

The Clinical Center at Richardson/Plano represents a new initiative for UT Southwestern. The new clinic is the first effort to create and operate multispecialty clinics away from the main campus so that the services are closer to the communities and populations that want and need improved access to UT Southwestern specialists. The clinic will be located near several major highways and roads and close to key highways. In addition, the DART Train System is planning to add a new station within walking distance of the new clinic.

This project is selected because it will add a new Primary Care clinic in the community, which will:

- Increase availability of primary care providers and selected specialists,

- Improve access to primary care and selected specialists, and
- Improve service availability.

All patient populations have difficult gaining timely access to primary care providers and the specialists to whom they refer. Once the new clinic is established and growth projections are achieved, the new clinic will further expand access and availability with the planned addition of evening and weekend hours.

### **Unique community need identification numbers the project addresses**

- CN.1 – Primary Care - Adults
- CN.3 – Prenatal Care (28% of women do not receive prenatal care per CNA)
- CN.6 – Need for more health professionals (Healthcare Professions Shortage)
- CN.8 – Diabetes
- CN.9 – Cardiovascular Disease

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

The RHP 18 Community Needs Assessment Report identifies the top 10 prevalent conditions that account for the most Potentially Preventable Admissions. All of the conditions are prevalent in Zip Codes close to the new clinic, including:

- Angina
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Diabetes – Short Term
- Diabetes – Long Term
- Hypertension

These conditions could be better managed in the continuity of ambulatory primary care clinic settings rather than episodic setting of hospital Emergency Departments and Inpatient Admissions. As part of a larger Chronic Disease Management strategy, monitoring indicators that will help prevent complications and slow the progress of several of these diseases are high priorities for UT Southwestern.

In addition, the annual Behavioral Risk Factor Survey (BRFSS) is a valuable national source of ongoing data regarding the key risk factors for diabetes in Texans 18 years of age or older. High blood pressure, high blood cholesterol levels, and obesity are the top three risk factors associated with diabetes prevalence, heart disorders, and other conditions.

For these reasons, the following two Outcome Measures have been chosen:

- **Measure IT-1.10: Diabetes Care: Hb1Ac poor control (>9.0%) (standalone measure)**
- **Measure IT-1.11: Blood Pressure Control (<140/80mm Hg) (standalone measure)**

### **Relationship to other Projects**

This project is directly related to the Category 1 – Establish More Primary Care Clinics proposed by Texoma Medical Center/Texas Health Presbyterian - WNJ Hospital. Both projects propose to expand basic primary care services in order to avoid unnecessary use of area hospital Emergency Departments and potentially avoid unnecessary hospitalizations. The project also indirectly complements the primary care services expansions for pediatric patients proposed by Children’s Medical Center in Plano. UTSW is



planning on developing a telemedicine/Telehealth service. Projections for when these services might become available are under development. If they come to fruition, those services would complement the Telemedicine/Telehealth Category 1 project proposed by Lakes Regional MHMR Center and Texoma Community Center. If the PCMH concept is implemented, it would complement The Category 2 project proposed by Children's Medical Center.

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

Healthcare transformation projects in RHP 18 are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, the needs span the region, and healthcare consumers may move across geo-political boundaries in this mixed urban and rural area of the state. Participating providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region.

### **Plan for Learning Collaborative**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

### **Project Valuation**

The UTSW Clinical Center at Richardson/Plano is being established, and is projected to have a series of phased-in openings beginning October 2012 and with a goal of reaching complete occupancy by May 2013. UT Southwestern has considered RHP 18's five (5) general criteria for valuing projects, in addition to the specific investments required by UT Southwestern. The project is focused to address several of the unique community needs of RHP 18, as previously described, but will require a significant investment by UT Southwestern. For example, the first year operating expenses are projected to be \$2,982,449. This new clinic is projected to provide a substantial increase in access to primary and preventive health care in RHP 18). The proximity of Medically Underserved Areas, low-income areas, the challenges of access to complex specialty care services, and the increased access to specialty services makes this project an important investment in the community.

126686802.1.1	1.1.1	1.1.1.1 – 1.1.1.13	Establishing a New Community Primary Care Outreach Center	
UT Southwestern			TPI 126686802	
OD-1	IT-1.10 IT-1.11	126686802.3.1 126686802.3.2	<ul style="list-style-type: none"> <li>• Diabetes Care: Hb1Ac poor control (&gt;9.0%)</li> <li>• Diabetes Care: BP Control (&lt;140/80mm Hg)</li> </ul>	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1 [P-1]:</b> Establish additional primary care clinics.</p> <p><b>Metric 1.1[P-1.1]:</b> Number of additional clinics.</p> <p><b>Baseline:</b> No previous UTSW clinic in Collin County.</p> <p><b>Goal:</b> Add one (1) additional primary care clinic to be located in Collin County.</p> <p><b>Data Source:</b> Documentation of detailed expansion plans.</p> <p><b>Rationale:</b> The national, regional and local supply of primary care does not meet the demand for primary care services. Moreover, it is the goal of health care improvement to provider more preventive and primary care in order to keep individuals and families healthy and, thus, avoid more costly ER and inpatient care.</p> <p><b>Milestone 1 Estimated Incentive Payment: \$500,000</b></p> <p><b>Milestone 2 [P-5]:</b> Train/hire additional primary care providers</p>	<p><b>Milestone 5 [P-4]:</b> Expand the hours of primary care clinic, including evening and/or weekend hours.</p> <p><b>Metric 5.1 [P-4.1]:</b> Increased number of hours at primary care clinic over baseline (DY2).</p> <p><b>Baseline:</b> Year 2 will be the baseline period because this is a new clinic.</p> <p><b>Goal:</b> 10% increase in number of hours (4 hours per week).</p> <p><b>Data Source:</b> Clinic documentation</p> <p><b>Rationale:</b> Expanded hours provide more choices for patients and allows for more patients to be seen.</p> <p><b>Milestone 5 Estimated Incentive Payment: \$500,000</b></p> <p><b>Milestone 6 [P-5]:</b> Train/hire additional primary care providers and staff.</p> <p><b>Metric [P-5.1]:</b> Documentation of increased number of providers and staff.</p> <p><b>Baseline:</b> Baseline is the number</p>	<p><b>Milestone 9 [P-4]:</b> Expand the hours of primary care clinic, including evening and/or weekend hours.</p> <p><b>Metric 9.1 [P-4.1]:</b> Increased number of hours at primary care clinic over baseline.</p> <p><b>Baseline:</b> Year 3 operating schedule will be the baseline period. Baseline from previous year projected to be 4 hours.</p> <p><b>Goal:</b> Additional 4 hours of evening and/or weekend on schedule per week.</p> <p><b>Data Source:</b> Clinic documentation.</p> <p><b>Milestone 9 Estimated Incentive Payment: \$600,000</b></p> <p><b>Milestone 10 [I-12]:</b> Increase number of unique patients.</p> <p><b>Metric [I-12.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other documentation</p>	<p><b>Milestone 12 [P-4]:</b> Expand the hours of primary care clinic, including evening and/or weekend hours.</p> <p><b>Metric 12.1 [P-4.1]:</b> Increased number of hours at primary care clinic over baseline.</p> <p><b>Baseline:</b> Year 4 operating schedule will be the baseline period. Baseline from previous year projected to be 4 hours.</p> <p><b>Goal:</b> Additional 4 hours of evening and/or weekend on schedule.</p> <p><b>Data Source:</b> Clinic documentation.</p> <p><b>Milestone 12 Estimated Incentive \$700,000</b></p> <p><b>Milestone 13 [I-12]:</b> Increase number of unique patients.</p> <p><b>Metric 13.1 [I-12.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other</p>	

126686802.1.1	1.1.1	1.1.1.1 – 1.1.1.13	Establishing a New Community Primary Care Outreach Center	
UT Southwestern			TPI 126686802	
OD-1	IT-1.10 IT-1.11	126686802.3.1 126686802.3.2	<ul style="list-style-type: none"> <li>Diabetes Care: Hb1Ac poor control (&gt;9.0%)</li> <li>Diabetes Care: BP Control (&lt;140/80mm Hg)</li> </ul>	
Year 2 (10/1/2012 – 9/30/2013)	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>and staff.</p> <p><b>Metric 2.1 [P-5.1]:</b> Documentation of increased number of providers and staff.</p> <p><b>Baseline:</b> This is a new community outreach clinic, therefore, the baseline is zero (0) UTSW providers and staff in Collin County or Richardson.</p> <p><b>Data Source:</b> New Primary Care schedules, Faculty Practice Plan and Human Resources hiring summaries and other related documents.</p> <p><b>Milestone 2 Estimated Incentive Payment: \$200,000</b></p> <p><b>Milestone 3 [I-12]:</b> Increase number of unique patients.</p> <p><b>Metric 3.1 [I-12.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients new to the UTSW system.</p> <p><b>Data Source:</b> EHR reports, other documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients the panel and is a method to assess the ability to increase capacity to</p>	<p>of providers and staff at the end of Year 2 of clinic operations.</p> <p><b>Data Source:</b> Primary Care schedules, Faculty Practice Plan and Human Resources hiring summaries and other related documents.</p> <p><b>Rationale:</b> As clinic volume grows, additional providers and staff may be added.</p> <p><b>Milestone 6 Estimated Incentive Payment: \$200,000</b></p> <p><b>Milestone 7 [I-12]:</b> Increase number of unique patients.</p> <p><b>Metric 7.1[I-12.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 7 Estimated Incentive Payment: \$200,000</b></p>	<p><b>Rationale:</b> This measures the increased volume of patients the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 10 Estimated Incentive Payment: \$500,000</b></p> <p><b>Milestone 11 [I-12]:</b> Increase number of unique patients.</p> <p><b>Metric 11.1 [I-12.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 11 Estimated Incentive Payment: \$112,320</b></p>	<p>documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 13 Estimated Incentive Payment: \$509,280</b></p>	

126686802.1.1	1.1.1	1.1.1.1 – 1.1.1.13	Establishing a New Community Primary Care Outreach Center	
UT Southwestern			TPI 126686802	
OD-1	IT-1.10 IT-1.11	126686802.3.1 126686802.3.2	<ul style="list-style-type: none"><li>Diabetes Care: Hb1Ac poor control (&gt;9.0%)</li><li>Diabetes Care: BP Control (&lt;140/80mm Hg)</li></ul>	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
provide care.  <b>Milestone 3 Estimated Incentive Payment: \$200,000</b>  <b>Milestone 4 [I-12]:</b> Increase primary care clinic volume of visits. <b>Metric 4.1 [I-12.1]:</b> Documentation of increased visits. <b>Baseline:</b> Patients previously seen by PCP within the past 18 months at the main campus. <b>Data Source:</b> EHR reports, other documentation <b>Rationale:</b> This measures the increased volume of visits and is a method to assess the ability to increase capacity to provide care.  <b>Milestone 4 Estimated Incentive Payment: \$248,000</b>		<b>Milestone 8 [I-12]:</b> Increase primary care clinic volume of visits. <b>Metric 8.1 [I-12.1]:</b> Documentation of increased visits. <b>Baseline:</b> Total number of visits from previous year. <b>Data Source:</b> EHR reports, other documentation <b>Rationale:</b> This measures the increased volume of visits and is a method to assess the ability to increase capacity to provide care. <b>Milestone 8 Estimated Incentive Payment: \$334,620</b>		
<b>Year 2 Estimated Milestone Bundle Amount: \$1,148,000.</b>		<b>Year 3 Estimated Milestone Bundle Amount: \$1,234,620</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$1,112,320</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$1,209,280</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$4,704,220</b>				

## **SUMMARY PAGE: UTSW: Pass 1 Category 1 Project/126686802.1.2**

**Project Title:** *UT Southwestern Clinical Center at Richardson/Plano: Establishing a New Specialty Care Community Outreach Center*

**Provider:** University of Texas Southwestern Medical Center (“UTSW” or “UT Southwestern”) operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. The physician faculty of UTSW provides patient care at UTSW University Hospitals & Clinics, Parkland Health & Hospital System, Children’s Medical Center Dallas, Texas Scottish Rite Hospital, VA North Texas Health Care System, and other affiliated hospitals and clinics in Dallas, Fort Worth and North Texas communities. Its Faculty physicians, residents and health care professionals at UTSW provide almost \$144 million in uncompensated clinical services annually.

**Intervention(s):** UT Southwestern Medical Center is in the process of establishing a new Specialty Care Clinic. The Specialty Care Clinic is planned to provide Orthopedics, Behavioral Health, a range of Cancer Services, and potentially other selected specialties depending on demand. As demand grows, evening and weekend hours are planned to be added.

**Need for the project:** The Community Needs Assessment for RHP 18 identifies CN.4 – Urgent and Emergency Care, CN.6 – Health Professions Shortage, and CN.7 as high priorities. This is particularly true for the area served by the new clinic. RHP 18 had 16,353 cases of cancer between 2005-2009. Cancer rates range from 413/100,000 (Collin) to 481.4/100,000 (Grayson). The incidence rate for Texas is 451/100,000. Having expanded capacity and access to cancer diagnosis and treatment resources is a noteworthy benefit to RHP 18. Cancer patients account for some of the most expensive ED encounters and subsequent inpatient admissions, which could be reduced with better access to specialty services.

**Target population:** The target population includes people living and working within an approximately 5-mile radius of the new clinic. Collin County has a diverse population that includes 5% Medicaid enrollees and 12% Uninsured.

**Category 1 or 2 expected patient benefits:** The new clinic will eventually add 6 new physicians and approximately 22 health professions support staff. Projections target approximately 4,000 unique patients and 8500 visits in the first year of full operations. Five-year projections estimate that the Specialty Care Clinic will have approximately 10,000 unique patients and 24,000 patient visits annually.

### **Category 3 outcomes:**

- **Measure IT-1.10: Diabetes Care: Hb1Ac poor control (>9.0%)** – The incidence of Diabetes is well above the national average in the Dallas/Fort Worth area. Our goal is to help our patient improve control of this chronic disease condition.
- **Measure IT-1.11: Blood Pressure Control (<140/80mm Hg)** – Hypertension is one of the most common problems associated with diabetes and obesity, which also has an incidence rate well above state and national averages. Our goal is to help patient control their high blood pressure as part of a larger chronic disease management strategy.
- *Evidence will be trends in normalization of health indicators and reduced risk for higher levels of care.*

**Title of Project:** Establishing a New Specialty Care Community Outreach Center

**Unique RHP project identification number:** 126686802.1.2

**Performing Provider Name:** UT Southwestern/126686802

### **Project Description**

UT Southwestern is in the process of establishing a new multispecialty clinic in Southern Collin County that is comprised of both Primary Care and Specialty Care Services. The Primary Care Clinical areas are distinct from the Specialty Care Clinical areas. This proposal addresses solely the **Specialty Care Clinic Services**. The Specialty Care Clinic components are planned to provide Orthopedics, Behavioral Health, a range of Cancer Services, and other selected specialties. RHP 18 had 16,353 cases of cancer between 2005-2009. Cancer rates range from 413/100,000 (Collin) to 481.4/100,000 (Grayson). We could not find equivalent cancer rates for Rockwall County. The incidence rate for Texas is 451/100,000. Having expanded capacity and access to cancer diagnosis and treatment resources is a noteworthy benefit to RHP 18.

The new clinic will have an electronic medical record that immediately will be integrated into the main UT Southwestern electronic medical record system. This will facilitate and increase referrals to other UT Southwestern specialists, clinics, and sophisticated diagnostic capabilities. Referrals within the system will be tracked.

The new clinic will require UT Southwestern to recruit additional physicians to the Faculty Practice Plan, which in turn will increase the capacity of the Health System to see more patients. The Specialty Care areas are currently planned to have up to 8 physicians and 25 support staff including nurses, medical office assistants, technologists, and other support staff. Newly recruited physicians and support staff will undergo orientation and training on the UT Southwestern main campus. A key element of that training will be in how to use Epic, the UTSW electronic medical record and how to make and track referrals within and outside of UT Southwestern.

Projections target approximately 4,000 unique patients and 8500 visits in the first year of full operations. Five-year projections estimate that the Specialty Care Clinic will have approximately 10,000 unique patients and 24,000 patient visits annually.

The new location will make it easier for patients to access the new providers and services. In addition, once the new clinic reaches certain growth projections, evening and weekend hours are planned to further improve access to services.

### **Goals and Relations to Regional Goals**

The overarching goal of the project is to expand Specialty Care capacity and access to patients needing diagnostic, treatment and preventive care services through increased specialty care clinic visits. The specific goals in support of this project are as follows:

- Establish a new specialty care clinic location to provide access to special populations;
- Expand the hours of the specialty care clinics; and
- Train/hire additional specialty care providers and staff.

This project is also related to the regional goal of providing seamless and timely access to a range of evidence-based health and medical services of such quantity and quality that will promote optimum outcomes for RHP 18 residents.

## **Challenges**

Historically, patients from RHP 18 have had to travel long distances to reach the UT Southwestern campus. Once there, they often found the campus difficult to navigate and had limited parking availability. Specialty Care resources were also limited due to the tradition of providing specialty care services for complex cases. Furthermore, UT Southwestern is challenged to expand many specialty care services on its current campus due to facility limitations. The new clinic addresses these challenges by locating in an area that is closer to a large population that is known to desire improved access. The new clinic is located near major highways and roads, making it easy to find. Parking is plentiful and free. In addition, a new DART Train station will be located within walking distance of the new clinic within the next few years.

## **Five year projected outcomes**

The clinic will have noteworthy impacts on the priorities of the region with the following data being highlighted:

- 6-8 new Specialty Care providers will be accessible in the community
- 21-30 additional health professionals supporting the physicians and services
- 9,000 – 14,000 patients in the community will have a nearby specialty care services
- 20,000 – 28,000 patient visits will be provided in the community

## **Starting Point/Baseline**

The new “UTSW Clinical Center at Richardson/Plano” is in the fast-track design-build process. The first phase of the new specialty care services is scheduled for December 2012 with the opening of the Orthopedics clinic area with two physicians and their support staff. The next phase is scheduled to open in March 2013, providing Behavioral Health, Medical Oncology, Cancer Infusion Services, and a spectrum of other cancer specialists. Other specialties may be represented depending on demand. As a result of this being a new clinic, the baseline is zero for the number of unique patients and patient visit volumes served by the project. Projections target unique patients and patient visit volumes are still being developed. The baseline period is the first year of operation.

The new specialty clinic will require UT Southwestern to provide physicians in Orthopedics, Physical Medicine and Rehabilitation, Oncology, Behavioral Health and selected other specialties depending upon demand. Newly recruited physicians and support staff will undergo orientation and training on the UT Southwestern main campus. A key element of that training will be in how to use Epic, the UTSW electronic medical record and how to make and track referrals within and outside of the UT Southwestern Health System. While we do not contemplate training residents at the new location during the first year, the clinic would provide an ideal setting to train medical students and residents in how to practice in a traditional community setting.

## **Rationale**

The Clinical Center at Richardson/Plano represents a new initiative for UT Southwestern. The new clinic is part of the first effort to create and operate multispecialty clinics away from the main campus so that the services are closer to the communities and populations that want and need improved access to UT Southwestern specialists. The clinic will be located near several major highways and roads and close to key highways. In addition, the DART Train System is planning to add a new station within walking distance of the new clinic.

The new clinic will have an electronic medical record that immediately will be integrated into the main UT Southwestern medical record system. This will facilitate and increase referrals to other UT Southwestern specialists, clinics, and sophisticated diagnostic capabilities. Referrals within the system will be tracked.

This project is selected because it will add new Specialty Care services to the community, which will:

- Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties (I-22)
- Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. (I-23)

### **Unique community need identification numbers the project addresses**

CN.5 – Co-Morbid Medical Conditions  
CN.6 – Healthcare Professions Shortage  
CN.7 – Preventable Acute Care Admissions  
CN.8 – Diabetes Care Management  
CN.12 – Other Special Populations

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

The RHP 18 Community Needs Assessment Report identifies the top 10 prevalent conditions that account for the most Potentially Preventable Admissions. All of the conditions are prevalent in Zip Codes close to the new clinic, including:

- Diabetes – Short Term
- Diabetes – Long Term
- Hypertension

These conditions could be better managed in the continuity of ambulatory clinic settings rather than episodic setting of hospital Emergency Departments and Inpatient Admissions. As part of a larger Chronic Disease Management strategy, monitoring indicators that will help prevent complications and slow the progress of several of these diseases are high priorities.

In addition, the annual Behavioral Risk Factor Survey (BRFSS) is a valuable national source of ongoing data regarding the key risk factors for diabetes in Texans 18 years of age or older. High blood pressure, high blood cholesterol levels, and obesity are the top three risk factors associated with diabetes prevalence, heart disorders, and other conditions.

For these reasons, the following two Outcome Measures have been chosen:

- **Measure IT-1.10: Diabetes Care: Hb1Ac poor control (>9.0%) (standalone measure)**
- **Measure IT-1.11: Blood Pressure Control (<140/80mm Hg) (standalone measure)**

### **Relationship to other Projects**

This appears to be the only project directly related to specialty care services access, particularly as they related to Orthopedics, Oncology, Imaging, and other specialties to be determined. However, there may be opportunities for referrals or care coordination with the Grayson County Health Clinic Category 1



project proposed by Texoma Medical Center/Texas Health Presbyterian – WNJ Hospital for Establishing More Primary Care Clinics.

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

Healthcare transformation projects in RHP 18 are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, the needs span the region, and healthcare consumers may move across geo-political boundaries in this mixed urban and rural area of the state. Participating providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region.

### **Plan for Learning Collaborative**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

### **Project Valuation**

The UTSW Clinical Center at Richardson/Plano is being established, and is projected to have a series of phased-in openings beginning December 2012 and with a goal of reaching complete occupancy by May 2013. UT Southwestern has considered RHP 18's five (5) general criteria for valuing projects, in addition to the specific investments required by UT Southwestern. The project is focused to address several of the unique community needs of RHP 18, as previously described, but will require a significant investment by UT Southwestern. For example, the first year operating expenses are projected to be at least \$4,000,000. This new clinic is projected to provide a substantial increase in access to specialty care diagnostic, treatment and preventive health care in RHP 18. The proximity of Medically Underserved Areas, low-income areas, the challenges of access to complex specialty care services, and the increased access to specialty services makes this project an important investment in the community.

126686802.1.2	1.9.2	1.9.2.1 - 1.9.2.10	Establish and/or Expanding Specialty Care	
UT Southwestern			TPI 126686802	
OD-1	IT-1.10 IT-1.11	126686802.3.3 126686802.3.4	<ul style="list-style-type: none"> <li>• Diabetes Care: Hb1Ac poor control (&gt;9.0%)</li> <li>• Diabetes Care: BP Control (&lt;140/80mm Hg)</li> </ul>	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1 [P-11]:</b> Launch/expand a specialty care clinic.</p> <p><b>Metric [P-11.1]:</b> Establish/expand specialty care clinic.</p> <p>Baseline: No previous UTSW clinic in Collin County.</p> <p>Documentation of detailed expansion plans.</p> <p>Goal: Add one additional specialty care clinic to be located in southern Collin County.</p> <p>Data Source: Design and construction documents. Lease for new property. Rationale: The national, regional and local supply of specialty care physicians does not meet the demand for specialty care services.</p> <p><b>Milestone 1 Estimated Incentive Payment: \$1,000,000</b></p>	<p><b>Milestone 3 [I-22]:</b> Expand the hours of specialty care clinic, including evening and/or weekend hours.</p> <p><b>Metric [I-22.2]:</b> Increased number of hours at specialty care clinic over baseline.</p> <p><b>Baseline:</b> Year 1 will be the baseline period because this is a new clinic.</p> <p><b>Goal:</b> 10% increase in number of hours (4 hours).</p> <p><b>Data Source:</b> Clinic documentation of clinic hours</p> <p><b>Rationale:</b> Expanded hours providers more choices for patients and more allows for more patients to be seen.</p> <p><b>Milestone 3 Estimated Incentive Payment: \$750,000</b></p> <p><b>Milestone 4 [I-23]:</b> Increase specialty care volume of visits and procedures.</p> <p><b>Metric [I-23.1.1]:</b> Documentation of increased</p>	<p><b>Milestone 6 [P-4]:</b> Expand the hours of primary care clinic, including evening and/or weekend hours.</p> <p><b>Metric [P-4.1]:</b> Increased number of hours at primary care clinic over baseline.</p> <p>Baseline: Year 1 and Year 2 operating schedule will be the baseline period. Baseline from previous year projected to be 4 hours.</p> <p>Goal: Additional 4 hours of evening and/or weekend on schedule.</p> <p>Data Source: Clinic documentation of clinic hours</p> <p><b>Milestone 6 Estimated Incentive Payment: \$600,000</b></p> <p><b>Milestone 7 [I-23]:</b> Increase specialty care volume of visits and procedures.</p> <p><b>Metric [I-23.1.1]:</b> Documentation of increased number of visits and</p>	<p><b>Milestone 9 [I-23]:</b> Increase number of unique patients.</p> <p><b>Metric [I-23.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients on the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 9 Estimated Incentive Payment: \$900,00</b></p> <p><b>Milestone 10 [P-4]:</b> Expand the hours of primary care clinic, including evening and/or weekend hours.</p> <p><b>Metric [P-4.1]:</b> Increased number of hours at primary care clinic over baseline.</p> <p>Baseline: Clinic schedule from previous year.</p>	

126686802.1.2	1.9.2	1.9.2.1 - 1.9.2.10	Establish and/or Expanding Specialty Care	
UT Southwestern			TPI 126686802	
OD-1	IT-1.10 IT-1.11	126686802.3.3 126686802.3.4	<ul style="list-style-type: none"> <li>Diabetes Care: Hb1Ac poor control (&gt;9.0%)</li> <li>Diabetes Care: BP Control (&lt;140/80mm Hg)</li> </ul>	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Milestone 2:</b> Complete planning and installation of new specialty imaging systems. [P-13]</p> <p><b>Metric: Documentation of planning and installation of new systems.</b></p> <p><b>Data Source:</b> Documentation of systems implementation plan and budget.</p> <p><b>Milestone 2 Estimated Incentive Payment: \$512,000</b></p>	<p>number of visits and procedures.</p> <p><b>Baseline:</b> Baseline is the number of visits and procedures in Year 1 of clinic operations.</p> <p><b>Data Source:</b> EHR and billing reports.</p> <p><b>Milestone 4 Estimated Incentive Payment: \$600,000</b></p> <p><b>Milestone 5 [I-23]:</b> Increase number of unique patients.</p> <p><b>Metric [I-23.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients on the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 5 Estimated Incentive Payment: \$589,480</b></p>	<p>procedures.</p> <p><b>Baseline:</b> Baseline is the number of visits and procedures in Year 1 of clinic operations.</p> <p><b>Data Source:</b> EHR and billing reports.</p> <p><b>Milestone 7 Estimated Incentive Payment: \$600,000</b></p> <p><b>Milestone 8 [I-23]:</b> Increase number of unique patients.</p> <p><b>Metric [I-23.2]:</b> Documentation of unique visits.</p> <p><b>Baseline:</b> Baseline volume of unique patients from previous year.</p> <p><b>Data Source:</b> EHR reports, other documentation</p> <p><b>Rationale:</b> This measures the increased volume of patients on the panel and is a method to assess the ability to increase capacity to provide care.</p> <p><b>Milestone 8 Estimated Incentive Payment: \$750,000</b></p>	<p>Goal: Additional 4 hours of evening and/or weekend on schedule.</p> <p>Data Source: Clinic documentation of clinic hours</p> <p><b>Milestone 10 Estimated Incentive Payment: \$913,920</b></p>	

126686802.1.2	1.9.2	1.9.2.1 - 1.9.2.10	Establish and/or Expanding Specialty Care	
UT Southwestern			TPI 126686802	
OD-1	IT-1.10 IT-1.11	126686802.3.3 126686802.3.4	<ul style="list-style-type: none"><li>• Diabetes Care: Hb1Ac poor control (&gt;9.0%)</li><li>• Diabetes Care: BP Control (&lt;140/80mm Hg)</li></ul>	
Year 2 (10/1/2012 – 9/30/2013)		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: \$1,512,000		Year 3 Estimated Milestone Bundle Amount: \$1,689,480	Year 4 Estimated Milestone Bundle Amount: \$1,668,480	Year 5 Estimated Milestone Bundle Amount: \$1,813,920
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$6,683,880				

## **SUMMARY PAGE: Texoma Medical Center Pass 1 Category 1 Project/194997601.1.1**

**Provider:** Texoma Medical Center is a 251-bed regional medical center including a 170-bed acute care hospital, a 21-bed freestanding rehabilitation hospital, and a 60-bed behavioral health center. Texoma Medical Center serves Grayson County and contiguous Texas and Oklahoma counties with a population base of 121,419 (13% Medicaid, 2011) in Grayson County.

**Intervention:** Two hospitals (Texoma Medical Center and Texas Health Presbyterian Hospital-WNJ), a local health department (Grayson County Public Health Department) and a local non-profit health foundation (Texoma Health Foundation) will collaborate to fund and staff a new primary care/urgent care clinic in Grayson County Texas.

**Need for the project:** Grayson County Texas is a rural area with a large percentage of adults and children who lack health insurance (approx.. 27% of adults and 20% of children). There are more than \$236 million in potentially preventable hospital charges from 2005-2010 according to Texas Department State Health Services.

**Target population:** The target population for the new clinic is strategically directed towards 10 Medicaid participants; 2) uninsured residents; and 3) underinsured residents.

**Category 1 or 2 expected patient benefits:** The project seeks to divert non-emergent patients away from emergency departments at two participating hospitals in Grayson County, TX and 2) expand access to primary and urgent health care to indigent health care to indigent health patients, Medicaid patients, Medicaid-eligible patients, and uninsured and underinsured residents. We expect to accomplish this by extended clinic hours, providing transportation from the emergency department, staffed with a trained provider team, and a marketing campaign to inform the community of the new services.

**Category 3 outcomes:** By the end of the waiver year 5, we will ensure an average daily goal of reaching the third next available appointment numerator and have implemented a cholesterol management program.

**Title of project:** Establish More Primary Care Clinics

**Unique RHP Project Identification Number:** 194997601.1.1

**Performing Provider Name/TPI:** Texoma Medical Center/

## **Project Description**

### **Describe the project and how it fits the Project Area and Intervention:**

**Challenge:** Grayson County is a rural area, with a large percentage of adults and children who lack health insurance (approx. 27% of adults and 20% of children). The 2010 Census revealed that Sherman (pop. 37,770) had 10,957 uninsured citizens and Denison (pop. 22,300) had 5,448 uninsured residents. The state health department reports a 2009 population of Medicaid clients of 20,974. With a population of nearly 121,000 residents and more than \$236 million in potentially preventable hospital charges from 2005-2010 (TDSHS, 2012), Grayson County, in collaboration with its two primary hospitals and a public, not-for profit health care foundation (Texoma Health Foundation or THF) has identified a strong need for an emergency room diversion program and for the creation of a primary care/urgent care medical clinic which is strategically directed towards 1) Medicaid participants; 2) uninsured residents; and 3) underinsured residents.

**Solution:** Two competing hospitals in Grayson County [Texas Health Presbyterian Hospital – WNJ (Sherman) and Texoma Medical Center (Denison)] will collaborate with the Grayson County Health Department and Texoma Health Foundation. These entities will fund and staff a new primary care/urgent care clinic located in a former (currently closed) hospital in north Sherman (owned by PWNJ), which is the county seat of Grayson County, and which is centrally-located between the two largest municipalities in the County (Sherman and Denison).

### **Describe the project goals, including the purpose of performing a project in this project area:**

The goals will be to 1) divert non-emergent patients away from the emergency departments as PWNJ and TMC and 2) expand access to primary and urgent health care to indigent health patients, Medicaid patients, Medicaid-eligible patients, and the working poor (i.e. uninsured and underinsured residents). This new program is designed to work as follows:

- The emergency departments (ED's) at each hospital will triage all patients presenting at each facility. Patients who are deemed "non-emergent" by the triage clinician will be referred to the new Grayson County Primary Care Clinic during normal office hours - 7 days each week, 9:00 am to 8:00 pm – by DY 4
- Those non-emergent patients who are diverted from the ED and instructed to proceed to the new Clinic who lack transportation will be provided public transportation by the Texoma Area Paratransit System (TAPS)
- The urgent care clinic will eventually be open seven days each week, 11 hours each day, tentatively scheduled to be 9 a.m. to 8 p.m. Sunday through Saturday – by DY 4
- The urgent care clinic will be staffed by a team of four clinicians (lead by a Family Practitioner) and eight support staff
- The urgent care clinic will have an eventual capacity of 20 patient visits per day by DY 3
- An initial marketing and advertising budget will be included, which will allow a multi-media campaign to educate citizens to avoid visiting either hospital ED for routine primary care concerns and urgent care needs

**Describe any challenges or issues faced by the performing provider and how the project addressed those challenges:**

As this is a new project created through the collaboration of two private hospitals, a county health department, and a local healthcare foundation, this is a new venture for all performing providers and community organizations involved in the process.

**Describe the 5-year expected outcome for the performing provider and patients:**

Over a four-year period, the number of non-emergent hospital services at Texas Health Presbyterian Hospital – WNJ in Sherman and Texoma Medical Center in Denison will be reduced.

**Describe how the project is related to regional goals:**

Expands the capacity of primary and urgent care in Grayson County to better meet the needs of the patient population and community so that care can be better coordinated and patients can be treated by experienced providers

Successfully diverts patients who are seeking general medical services from congested emergency rooms (enhancing quality of care for “true emergent” patients, and reducing overall costs for Uncompensated Care)

**Describe the project’s starting point/baseline:**

Texas Health Presbyterian Hospital - WNJ will provide the facility for the project and through a contractual agreement with Grayson County, Texoma Medical Center will contract with Grayson County to hire and manage clinic staff and operate the Clinic. Texoma Health Foundation will provide start-up costs (infrastructure improvements inclusive of furniture, fixtures, and equipment).

**Rationale:**

Hospital space is available and both hospitals have a need to reduce non-emergency ED visits.

**Describe the reason(s) for selecting this project option:**

Both hospitals and the health department have individually considered opening a clinic for several years. The 1115 Waiver provides this opportunity.

**Describe the reason(s) for selecting these project components:**

After several meetings to discuss resources and healthcare goals, it was determined that Texoma Medical Center, as the only safety-net hospital in the region, should be the lead provider in this 50-50-hospital partnership with the health department.

**Reasons for selecting the milestones and metrics:**

The milestones and metrics provided by HHSC fit with the previously identified milestones identified by the hospitals and health department.

**Specify the unique community need identification number the project addresses (new):** CN.1 – Primary Care – Adults

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

This is a brand new clinic and a first endeavor for the two competing hospitals, teaming with the Grayson County Health Department and Texoma Health Foundation to serve the community's needs.

### **Related Category 3 Outcome Measures**

#### **Outcome Measure #1: OD-1/IT-1.1: Third next available appointment**

The clinic plans to enhance primary care by the end of DY 2 by reducing the average length of time in days between the day a patient makes a request for an appointment and the third available appointment for a new patient physical, routine exam or return visit exam.

**Relationship to other Projects:** Describe how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan.

The Grayson County Clinic will be directly partnered with the county's two primary hospitals. Therefore, any person in need of advanced treatment will be referred to either PWNJ or TMC, in a manner which results in an equal split of referrals. However, this is not connected to other plans in RHP-18.

### **Describe the related Category 1 and 2 projects**

The Grayson County Clinic can work cooperatively with the Texoma Community Clinic, which provides behavioral health services, also in Grayson County, by providing primary health services for the behavioral health population.

### **Describe the related Category 4 Population-focused improvements with the unique RHP project identification number based on the requirements above:**

The clinic plans to address patient-centered healthcare, a reduction in ED use by non-emergency patients by increasing potentially preventable admissions through clinic services.

### **Relationship to Other Performing Providers' Projects in the RHP.**

As stated above, the clinic is available to provide primary care services for behavioral health patients at Texoma Community Center.

**Project Valuation:** Describe the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums].

The clinic's value to the community can be described as follows:



Reduction in non-emergent patients in emergency departments in PWNJ and TMC – Each patient diverted through a triage process away from each hospital’s ED will allow ED clinicians to focus their health care efforts on truly emergent patients.

This new clinic will become the medical home for a significant number of Grayson county residents who are either uninsured or who are Medicaid beneficiaries. Access to primary care will be enhanced for these two populations. Because uninsured citizens will have routine access to “sick care”, it is believed that many of these residents will cease the habit of “deferred health care”, and seek care prior to their illness becoming emergent. One major guiding principle of this new clinic will be to expand the health department’s current Potentially-Preventable Hospitalization (PPH) project. Clinician’s at the clinic will use multiple evidence-based interventions to reduce the number of chronically ill patients who are hospitalized and to reduce these patients’ frequency of hospitalizations. Potential annual savings to Medicaid and Medicare exceed the federal share of this DSRIP due to this PPH effort.

Reduction in lost productivity and lost wages in Grayson County’s small businesses: Similar to other rural counties in Texas, Grayson County’s overall economy is heavily dependent on small businesses. In Sherman alone, there are 2,217 businesses which employ from one to 99 people. Throughout Grayson County, there are 4,745 small businesses. A large percentage of these businesses lack the financial means to offer health insurance coverage to their workers. This cohort of the “Working Poor” often delays visits to health care providers due to the patient’s inability to afford the office visit. Lacking primary care, these individuals often miss work until their condition improves. This lost productivity has multiple adverse impacts on the communities of Sherman, Denison and surrounding towns. The reduction in total productivity harms the small business, due to reductions in sales, in services rendered, or in products manufactured. In addition, many of these employees lack paid sick leave, resulting in lowered wages for the sick days missed. The clinic will allow the working poor to quickly access primary care and have access to lower cost generic prescription medications, resulting in lowered absenteeism, increased annual wages, and increased annual productivity for employers.

Reduction in Public School Absenteeism: In Texas, public schools receive funding assistance from the State using a formula called Average Daily Attendance or ADA. For example, in the Sherman Independent School District, the district is paid approximately \$28 for each student attending school on any particular school day. Consequently, any day that any student is absent (due to sickness or other reason), the district loses that incremental amount of state support. The new Grayson County Primary Care Clinic (GCPCC) will act, for some parents, as an urgent care clinic (including evenings and weekends). When a school age child develops an illness, the parents can obtain rapid health care, resulting in early treatment of ailments like ear infections, sore throat, colds, flu, and enteric infections. Rapid access to urgent care will result in fewer days missed from school, and increases in ADA reimbursements for the 16 independent school districts in Grayson County. In addition, the ability of parents of school-age children to access care after the parent’s normal work day (and on weekends) will decrease the parent’s lost work time and enhance productivity for their employers.

Opportunities for Expansion of Primary Care and Disease Prevention Programs: The creation of Grayson County’s first primary care clinic (housed within a former hospital) will afford the community an almost unlimited set of possibilities for expansion of services to the uninsured and to Medicaid and Medicare beneficiaries. The GCPCC will utilize only 5000 square feet of a medical building with over 20,000 square feet of additional health care space available. The clinic will seek novel funding opportunities for the following health care possibilities:

- A Dental Clinic for uninsured adults
- Behavioral Health services for uninsured children and adults

- Employee Health Clinic services for major employers in the County (e.g. Grayson County, cities of Sherman and Denison, Independent School Districts, large private employers)
- Expanded cancer screening and diagnostic services using evidence-based interventions (for breast, cervical, and colo-rectal cancers)
- Expansion of existing Women's Health Clinic (currently one day per week)
- Expansion of clinic's STD services
- Expansion of clinic's TB services
- Creation of a Nurse "Hotline" (24/7) to complement the new emergency department diversion program created by the GCPCC
- Creation of a Well Child clinic for uninsured residents
- Creation of a second DSRIP project for DY 3 related to expanded access to Specialty care
- Possible creation of a Tri-County Health District (consisting of Grayson, Cooke and Fannin counties)
- Possible creation of a Federally-Qualified Health Center (FQHC) to serve the tri-county region
- Enhancement of Grayson County's Emergency Management capabilities, due to integration of three additional clinicians (one physician and two nurse practitioners) into Grayson County's Emergency Operations Plan
- Creation of one additional point of distribution site for use during major epidemics (like pandemic influenza)
- Creation of Chronic Disease Registry
- Creation of Chronic Disease Case Management Program
- Creation of Telemedicine base-of-operations for chronically-ill Medicare and Medicaid beneficiaries
- Enhanced opportunities for Grayson County physicians, dentists, and behavioral health clinicians to volunteer services on a regular basis

This project was valued based on the valuation tool provided by RHP-18. The valuation tool provides a scale of 1-5, with 5 providing the optimum conditions for a project. With a consistent top score, combined with anticipated start-up and operating costs, the project is valued at \$5 million per year.

## **References**

Center for Health Statistics, Texas Department of State Health Services, Potentially Preventable Hospitalizations (2005-2010), printed March 28, 2012.

194997601.1.1	<b>RHP 18</b>		<b>1.1.1 – ESTABLISH MORE PRIMARY CARE CLINICS</b>
<b>Texoma Medical Center</b>			<b>TPI# 194997601</b>
<b>Related Category 3 Outcome Measure(s):</b>	194997601.1.1	OD-1/IT-1.1/IT-1.6	<i>Quality of Life</i>
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>P-1 Process Milestone:</b> Establish a primary care clinic  <b>P-1.1 Metric:</b> Open the clinic by August 30, 2013.  <b>Data Source:</b> New primary care plans or schedule submission  <b>I-10 Improvement Milestone:</b> Enhance patient access to primary care by reducing days to third next available appointment.  <b>I-10.1 Metric:</b> Average number of days to next appointment is less than three days.  <b>Data Source:</b> Scheduling system information  Est. Incentive Payment: \$4,200,000	<b>P-1 Process Milestone:</b> Expand the primary clinic  <b>P-5.1 Metric:</b> Hire and train additional staff - up to eight key primary care staff members by June 2014.  <b>Data Source:</b> Reports and policies  <b>I-11 Improvement Milestone:</b> Patient satisfaction with primary care services.  <b>I-11.3 Metric:</b> Survey response rate.  <b>Data Source:</b> Evidence-based assessment tool implemented and utilized by June 2014.  Est. Incentive Payment: \$3,800,000	<b>P-1 Process Milestone:</b> Expand primary care clinic  <b>P-4.1 Metric:</b> Expand hours to seven days per week by June 2015.  <b>Data Source:</b> Clinic documentation  <b>I-12 Improvement Milestone:</b> Increase primary care clinic volume of visits/evidence of improved access for patients seeking services.  <b>I-12.1 Metric:</b> Total number of visits reported.  <b>Data Source:</b> Registry  Est. Incentive Payment: \$3,500,000	<b>P-7 Process Milestone:</b> Establish a nurse advice line  <b>P-7.1 Metric:</b> Provide a phone line for nurse questions and answers during the business day by June 2016.  <b>Data Source:</b> Documentation of advice line  <b>I-14 Improvement Milestone:</b> Increase the number of patients served on nurse advice line.  <b>I-14.1 Metric:</b> Number of patients served.  <b>Data Source:</b> Scheduling system information/Automated data  Est. Incentive Payment: \$1,235,000
Year 2 Estimated Milestone Bundle Amount: \$4,200,000	Year 3 Estimated Milestone Bundle Amount: \$3,800,000	Year 4 Estimated Milestone Bundle Amount: \$3,500,000	Year 5 Estimated Milestone Bundle Amount: \$1,235,000
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$12,735,000</b>			

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

**Provider Description:** Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County which has a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics providing treatment to over 1,200 adults, children, and families who range from zero to death. Less than 1% of TCC's patients have private insurance and 38% have Medicaid, and 88% of children and 81.34% of adult patients are at or below the federal poverty level. TCC provides an average of 10,226 face to face patient contacts per month. (1b)

**Interventions:** This project implements both new and expanded telemedicine services and electronic health records for all patients in Grayson County. The interventions that can be improved and expanded through this project include psychiatric appointments, psychosocial rehabilitation, skills training, case management, service coordination, assessments, counseling and crisis intervention.

**Need for the Project:** TCC selected this project to expand and improve medical and behavior health services in Grayson County. Grayson County is identified by HRSA as an underserved behavioral health provider area. (1c) This project is essential to enhance the quality, efficiency, accuracy, and accessibility to medical and/or treatment data for individuals accessing public mental health in extremely under-funded, rural service area. Both expanded telemedicine options and an Electronic Health Record System will improve TCC's ability to provide prompt, clinically efficient and appropriate services to a broader patient base. Finkelstein, et. al., (2012) said: "Ninety-two studies evaluated the impact of health IT applications on clinical outcomes. . . . Overall, we found that various health IT applications implemented to enhance PCC [patient centered care] generally improved clinical outcomes for patients with diabetes, heart disease, cancer, and other health conditions, and several of these interventions showed a statistically significant favorable impact." (1d)

**Target Population:** The target population for Project 084434201.1 consists of patients who need psychiatric appointments, psychosocial rehabilitation, skills training, case management, education training and support, biopsychosocial assessments, counseling and crisis intervention both internally and in the community where telemedicine capabilities can be established, such as an emergency department. Approximately 38-40% of TCC patients are Medicaid eligible, and more are Medicaid eligible. Almost 100% are low-income or completely indigent, so it is expected that nearly all current and potential TCC patients will benefit from this project.

**Category 1 or 2 Expected Patient Benefits:** The project seeks to provide benefits to the 1,200 existing TCC patients and to at least an additional 6% of the qualifying target population in this region by DY 5.

**Category 3 Outcomes:** TCC's Category 3 goal is to improve patients' Quality of Life which, in turn, has been shown to have a community monetary value of \$50,000 per life-year gained in reduced health care costs. *Critical metric will be full utilization of Telemedicine capacity offered.*

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

**Unique RHP Project Identification Number:** 084434201.1.1

**Performing Provide Name/TPI:** Texoma Community Center/08443201

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

**Required core project components**

- a) Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.
- b) Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.
- c) Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer.
- d) Identify modifiers needed to track encounters performed via telehealth technology.
- e) Develop and implement data collection and reporting standards for electronically delivered services
- f) Review the intervention(s) impact on access to specialty care and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.
- g) Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully-functional telehealth, telemonitoring, telementoring, or telemedicine program. Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations.
- h) Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions)

**Project Description:**

Texoma Community Center (TCC) intends to expand & improve service access, facilitate quality patient care and enhance the number of patients served by scaling up an existing telemedicine system into broader, more comprehensive telehealth services. TCC is committed to patient safety and uninterrupted access to critical patient information, clinicians and staff. Most counties in Texas (CN.6, CN.11) face several access barriers that make the deployment of workable integrated health care models a challenge and this is particularly true for the three-county area served by TCC, which includes Fannin County. Also, the RHP Needs Assessment (CN.6) clearly shows that the availability of health care providers is severely limited in many of these sparsely populated areas. The University of Wisconsin Population Health Institute’s 2012 County Health Rankings shows Grayson County has a ratio of 1,305 residents to 1 health provider.(11) TCC agrees that modern communications technology holds the greatest promise

of bridging the gap between medical need in underserved areas and the provision of needed services (CN.6, CN.11). The State of Texas has 195 counties (77% of all Texas counties) that have been designated by the US Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) in relation to behavioral health providers and all three of TCC's three-county service area fall in this category as being underserved in the area of behavioral health. (12) (13)

TCC's goal to use internet-based communications will help extend services to more individuals through high quality, real time technology. This will require TCC to provide additional technological infrastructure development by enhancing the telecommunications system in all TCC facilities, adding an Electronic Health Record system, and installing additional telehealth equipment in expanded service sites. TCC proposes to expand services to potentially include mental health assessments, treatment, education, monitoring, mentoring and collaboration in addition to the existing psychiatric treatment. This expansion project is absolutely essential to improve TCC's treatment quality, reduce risk of harm, and improve cost-effectiveness, efficiency, accuracy, and access to medical and behavioral health treatment.

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

**Starting Point/Baseline:** TCC has four primary clinics in a three county area providing treatment to over 1,200 adults, children, and families with severe and persistent mental illnesses, co-occurring substance abuse issues, emotional disturbances, and/or developmental delays with an average of 10,226 face to face contacts per month. The child and adolescent psychiatrists serve over 140 individuals and families, over-serving by 103%. (15) In the Child and Adolescent Department, access to psychiatric care is exclusively through telemedicine and currently both the telemedicine and face to face services are limited by a paper/chart system where access to vital patient information is delayed, clerical staff time is wasted by scanning and uploading patient data from charts for physician access, and clinician time is regularly wasted by inability to access critical patient data on an immediate basis. TCC has received no funding of any type, including federal funding, for implementing an Electronic Health Record system. The current telecommunications system is degraded to the point that all telemedicine contact is frequently disrupted and telephone calls are dropped and/or static-laden on a daily basis for all staff, including Crisis Team staff handling potentially life-threatening emergency calls. TCC employs 138 individuals who provide or support services to these 1,200+ people as well as other citizens in Cooke, Grayson and Fannin counties who are in crisis. Patient safety is compromised by the current telecommunications system, especially in the midst of a crisis call where there is potential for risk of harm with a suicidal patient if consistent, clear contact is not maintainable.

The current baseline beginning in DY 2 is limited psychiatric telemedicine appointment time, a degraded, disruptive and inadequate communications system with rudimentary telemedicine capacity and no EHR system at all. LMHA's, specifically TCC, have not received federal funding for EHR systems.

**Rationale:** Texoma Community Center selected this broad project in order to move our services firmly into the future. In RHP 18, a primary need has been identified (CN.4) regarding insufficient access to physician and behavior health services in Grayson County. In order to address these needs and enhance service improvement, overhauling the telecommunications infrastructure will be necessary. Upgrading and expanding the electronic and communications infrastructure will vastly improve patient safety, enhance communication as well as continuity of care for patients while allowing for more patients to be served with better quality care.

The Institute of Medicine (US) reports that not only does telemedicine address the distance from services barrier, but other barriers are hurdled as well, such as “poor transportation ... inadequate financial resources ... cultural factors ... delivery system characteristics ... and gaps in our knowledge about how these factors interact ...” (16) It can be concluded, then, that efficient, reliable technology is vital in providing all of TCC services and for meeting regional health care goals. TCC recognizes that there is a need to facilitate: (a) new and increased service access across counties; (b) allow for immediate and collaborative treatment by clinicians across service sites; and (c) implement concurrent documentation. In order to meet these goals, TCC will develop appropriate administrative and clinical protocols for all telecommunication services, engage in rapid-cycle improvement strategies through the accomplishments of another DSRIP project to create a quality improvement department, and utilize the qualified and trained staff already employed, plus add and train new staff, to be successful in meeting the provider and regional goals. TCC already tracks all encounters, including telemedicine encounters, and will continue to do so as part of the utilization management and quality improvement endeavors. As part of the regional collaborations, TCC will also evaluate the impact these services have on specialty care, identify any “lessons learned” and will look for key challenges as expanded services occur. TCC intends to serve a larger patient population through telehealth services than currently is being served, and will engage in a continuous quality improvement process to assess patient experience as well as determine patient outcomes and community impact.

These improvements to the system will allow TCC to thus improve efficiency and have a reliable communication infrastructure that will improve contact quality through a comprehensive telehealth system. The RHP 18 and TCC service area is identified by HRSA as an underserved area in behavioral health services and there is a significant community need to expand all behavioral health services, especially for those with severe and persistent mental illness, substance abuse problems, or those with co-occurring physical health disorders (CN.11). This project is essential to improve treatment quality, reduce risk of fraud, improve patient satisfaction, and enhance the quality, efficiency, accuracy, and access to medical and/or treatment data for individuals accessing public mental health in extremely under-funded, rural service areas (CN.4, CN.5, CN.6, CN.11).

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

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status  
IT-10.1 Quality of life- (standalone measure)

**Rationale/Evidence:** The Quality of Life/Functional Status Outcome Measure was selected by TCC in order to assess service delivery improvement across expansion efforts and to collect data to measure the Category 3 outcomes. Without an improved telecommunications infrastructure, including an EHR system and expanded technological abilities, the Category 3 Outcome Measures will be difficult to track and assess. “Health IT,” an on-line EHR resource, reports on studies that have demonstrated how EHR systems improve health care and reduce costs, stating that EHR systems create: “Increased accuracy in coding, leading to average billable gains of \$26 per patient visit . . . Increased patient flow, staff productivity, and increased revenue” (17) are all benefits to health. These efforts support the regional goals of improving quality of care and patient satisfaction, improving over population health and reducing the cost of health care. The related Category 1 Projects (1.1.1) that will improve the technological system and expand services will help realize the selected Category 3 outcome measure of improved patient functioning and quality of life. Quality of Life and functional status are a key element in assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful telehealth system (Project 1.1.1) is vital to enhancing service access and thus improving the functional abilities and Quality of Life status of the target populations served. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

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

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

**Relationship to other Projects:** This project will enhance overall service availability and broaden the range of services for three of the other projects submitted by our RHP, specifically those related to substance abuse (1.1.1), counseling (1.1.2), expanding behavioral health care and combining primary care and behavioral health care (1.2.1). These services will be more effective and efficient when supported by improved telehealth/telemedicine technologies which will allow for more accurate, timely and cost-effective continuity of care and collaboration. EHR and Telemedicine additions and expansions will facilitate an integrated healthcare model (1.2.1) to allow for both physical and behavioral health issues to be addressed efficiently, while broadening access to unfunded and underserved individuals within our community (CN.6, CN.11).



**Relationship to Other Performing Providers' Projects in the RHP:** Texoma Community Center's Telehealth Project supports, reinforces and relates to the other projects and providers in RHP 18 by enhancing collaboration, sharing data and information, as well as engendering referrals as appropriate. TCC has designed projects that fulfill the community needs (CN.4, CN.5, CN.6, CN.11). There are no specific TCC projects that are combined in implementation with other providers in the region, but all TCC projects will contribute to the RHP 18 initiatives through collaboration and sharing data, expanding knowledge and experiences with other providers in RHP 18 and expand services in order to enhance best-practice models throughout the region. TCC will communicate directly with providers to enhance services, such as Lakes Regional MHMR for both substance abuse treatment and counseling projects or LifePath Center. Our projects meet specific needs for the underserved in our area, and will not duplicate services since the needs far exceed provider capacity in this region (CN.11).

**Plan for Learning Collaborative Plan for Learning Collaborative:** The RHP 18 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. TCC will participate in the RHP-18 learning collaborative with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes and to facilitate success throughout the region. This project will significantly improve TCC's ability to share information and experiences in a collaborative way with others by recording patient information rapidly. This experience will help direct TCC's growth and expansion toward even more cost-effective, evidence-based practices. One goal of participating in the learning collaborative will be to identify and expand the projects to a broader patient population.

**Project Valuation:** TCC recognizes the need for a high-cost, front-end technological infrastructure development that will rapidly increase overall community and patient value by providing rapid access to information and improve treatment access. This initial cost will reduce operational costs over an indefinite period of time. Principal patient benefactors of the improved telecommunication system will be people who are uninsured, under-insured, or have Medicaid. In fact, Grayson County's health ranking from the US Department of Health & Human Services' *"2012 County Health Rankings"* shows that Grayson County residents have "5.8 poor mental health days" compared to the Texas average of "3.3 poor health days." (CN.4, CN.5, CN.6)." Furthermore, Grayson County shows to have identified "73 preventable hospital stays, compared to the national average of 49 hospital stays." Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment, especially if they lack health insurance because unfunded patients tend to use the ED as a primary care clinic for minor medical issues. The project will produce higher quality behavioral/medical care through patient-centered telemedicine treatment, collaborative stakeholder communications, and expedited input and access of secure electronically transmitted and stored information.

TCC's service area is comprised of a sparsely populated rural geographical area that has four, almost equally distanced nuclear communities, which is a natural barrier to expanding service. Service access has been identified as a recognized community need (CN.6) such that rapid access to care is not currently a reasonable/obtainable outcome. Enhancing the telecommunication infrastructure will result in cost savings through reduced staff travel, a reduction in personnel currently needed to manage massive amounts of paperwork, and reduced higher-cost hospital visits by increasing out-patient service access.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program

while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. **(9a)**

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A search of the scientific literature identified the following two studies. **(9a)** The first study we identified looking at telemedicine and mental health was conducted by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. **(9c)** Another study by Hollinghurst et. al. (2010) examined online cognitive behavioral treatment (CBT) of depression and found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245. **(9d)** This large project is valued at \$353,841 and will benefit at least 288 people in the region.

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

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center			084434201	
OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Milestone 1-P-4 – Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment P-4.1 Metric: Inventory of new equipment purchased Baseline: No equipment purchased Goal: Necessary equipment purchased Data Source: Purchase Orders/Receipts Milestone 1 Estimated Incentive Payment (maximum amount): \$80,272.00	Milestone 2-P-6- Establishment of Remote Site Locations where equipment/software will be available to consumers P-6.1 Metric: Documentation of completion of site acquisition/remodel Baseline: No documentation in place Goal: Purchase/contractor/lease documentation in place Data Source: Purchase/contractor receipts/financial records Milestone 2 Estimated Incentive Payment (maximum amount): \$44,076.00 Milestone 3-P-8- Continue Training for providers / peers on use of equipment / software	Milestone 4-P-9- Develop operations manual of telemedicine or telehealth with protocols and clinical guidelines P-9.1 Metric: Documentation of completion of manual and of use of manual in training sessions of providers/peers Baseline: No documentation in place Goal: Documentation in place Data Source: Operations manual with written protocols and guidelines Milestone 4 Estimated Incentive Payment (maximum amount): \$23,575.00 Milestone 5-P-11- Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and/or telemonitoring services for treatment of mental illness / substance use disorders P-11.1Metric: 1% increase in number of individuals residing in underserved areas of the health partnership region who have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness / substance use disorders Baseline: Number of individuals served by TCC residing in underserved areas that have	Milestone 8- I-18- Improve access to substance abuse treatment for individuals residing in underserved areas that have used telemedicine, telehealth, and/or telemonitoring services 5% over baseline. I-18.2 Metric: – Percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an outpatient telehealth or telemedicine visit within 14 days of the diagnosis and who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit. Baseline Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD and had two or more additional services with an AOD diagnosis within 30 days	

<b>084434201.1.1</b>	<b>PROJECT OPTION 1.11.2</b>	<b>PROJECT COMPONENTS: 1.11.2.A-H</b>	<b>IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES</b>	
<b>Texoma Community Center</b>			<b>084434201</b>	
<b>OD-10</b>	<b>084434201.3.1</b>	<b>IT-10.1</b>	<b>Quality of Life/Functional Status</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	<p>P-8.1 Metric: Documentation of completions of training on use of equipment / software Baseline: Zero staff trained Goal: 75% staff trained Data Source: Training Rosters</p> <p>Milestone 3 Estimated Incentive Payment (maximum amount): \$44,076.00</p>	<p>used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders. Data Source: Encounter and Claims data (based on coding DSHS modifiers or HCPC's level II Modifiers) Milestone 5 Estimated Incentive Payment (maximum amount): \$23,575.00 Milestone 6: P-14 – Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</p> <p>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</p>	<p>of the initial telemedicine or telehealth visit. b. Denominator: Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence who are referred for telemedicine, telehealth, or telemonitoring services. Data Source: Center Encounter Data Milestone 8 Estimated Incentive Payment (maximum amount): \$91,115.00</p>	

<b>084434201.1.1</b>	<b>PROJECT OPTION 1.11.2</b>	<b>PROJECT COMPONENTS: 1.11.2.A-H</b>	<b>IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES</b>	
<b>Texoma Community Center</b>			<b>084434201</b>	
<b>OD-10</b>	<b>084434201.3.1</b>	<b>IT-10.1</b>	<b>Quality of Life/Functional Status</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
			<p>from presentations, and/or meeting notes.  Rationale/Evidence: The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.  P-14.2 Metric -- Implement the “raise the floor” improvement initiatives established at the semiannual meeting.  Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.  Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.  Milestone 6 Estimated Incentive Payment (maximum amount): \$23,575.00</p>	

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center			084434201	
OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
		<p>Milestone: 7- I-18 – Improve access to substance abuse treatment for individuals residing in underserved areas that have used telemedicine, telehealth, and/or telemonitoring services.</p> <p>I-18.2 Metric: – Percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an outpatient telehealth or telemedicine visit within 14 days of the diagnosis and who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit.</p> <p>a. Baseline Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD and had two or more additional services with an AOD diagnosis within 30 days of the initial telemedicine or telehealth visit.</p> <p>b. Denominator: Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence who are referred for</p>		

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount:\$80,272.00	Year 3 Estimated Milestone Bundle Amount: \$ 88,152.00	telemedicine, telehealth, or telemonitoring services Milestone 7 Estimated Incentive Payment (maximum amount): \$ 23,576.00 Year 4 Estimated Milestone Bundle Amount: \$ 94,301.00		Year 5 Estimated Milestone Bundle Amount: \$91,115.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$353,840.00				

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

**Provider Description:** Texoma Community Center (TCC) TCC is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County which has a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics providing treatment to over 1,200 and 10,226 face-to-face encounters with adults, children, and families ranging from zero to death. Less than 1% of TCC's patients have private insurance and 38% have Medicaid, 88% of children and 81.34% of adult patients are at or below the federal poverty level. (1b)

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

**Need for the Project:** TCC selected this project to expand and improve behavioral health services in Grayson County. Grayson County is identified by HRSA as an underserved behavioral health provider area. (1c) Currently, TCC can only provide substance abuse treatment for individuals who have a co-occurring severe and persistent mental illness, with one of the state-mandated target diagnoses of schizophrenia, bipolar disorder or major depressive disorder. TCC's own crisis service data reveals that, of the average 124 face to face crisis encounters each month, 57% report substance abuse as a precipitating cause of their crisis event. (1d) Substance abuse is a significant cause of crisis events and is a nation-wide problem. The SAMHSA Dawn Report (July 11, 2012) that says "... and 47% of the ER visits they reviewed were due to drug abuse or misuse" which is a 115 % increase in just six years. (1e) The baseline for treating individuals without a co-occurring target diagnosis of severe and persistent mental illness is zero for TCC.

**Target Population:** The target population for Project 084434201.1.2 is patients that need intensive substance abuse treatment along with access to all other TCC services. Less than 1% of TCC's patients have private insurance and 38-40% have Medicaid, 88% of children and 81.34% of adult patients are at or below the federal poverty level and considered indigent. (1b)

**Category 1 or 2 Expected Patient Benefits:** TCC expects to establish one new substance abuse treatment site, provide intensive SA out-patient treatment to a minimum of 20 patients and provide LCDC supervision to at least 3 interns. We expect the same TCC Medicaid and poverty level percentages will apply to all patients treated in these programs, with additional patients treated by the providers who complete the internship program through TCC exponentially.

**Category 3 Outcomes:** Expanding SA treatment services and developing an internship program for additional LCDC providers by DY 5 will positively impact the functional status and overall quality of life of individuals served through these projects. Additional quality improvement outcomes will be experienced in the community in the form of reduced emergency department visits, reduced psychiatric hospitalizations and reduced preventable admits and re-admits.



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

**Unique RHP Project Identification Number:** 084434201.1.2

**Performing Provide Name/TPI:** Texoma Community Center/08443201

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

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

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

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

**Rationale:** Texoma Community Center has successfully demonstrated clinical and fiduciary responsibility while improving and enhancing service provision. This is evident in the reduction of average psychiatric hospitalizations for Alternative Treatment Team patients over a four year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. (22) There is a direct link between the intensified and improved services provided to "high-utilizer" patients and the reduction of hospitalizations overall.

TCC's own crisis service data reveals that, of the average 124 face to face crisis encounters each month, 57% report substance abuse as a precipitating cause of their crisis event. (20) However, substance abuse

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

Our own experience as the Local Mental Health Authority has been frustrating at the lack of substance abuse treatment options within the tri-county service area (CN.11). SAMHSA reports that: “By 2020, mental & substance use disorders (M/SUDs) will surpass all physical diseases as a major cause of disability worldwide.” (23) With state-funded substance abuse reductions having occurred in the past few years, patients have to be sent out of area, separated from families and support, to receive treatment when the few existing resource options are at capacity, which is all of the time. Providing substance abuse treatment is not a new initiative for TCC but establishing a separate, licensed substance abuse treatment program that also provides LCDC Internship opportunities is a new initiative plus it significantly enhances the current service effort. TCC is dedicated to achieving these desired health outcomes, to improving efficiency and reducing costs; therefore, enhancing substance abuse treatment and provider licensing internship programs will improve outcomes and making a positive impact on the lives and well-being of the populations served.

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status  
IT-10.1 Quality of life- (standalone measure)

- a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
- b. Data source: Assessment of Quality of Life Tool Data Results
- c. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was selected

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

Expanding substance abuse treatment services and developing an internship program for additional LCDC providers will definitely impact the functional status and overall quality of life of individuals serviced through these projects. Laudet (2011) writes in his article *The case for Considering Quality of Life in Addiction Research and Clinical Practice*, that: “Substance use disorders (SUDs) are

characterized as ‘maladaptive patterns of substance use leading to clinically severe impairment or distress’ potentially affecting physical or psychological functioning; personal safety; social relations, roles, and obligations; work; and other areas (American Psychiatric Association, 1994) ... SUD is a chronic condition for most affected individuals, and QOL [Quality of Life] improvement is a particularly important goal in treating conditions that cannot be cured.” (24) As such, having the Quality of Life/Functional Status Outcome Measure to determine impact to patient care. Assessing patient access and outcomes is relevant to contributing to the overall goals identified in Category 3.

**Relationship to other Projects:** This project relates directly to this RHP's proposals involving expanding counseling services (084434201.1.3) to non-priority populations, combining primary and behavioral healthcare (084434201.2.1), and expanding telehealth services (084434201.1.1) in that its development and implementation will significantly augment the other projects and it will satisfy a need for additional service options and increase providers. This, in turn, will support and reinforce the regional goals to improve quality of care, improve the health of this population and improve access. This augmentation will have notable implications on the initial and ongoing success of the project due to enhanced availability and range of services which can be accessed by individuals seeking treatment, as well as improved and expanded communication between various treatment providers.

**Relationship to Other Performing Providers’ Projects in the RHP:** The primary relationship that the Behavioral Health Expansion (Counseling Services) will have to the other Projects in RHP 18 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 1 in order to enhance best practice models is a definite TCC goal. It is acknowledged that Lakes Regional MHMR Center is the contracted LMHA providing DSHS substance abuse treatment in Grayson County, however, and the TCC expansion is in no way intended to replace that provider source for the area. The community need (CN.6, CN.11) for additional substance abuse and behavioral health providers in Fannin County allows for both LMHA’s to provide substance abuse treatment without duplicating services or even meeting the need fully.

**Plan for Learning Collaborative:** The RHP 18 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. Texoma Community Center does plan to participate in the RHP-1 learning collaborative meetings with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. In fact, TCC intends to learn from other entities in the region, especially Lakes Regional MHMR Center and LifePath Center, about what has “worked or not worked” in their experience and to bring that information back to the management table to facilitate TCC’s growth and expansion toward sound, cost-effective, evidence-based substance abuse treatment practices as well as to share those “lessons learned” with the interns in the planned LCDC Internship Program. Focus of the learning collaborative will be to identify project impacts, what has been learned within the Center and from other entities, and expanding the projects to a broader patient population. Substance abuse issues present significant challenges for any community and the synergy of that collaboration will enhance all providers’ abilities to meet these challenges.

**Project Valuation:** The value of this project expands the scope of TCC's services to a population identified as a primary contributor to community costs. RHP needs assessments (CN.4, CN.5, CN.6, CN.11) indicate that there is a recognized need for additional outpatient treatment services for persons with chemical dependency problems.

The individuals to be served by this new program are those who create the greatest distress within the community and are often found in crisis in local emergency rooms, or who are frequently incarcerated. Both are high-dollar expenses for the community. This expansion of TCC services will create increased community value by providing additional treatment support services which, in turn, reduces higher dollar intervention services by providing additional options and affording the opportunity for greater numbers of individuals to become stable. Additional treatment options and additional providers will enhance crisis intervention responsibilities for the Local Mental Health Authority, reducing ED and jail costs. The cost for the project will be greatly outweighed by the evidence-based recognition of a multiplier impact on cost reduction as interventions and treatment reduce emergency room and hospital re-admissions, lower the prospect of future encounters with the medical and criminal justice systems, and help individuals into recovery where they can become contributing members of their community. Adding a certified internship program will make a needed contribution to the practitioner resource pool, and will increase the prospect for TCC and other local providers to hire and retain practitioners that are difficult to find.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)**

A search of the scientific literature identified the following two studies to support the valuation methodology. The first study was conducted by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. **(9c)** Another study by Hollinghurst et. al. (2010) examined online cognitive behavioral treatment (CBT) of depression and found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245. **(9d)** Two more studies were identified featuring alcohol and substance abuse treatment. A cost-utility study for substance/alcohol treatment using Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. **(9e)** Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. **(9f)** The average of these two values is 0.11135.

The cost of the project will increase over time, but it is expected that there will be an exponentially greater value brought to community by bringing earlier resolution to challenges for individuals that currently cost our communities a great deal through emergency room admissions and re-admissions, and

to the criminal justice systems for adjudication and detention. TCC expects to continue expansion of both the treatment and counselor training program, and will look to other local sources of support and third-party payment systems for continuation and expansion.

084434201.1.2	1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013- 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p>Milestone 1- Identify licenses, equipment requirements and other components needed to implement and operate options selected.</p> <p>P.2.1 Metric- Develop a project plan and timeline detailing the operational needs, training materials, equipment and components—</p> <p>Baseline/Goal:</p> <p>-Research existing regulations pertaining to the licensure requirements of substance abuse clinics to determine what requirements must be met.</p> <p>-When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate.</p> <p>a. Data Source: Project Plan</p> <p>Milestone 1 Estimated</p>	<p>Milestone 3- P-4- Hire and train 1 Certified &amp; experienced licensed counselor/program coordinator to manage and oversee Substance Abuse Treatment &amp; Internship Program and 1 clerical staff to support program administration.</p> <p>P-4.1 Metric - Number of Staff secured and trained</p> <p>Baseline: Zero staff secured and trained</p> <p>Goal: Both positions filled &amp;</p> <p>staff trained in respective duties</p> <p>Data Source: Project records, HR records and training records</p> <p>Milestone 3 Estimated Incentive Payment: \$24,536.00</p> <p>Milestone 4-P-6 – Establish 1 new behavioral health service site in community-based</p>	<p>Milestone 6-I.11- Increase utilization of substance abuse community behavioral healthcare program by 15 patients over zero baseline and have 2 internship positions filled.</p> <p>I-11.1 Metric– Number of patients and interns receiving TCC substance abuse community behavioral healthcare services.</p> <p>a. Baseline: Zero patients receiving services; zero interns receiving supervision</p> <p>b. Goal: 15 patients receiving substance abuse services after access expansion; 2 interns receiving supervision after expansion</p> <p>c. Data Source: Claims data and encounter data from behavioral health site; internship verification reports</p> <p>Milestone 6 Estimated Incentive Payment: \$39,411.00</p> <p>Milestone 7- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least</p>	<p>Milestone 8-I.11- Increase utilization of substance abuse community behavioral healthcare program by 20+ patients over zero baseline and have minimum of 3 internship positions filled.</p> <p>I-11.1 Metric– Number of patients and interns receiving TCC substance abuse community behavioral healthcare services.</p> <p>d. Baseline: Zero patients receiving services; zero interns receiving supervision</p> <p>d Goal: 20+ patients receiving substance abuse services after access expansion; 3 interns receiving supervision after expansion</p> <p>e. Data Source: Claims data and encounter data from behavioral health site; internship verification reports</p> <p>Milestone 8 Estimated Incentive Payment: \$38,079.00</p> <p>Milestone 9- P-10- Participate in face-to-face learning (i.e.</p>	

084434201.1.2	1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013- 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p>Incentive Payment: \$33,548.00</p> <p>Milestone 2-P-3- Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for the substance abuse and internship programs)</p> <p>P-3.1 Metric- Manual detailing administrative protocols and clinical guidelines are in place Baseline/Goal: Manual written and in place.</p> <p>a. Data Source: Administrative protocols; Clinical guidelines</p> <p>Estimated Milestone 2 Incentive Payment (<i>maximum amount</i>): \$33,548.00</p>	<p>setting in underserved areas with 8 patients being served.</p> <p>P-6.1 Metric –Number of new community-based sites where behavioral health services are delivered and number of patients being served.</p> <p>a. Number of patients served at these new community-based sites: Baseline: Zero patients served Goal: 8 Patients served</p> <p>Milestone 4 Estimated Incentive Payment: \$24,536.00</p> <p>Milestone 5- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers</p>	<p>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> <p>P-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP.</p> <p>a.Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</p> <p>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</p>	<p>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> <p>P-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP.</p> <p>a.Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</p> <p>b.Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous</p>	

084434201.1.2	1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013- 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	<p>can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</p> <p>P-10.1 Metric: – Participate in semi-annual face- to-face meetings or seminars organized by the RHP:</p> <p>a.Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</p> <p>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.</p> <p>P-10.2 Metric -- Implement</p>	<p>providers and decide collectively how to “raise the floor” for performance across all providers.</p> <p>P-10.2 Metric -- Implement the “raise the floor” improvement initiatives established at the semiannual meeting.</p> <p>a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.</p> <p>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” and “raise the bar” for performance across providers.</p> <p>Milestone 7 Estimated Incentive</p>	<p>learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.</p> <p>P-10.2 Metric -- Implement the “raise the floor” improvement initiatives established at the semiannual meeting.</p> <p>a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.</p> <p>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” and “raise the bar” for performance across providers.</p>	



084434201.1.2	1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013-9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	<p>the “raise the floor” improvement initiatives established at the semiannual meeting.</p> <p>a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.</p> <p>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” and “raise the bar” for performance across providers.</p> <p>Milestone 5 Estimated Incentive Payment (<i>maximum amount</i>): \$24,609.00</p>	<p>Payment (maximum amount): \$39,410.00</p>	<p>Milestone 9 Estimated Incentive Payment (maximum amount): \$38,079.00</p>	

084434201.1.2	1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013- 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Year 2 Estimated Milestone Bundle Amount: \$67,096.00		Year 3 Estimated Milestone Bundle Amount: \$73,681.00	Year 4 Estimated Milestone Bundle Amount: \$78,821.00	Year 5 Estimated Milestone Bundle Amount: \$76,158.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$295,756.00				

## **SUMMARY PAGE: Texoma Community Center: Pass 1 Category 1 Project/084434201.3**

**Provider Description:** Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County which has a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics treating over 1,200 adults, children, and families ranging in age from zero to death and staff provide an average of 10,226 face to face patient contacts per month. Less than 1% of TCC's patients have private insurance, between 38% and 40% have Medicaid on average and 88.05% of children and 81.34% of adult patients are at or below the federal poverty level.

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

**Need for the Project:** TCC selected this project to expand and improve behavior health services in Grayson County, specifically evidenced-based counseling. TCC's current DSHS diagnostic criteria are very restrictive as to who can access state-funded services. TCC's internal data show that in 2011 and to-date in 2012, 618 individuals sought but were denied mental health treatment due to the exclusionary diagnostic criteria. Of those 618, all but a few had valid emotional disturbance problems and needed counseling. (1f) Area private providers serve ONLY those with insurance or self-pay abilities. Grayson County is an underserved behavioral health provider area. (1c) This project will enhance the quality and access to counseling treatment for individuals on Medicaid or who are accessing public mental health because they have no other resources to pay for those services in this extremely under-funded, rural service area.

**Target Population:** The target population for Project 084434201.1.3 is patients that need therapeutic intervention in the form of counseling specifically for Medicaid and/or low-income patients. TCC clinicians are properly credentialed in providing evidenced-based therapy appropriate to the individual presenting problems.

**Category 1 or 2 Expected Patient Benefits:** Patient benefits will include one additional resource site for Medicaid-funded or indigent counseling and a conservative minimum target of 25 individuals **over** the current counseling patient population by DY 5 to initiate the program.

**Category 3 Outcomes:** Based on the Category 3 methodology used in the narrative, expanding on the minimum 25 patients up to 290 through DY 5, the Quality of Life benefit to the community would be \$470,370.00 and with TCC's "track record" of program efficiency, it is very realistic to expect the outcomes over the four years will be reached and exceeded.

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

**Unique RHP Project Identification Number:** 084434201.1.3

**Performing Provide Name/TPI:** Texoma Community Center/08443201

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

**Project Description:** Texoma Community Center (TCC) will **expand counseling services** to additional behavioral health patients by providing additional licensed staff designated to provide evidenced-based therapeutic counseling to those who do not meet criteria for TCC’s DSHS-funded services as well as provide the office space, furniture, telementalhealth and other equipment, supplies and clerical support for efficient business operations. The TCC service area is deemed underserved in behavioral health services and the community has a need for counseling options (CN.6, CN.11). Expanding TCC’s counseling services by hiring a minimum of two (2) licensed clinicians to serve non-target population patients. Those clinicians will provide evidenced-based counseling interventions to unfunded and low income patients in this underserved area which will allow access to behavioral health treatment (CN.11). The current DSHS diagnostic criteria are very restrictive and regimented for who can be served with state funds. TCC’s own internal data sources show that in 2011 and to-date in 2012, 618 individuals sought mental health treatment, but were denied services because they did not have a “target population” diagnosis. The majority of those 618 individuals had a valid mental health or emotional disturbance issue and could have benefitted from counseling services. (25) Because these individuals had no health coverage, there were no counseling resources available except for support groups primarily based in the Dallas area. There are area counselors, but they all require a funding source.

The ability to broaden the scope of counseling treatment and opening up the restrictive diagnostic criteria will allow staff clinicians to provide a much needed service, as evidenced by the 618 individuals a year seeking TCC services who have to be denied due exclusively to diagnostic criteria. While some of the individuals who were denied services might not require counseling, the majority definitely requested counseling and could benefit from such a service. Internal clinical data shows that many of those individuals assessed suffered from Post-Traumatic Stress Disorder and/or depressive disorders with Global Assessment of Functioning Scores (26) above 50, thus ruling them out of services, or they had anxiety disorders, all of which respond well to appropriate evidenced-based therapy. A significant number of patients accessing emergency rooms and/or psychiatric hospitals suffer from one of these disorders. Providing expanded out-patient services to these individuals and using the best evidenced-based treatment modalities for the identified diagnosis will improve treatment outcomes, reduce potentially preventable hospital admits and reduce potentially preventable and very costly hospital readmissions. Expanding services to non-DSHS target individuals will address a deficit in this underserved area for individuals needing therapeutic counseling services but lacking a funding source (CN.11).

The expected five-year outcome will be expanded evidenced-based therapeutic counseling treatment options for non-funded or funded individuals, a reduction in the use of emergency rooms and psychiatric or acute-care hospitals for illnesses precipitated or exacerbated by an affective mental health disorder, and an increase in stabilized citizens in the community.

**Starting Point/Baseline:** Currently TCC is only allowed to provide counseling services to individuals diagnosed with one of the DSHS state-mandated target diagnoses of schizophrenia, bipolar disorder or

major depressive disorder. While treating these disorders is a priority (TCC serves over 900 adults and 140 children and adolescents with mental illness or emotional disturbance), individuals who do not have one of these three diagnoses are not allowed treatment with TCC. The majority of our crisis events involve individuals who do NOT have a co-occurring severe and persistent mental illness. The baseline for treating individuals **without** a target diagnosis of severe and persistent mental illness in a stand-alone counseling facility is currently zero for TCC.

**Rationale:** Overall, Texas healthcare is grossly underfunded. A lack of insurance by many Texans causes them to use the emergency rooms as a primary care clinic. Texas has 1,247,300 children and 4,886,100 adults who are uninsured and ranks 51<sup>st</sup> among all states in providing health care for individuals with mental illness and developmental delays.(27) All of the TCC projects, including expanded counseling access, are designed to help solve several identified needs in the region by increasing the number of patients served and preventing unnecessary emergency room visits. (CN.4, CN.6, CN.11). TCC was approved for the National Health Service Corp's federal loan repayment program for qualified staff specifically due to NHSC statistics showing that the three county service area was significantly underserved by all licensed providers, including counselors and psychiatrists. Expanding therapeutic services reduces these shortages. (CN.6) While counseling is not a new initiative for TCC, expanding those services beyond the DSHS target population will be new. Being able to expand the diagnostic criteria will also be a new and exciting initiative for TCC.

As previously stated, especially during the past six years, Texoma Community Center has successfully demonstrated clinical and financial responsibility while improving and enhancing service provision. Providing an additional counseling treatment site and employing additional clinicians to provide needed services (CN.6), in addition to ensuring the support, oversight and guidance necessary to meet and exceed performance measures, will expand and enhance the quantity and quality of services to patients. There is a direct correlation between the intensified and improved out-patient services provided to "high-utilizer" patients seeking care in emergency rooms and local hospitals, including psychiatric hospitals, and the reduction of hospitalizations and incarcerations overall which supports and reinforces regional goals. TCC tracked hospitalizations for the "high utilizer" psychosocial rehabilitation patients and an outcome was that increased services appeared to reduce crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (29) The ability to provide intensive oversight of services while demanding highly ethical provider behavior, along with our willingness to collaborate with other providers and stakeholders, has helped produce positive outcomes over time. TCC is dedicated to achieving these desired health outcomes, to improving efficiency and reducing costs. Those measures have a positive impact on the lives and well-being of the populations served.

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status  
IT-10.1 Quality of life- (standalone measure)

- a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
- b. Data source: Assessment of Quality of Life Tool Data Results
- c. Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and

functional status is by direct patient survey. The importance of such patient-reported status is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

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

Treatment efficacy can be determined by assessing the functioning and quality of life outcomes

of individual patients, which in turn, supports Category 3 goals. Clark & Kirisci (1996) report in a study of adolescents suffering from affective disorders, including PTSD, that: PTSD showed significant adverse effects on Psychological, physical, and social functioning. Major depression showed a similar pattern. In contrast, alcohol use disorders primarily affected role functioning. While PTSD, major depression, and alcohol use disorders all adversely influenced adolescent QOL [quality of life] ....”(30) In addition, Zatrnick, MD ((1997) stated: “The prevalence of PTSD also increased consistently with the number of self-reported chronic diseases (t2). Only 9.6% of subjects reporting no chronic conditions had PTSD, whereas 31.9% of subjects with four or more conditions had PTSD . . . . Subjects with PTSD demonstrated consistently higher risks of functional impairment; for five of the six outcomes the risks of impaired functioning . . . exceeded 20% (t3).” (31)

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

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

**Relationship to Other Performing Providers' Projects in the RHP:** The primary relationship that the Expansion of Counseling Services Project will have to the other Projects in RHP 18 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve

specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 18 in order to enhance best practice models is a definite TCC goal. There are several projects where telehealth is included in implementation, as it is with TCC, which will open up the possibility of communicating directly with these specific providers through telecommunications. Also, Lakes Regional MHMR Center also plans to expand counseling services and cross-referrals and collaboration will be sought. The extensive need (CN.6) for additional behavioral health providers allows for both LMHA's to expand counseling services outside of their respective county diagnostic restrictions without duplicating services or even meeting the need fully.

**Plan for Learning Collaborative:** The RHP 18 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. Texoma Community Center does plan to participate in the RHP-1 learning collaborative meetings with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. TCC has demonstrated therapeutic collaborations with community stakeholders, and is willing to exchange our expansion experiences with others in the region, learn from other entities in the region what has “worked or not worked” in their experience and to bring that information back to the management table to help direct center growth and expansion toward sound, cost-effective, evidence-based practices. Focus on the learning collaborative will be to identify project impacts, what was learned within the Center and from other entities, producing positive clinical outcomes and expanding the projects to a broader patient population. Addressing key challenges will be done internally and as part of the learning collaborative within the region because TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences. It is especially important in the area of therapy and clinical treatment to maintain awareness of the research and evidenced-based practices and to share that knowledge base with other clinicians in order to “do no harm” and provide the best services possible. Sharing clinical experiences in a collegial environment is the best way possible to produce positive outcomes that can spread throughout the region.

**Project Valuation:** The value of this project expands the scope of TCC's services to a population identified as a primary contributor to community costs. RHP needs assessments (CN.4, CN.6, CN.11) indicate that there is a recognized need for additional outpatient treatment services for persons with affective behavior problems. The individuals often create the greatest distress in the community by being found in emergency rooms in crisis and they often manifest the emotional distress in physician ways, also driving health costs up. This expansion of TCC services will create community value by providing the treatment to those who have no funding source to become stable.

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

Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The

valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. We also looked at cost savings in valuing this program. (9a)

A study by Jones et al. (2003) showed that participants receiving Critical Care Intervention had 58 fewer homeless nights compared with standard treatment participants. A night of homelessness was valued at \$152 using a societal perspective which results in a value gain of \$8,816 per participant. (9j) Larimer et al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost-offset of \$2,449 per month per individual. (9k)

The cost for the project will be outweighed by the recognition of a multiplier impact on cost reduction as such evidence-based interventions and treatment that reduce emergency room and hospital re-admissions, lower the prospect of future encounters with the medical and criminal justice systems. The value of the project will increase over time, but it is expected that there will be an exponentially greater value brought to the community by early resolution of challenges that currently cost our communities through emergency room admissions and re-admissions and to the criminal justice system for adjudication and detention. TCC expects to continue expansion of the counseling program and will look to other local sources of support and third-party payment systems for continuation and expansion.



<b>084434201.1.3</b>	<b>Project Option:1.12.2</b>	<b>N/A</b>	<b>Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.</b>	
<b>Texoma Community Center</b>			<b>084434201</b>	
<b>OD-10</b>	<b>084434201.3.3</b>	<b>IT 10.1</b>	<b>Quality of Life/Functional Status</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>Milestone 1- Identify licenses, equipment requirements and other components needed to implement and operate options selected.</p> <p>P.2.1-Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components—</p> <p>Baseline/Goal:</p> <p>-Research existing regulations pertaining to the licensure requirements of clinicians to determine what requirements must be met.</p> <p>-When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate.</p> <p>a. Data Source: Project Plan</p>	<p>Milestone 3- P-4- Hire and train 2 licensed clinicians to provide counseling services in newly established counseling program.</p> <p>P-4.1-Metric : Number of Staff secured and trained</p> <p>Baseline: Zero staff secured and trained</p> <p>Goal: 2 staff secured and trained in respective positions</p> <p>Data Source: Project records, HR records and training records</p> <p>Milestone 3 Estimated Incentive Payment: \$39,022.00</p> <p>Milestone 4-P-6 – Establish counseling services in 1 new community-based setting in underserved area providing counseling to 1.5% over baseline (810) TCC mental health patients.</p> <p>P-6.1-Metric : Number of patients receiving counseling services in 1 new community-based setting</p>	<p>Milestone 6-I.11- Increase utilization of counseling behavioral healthcare program by 5 patients over baseline of # served in program in DY3.</p> <p>I-11.1 Metric– Number of patients receiving TCC counseling community behavioral healthcare services.</p> <p>b. Baseline: 14 patients receiving counseling services at new site</p> <p>Goal: 19 patients receiving counseling services after access expansion</p> <p>Data Source: Claims data and encounter data from behavioral health site; internship verification reports</p> <p>Milestone 6 Estimated Incentive Payment: \$ 62,679.00</p> <p>Milestone 7- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP</p>	<p>Milestone 8-I.11- Increase utilization of counseling behavioral healthcare program by 6 patients over baseline of # served in program in DY4.</p> <p>I-11.1 Metric– Number of patients receiving TCC counseling community behavioral healthcare services.</p> <p>c. Baseline: 19 patients receiving counseling services at new site</p> <p>Goal: 25 patients receiving counseling abuse services after access expansion</p> <p>Data Source: Claims data and encounter data from behavioral health site; internship verification reports</p> <p>Milestone 8 Estimated Incentive Payment: \$ 60,561.00</p> <p>Milestone 9- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP</p>	

<b>084434201.1.3</b>	<b>Project Option:1.12.2</b>	<b>N/A</b>	<b>Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.</b>	
<b>Texoma Community Center</b>			<b>084434201</b>	
<b>OD-10</b>	<b>084434201.3.3</b>	<b>IT 10.1</b>	<b>Quality of Life/Functional Status</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>Milestone 1 Estimated Incentive Payment: \$ 53,039.00</p> <p>Milestone 2-P-3- Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for the counseling project).</p> <p>Metric-P-3.1 – Manual of operations for the project detailing administrative protocols and clinical guidelines</p> <p>b. Data Source: Administrative protocols; Clinical guidelines</p> <p>Milestone 2 Estimated Incentive Payment: \$53,039.00</p> <p>Estimated Incentive Payment (<i>maximum amount</i>): \$106,078.00</p>	<p>Baseline: 3 sites/zero patients Goal: 4 sites/ 14 patients served</p> <p>Milestone 4 Estimated Incentive Payment: \$ 39,002.00</p> <p>Milestone 5- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar 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> <p>P-10.1-Metric: Participate in semi-annual face- to-face meetings or seminars organized</p>	<p>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> <p>P-10.1-Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP.</p> <p>a.Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</p> <p>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</p>	<p>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> <p>P-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP.</p> <p>a.Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</p> <p>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</p>	

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	<p>by the RHP.</p> <p>a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</p> <p>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.</p> <p>Metric P-10.2--Implement “raise the floor” improvement initiatives established at the semiannual meeting.</p> <p>a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the</p>	<p>the floor” for performance across all providers.</p> <p>P-10.2 Metric: Implement the “raise the floor” improvement initiatives established at the semiannual meeting.</p> <p>a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented “raise the floor” improvement initiative after the semiannual meeting.</p> <p>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” and “raise the bar” for performance across providers.</p> <p>Milestone 7 Estimated Incentive</p>	<p>the floor” for performance across all providers.</p> <p>P-10.2- Metric: Implement the “raise the floor” improvement initiatives established at the semiannual meeting.</p> <p>a. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented “raise the floor” improvement initiative after the semiannual meeting.</p> <p>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” and “raise the bar” for performance across providers.</p> <p>Milestone 9 Estimated Incentive</p>	

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center			084434201	
OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	floor” improvement imitative after the semiannual meeting. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.  Milestone 5 Estimated Incentive Payment ( <i>maximum amount</i> ): \$39,139.00	Payment ( <i>maximum amount</i> ): \$ 62,678.00	Payment ( <i>maximum amount</i> ): \$ 60,561.00	
Year 2 Estimated Milestone Bundle Amount: \$106,708.00	Year 3 Estimated Milestone Bundle Amount: \$117,183.00	Year 4 Estimated Milestone Bundle Amount: \$ 125,357.00	Year 5 Estimated Milestone Bundle Amount: \$121,122.00	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 470,370.00				

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

**Provider Description:** Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County which has a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics treating over 1,200 adults, children, and families ranging in age from zero to death and staff provide an average of 10,226 face to face patient contacts per month. Less than 1% of TCC's patients have private insurance, between 38-40% have Medicaid on average and 88.05% of children and 81.34% of adult patients are at or below the federal poverty level. (1b)

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

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

**Target Population:** The target population benefit for Project 084434201.3 is spread across the entire existing and potentially new patient population in that each service area will have appropriate implementation, improved efficiency, and clinically sound application of services ensured through continuous quality improvement processes. Approximately 38-40% of TCC patients have Medicaid or are Medicaid eligible and almost 100% are indigent, so we expect all current and potential TCC patients will benefit from this project.(1b)

**Category 1 Expected Patient Benefit:** System improvements are projected to be 10% in DY3, 15% in DY 4, and another 10% in DY 5. The Quality Improvement Project will benefit the 1,200+ existing TCC patients, and all future patients as services are implemented or expanded and their quality of life improves.

**Category 3 Outcomes:** TCC expects to reduce emergency department visits for target populations significantly by DY5, but exact targets will be determined in DY 2. Based on TCC's proven track record in dramatically reducing hospitalizations for patients (1b) the health care savings will be significant as services expand and efficiencies continue to improve.

**Title of project:** Enhance Performance Improvement and Reporting Capacity

**Unique RHP Project Identification Number:** 084434201.1.4

**Performing Provide Name/TPI:** Texoma Community Center/08443201

### **Required core project components**

- Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.
- 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.

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

TCC commits to developing initiatives based on process improvement methodologies appropriate to rapid communication, integrated system workflows, providing data to providers and patients, eliminating waste, enhancing provider performance and improving patient-centered care. TCC will (1) develop protocols and tools designed to identify project impacts, (2) understand what “lessons have been learned,” (3) expand the patient population and services, (4) identify and solve key challenges to successful expansion and (5) identify special considerations for target populations.

TCC will accomplish the core components by providing training and education to all staff on the culture of change and the elements of process improvement methodologies and on process improvement strategies. TCC will also elicit employee feedback by developing an “employee suggestion system” to address the elements of “impact of the work environment, patient care and satisfaction, efficiency and other issues” to facilitate continuous process improvement. TCC will continue to address issues of safety, quality, and efficiency through continuous quality improvement in order to contribute to the regional (RHP 18) overarching goals to improve quality of care and patient satisfaction, reduce the cost of health care, and improve access to health care services while improving preventive services. (RHP 18 Anchor Plan) Texoma Community Center recognizes that project success requires essential quality improvement elements such as being open to change, fostering patient safety, problem solving, soliciting stakeholder feedback and engaging in continuous monitoring of performance in order to report findings and use those findings to direct and improve services.

The expected five-year outcome is to have a well-organized, evidenced-based Quality Improvement Program in place and operating at capacity for continuous quality improvement to enhance and expand behavioral health services to individuals in the underserved region. It is also expected that in five years, such a QI program will reduce internal costs as well as reduce high dollar costs for the area hospitals’ emergency rooms, in-patient acute care hospitals and psychiatric hospitals (CN.6. CN.11).

**Starting Point/Baseline:** While TCC has continuously addressed quality improvement and change elements on an on-going basis through management meetings and a weekly “Action Team” meeting, there has not been a concerted effort to develop evidenced-based strategies utilizing specific tools or a full time position just for quality improvement and reporting capacities. The baseline is no office dedicated full time to quality improvement and reporting capacities, no identified training programs to accomplish the specific goals, and no organized set of principles, strategies, tools or reporting capabilities based on evidenced-based processes. The baseline time frame begins with DY 2.

**Rationale:** TCC is starting this Quality Improvement Project with an established “track record” in stabilizing high utilizer patients in the area’s medical community. The following “look back” at what TCC has accomplished during the past six years is only to connect those accomplishments to the RHP 18 regional goals and the health care transformation goals because they exemplify what can be accomplished if expanded to a regional level. Since 2006, TCC’s management team has made comprehensive changes that have been an on-going process of consistent communication with supervisory and soliciting stakeholder feedback necessary to identify problems along the way. The management team has been aggressive in finding creative solutions that are both clinically sound with “evidenced-based” treatment, and financially sound with frequent oversight and open disclosure. These efforts were successful to differing degrees in our three-county service area. Overall, the changes and collaborations had a significant impact on improving the Center’s financial stability and contributed to positive outcomes. The following internal data exemplify goals that are completely consistent with current regional transformation goals. TCC intends to continue this improvement model by creating a specific department dedicated to enhance the reporting capacity, continue performance improvement and expand rapid solutions to inefficiencies, waste, and barriers.

The first major change for TCC occurred with the Assertive Community Treatment Program (ACT) for those with severe and persistent mental illness. Those out-patient, wraparound-style services were ramped up with specific goals to reduce hospitalization costs. The result was a reduction of average psychiatric hospitalizations for this discreet population over a four-year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. Hospitalization rates for these individuals in 2011 were at .56% due to adding new patients to this caseload who required initial stabilization. (2) Also, other “high utilizer” patients are in TCC’s out-patient psychosocial rehabilitation program. This group showed a reduction in crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, to 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (3) The following table also exemplifies how TCC already has expertise in reducing costs and TCC is poised to continue improving on these existing accomplishments: (4)

These initiatives and cost reductions show the broad improvements made by TCC between the years 2006 to present, which were accomplished largely due to a weekly oversight committee that was dedicated to identifying weaknesses, developing strengths and overseeing the changes that were essential for meeting DSHS contract measures and program requirements across all service areas. Strong oversight of rehab services provides the support and guidance necessary to meet and exceed performance measures, while increasing quality of services to patients.

The targeted changes led to dramatic reductions between 2006 to 2011 in both local hospitalization costs to the Center and reduced hospitalizations for funded Center patients as well. Medication costs were reduced by addressing prescribing practices with psychiatrists and developing a medication formulary and aggressively pursuing Patient Assistance Program medications, all while still ensuring patients were stabilized. This improvement trend has continued into 2012. There appears to be a direct link between the intensified and improved services provided to “high-utilizer” patients and the reduction of hospitalizations. Additionally, utilization of the Department of State Health Services’ State Hospital

allocation was reduced from 140% overuse in 2006 to its current rate of 60% of the DSHS allocation (5) already supporting regional goals to reduce health care costs and improve the quality of care.

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

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

As demonstrated above, enhancing the quality improvement and data management strategies is not a “new initiative” for TCC but this project will “significantly enhance” the improvement process that led to the outlined changes. This enhancement is essential to continue the endeavors, support the regional goals, and address the identified regional needs (CN.4, CN.5, CN.6, CN.11, and CN.12). TCC intends to accomplish additional improvements by adopting more specific, evidenced-based process-improvement techniques that will continue to identify inefficiencies, inadequate care and preventable errors. TCC recognizes that quality improvement is a dynamic process that requires a multitude of tools that address multiple areas of change in over-lapping systems, and an evidence-based, dedicated approach to improving these systems is



essential to meeting improvement outcomes while making a positive impact on the lives and well-being of the populations served.

**Related Category 3 Outcome Measure(s):** OD-9 Right Care, Right Setting IT-9.2 ED Appropriate utilization (standalone measure)

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

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

The Quality Improvement Project is especially relevant to the Category 3 emphasis on outcome measure assessment, and in fact, it is an essential ingredient for success of all project outcome measures. While the Right Care, Right Setting Domain seems to be a simple and single evaluation focus, directing attention and tracking the data for related hospitalizations will provide a more complete picture of the intervention impact on the behavioral health status of Fannin counties' low-income population. Focus on tracking the reduction in hospitalizations is particularly important in reducing overall health-related costs because Emergency Department visits are very costly. In fact, Grayson County's health ranking from the US Department of Health & Human Services' "*2012 County Health Rankings*" shows that Grayson County residents have "5.8 poor mental health days" compared to the Texas average of "3.3 poor mental health days." (CN.4, CN.5, CN.6)." Furthermore, Grayson County shows to have identified "73 preventable hospital stays, compared to the national average of 49 hospital stays." (7) Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment, especially if they lack health insurance because unfunded patients tend to use the ED as a primary care clinic for minor medical issues. With a dedicated Quality Improvement program as described in this project, TCC will be able to focus on tracking, assessing and improving the emergency department use, which will go a long way toward accomplishing the desired Category 3 goals for this health-professional underserved area (CN.5, CN.6, CN.11).

**Relationship to other Projects:** The Performance Improvement and Reporting Capacity project is central to all of the other projects submitted by Texoma Community Center. Implementation of this project will facilitate data driven oversight, coordination and facilitate outcome success of ALL other TCC projects (084434201.1.1, 084434201.1.2, 084434201.1.3, 084434201.2.1) as well as allow for inter-agency communication which will reduce redundancy in services and increase the compliance of individuals seeking services. This project is a vital element in assuring that milestones and metrics are achieved across the other projects. In addition to increasing compliance, this project will create opportunities for increased engagement with clients served by coordinating and enhancing treatment alternatives and continuity efforts. This one project undergirds the other projects by supporting the focus and data, by reinforcing goal attainment, and enabling the implementation in a coordinated, efficient manner. The data

and “lessons learned” will be shared in regional collaborations with other providers in order to support the overall regional goals.

**Relationship to Other Performing Providers’ Projects in the RHP:** The primary relationship that the Quality Improvement Project will have to the other Projects in RHP 18 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 1 in order to enhance best practice models is a definite TCC goal. There are several projects where telehealth is included in implementation, as it is with TCC, which will open up the possibility of communicating directly with these specific providers through telecommunications. For example, Lakes Regional MHMR Center plans to expand behavioral health care within this region and data sharing and collaboration will occur. Also, the LifePath Center will also be expanding care and collaboration will also occur. The need (CN.6) for additional behavioral health providers allows for all RHP 18 LMHA’s to expand behavioral health services outside of their respective county service restrictions without duplicating services or even meeting the need fully.

**Plan for Learning Collaborative:** The RHP 18 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. Texoma Community Center does plan to participate in the learning collaborative meetings in order to share knowledge, experience and outcomes across the region for quality improvement purposes. In fact, the Quality Improvement Project is designed specifically to create a position within our Center that focuses on data and experience sharing. Responsibilities of the person in this office will include regular exchange of TCC’s expansion experiences with others in the region, to learn from other entities in the region what “has or has not worked” in their experience, and to bring that information back to the management table to help direct TCC’s future growth toward even more sound, cost-effective, evidence-based practices.

**Project Valuation:** TCC’s establishment of a Quality Improvement Department will add value to all of its DSRIP projects, creating an even broader system of continuing self-evaluation and improvements consistent with the U.S. Department of Health and Human Services’ objective to “Reduce the growth of healthcare costs while promoting high-value effective care. “(8) Concurrent with the department’s review of specific DSRIP implementation, it will be establishing an even greater value for the organization by incorporating “best practice/evidence based” administrative and clinical quality improvement systems that train people in quality improvement, monitor progress, and continuously investigate new areas for improvement. TCC recognize that: “From the perspective of a service provider or program manager, quality ensures effectiveness and efficiency. From the perspective of the policy maker, quality is the key to improving the mental health population, ensuring value for money expended and accountability.” (9)

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health

goal, or outcome is the number of life-years added. The benefits of the proposed program are value based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. For example, Dewa et al. (2009) found that collaborative care saved \$503 per patient in disability benefits. **(9h)** A cost-utility analysis by Holtgrave, (2012) was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is \$62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life. **(9b)** Utilizing this methodology, this project's value will be \$143,249.00 and benefit a minimum of 88 low-income individuals in this region.

The value of a Quality Improvement Department will continue to expand well beyond its cost as it creates internal efficiencies, resulting in more services to more people, and as it eventually links to external quality improvement systems to assure an ever-improving network of services that enhance quality of life for individuals while reducing cost and treatment redundancies. The other projects, such as the Expansion of Telehealth project, will exponentially allow the Quality Improvement area to function at a significantly greater capacity than it currently has. **(10)**

084434201.4	I.10.3	I.10.3.A.B	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
Texoma Community Center			084434201	
OD-9	IT-9.2	P-1, IT-10.1; P-2, IT-10.1 P-3, IT-10.1; P-5, IT-10.1	Right Care, Right Setting	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p><b>Milestone 1 – P-6:</b> Hire/train 2 quality improvement staff who will be trained in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics for reporting purposes (e.g., to measure improvement and trends).</p> <p><b>P-6.1 Metric:</b> Hire and train 2 staff in quality and efficiency improvement principles</p> <p><b>Baseline:</b> zero</p> <p><b>Goal:</b> 2 trained staff</p> <p><b>Data Source:</b> HR records, Training Rosters and Sign-in Sheets or Certificates of Completion</p>		<p><b>Milestone 2 I-7:</b> Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports 20%</p> <p><b>I-7.1 Metric:</b> Increase the number of reports generated through these quality improvement data systems by 10% over baseline</p> <p><b>Baseline:</b> zero</p> <p><b>Numerator:</b> Number of reports generated</p> <p><b>Data Source:</b> Quality Improvement Data System</p>	<p><b>Milestone 3 – I-7:</b> Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports another 15%</p> <p><b>I-7.1Metric:</b> Increase the number of reports generated through these quality improvement data systems by 15% over baseline</p> <p><b>Baseline:</b> Reports generated in DY3</p> <p><b>Numerator:</b> Number of reports generated</p> <p><b>Data Source:</b> Quality Improvement Data System</p>	<p><b>Milestone 4 – I-7:</b> Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports another 10%</p> <p><b>I-7.1Metric:</b> Increase the number of reports generated through these quality improvement data systems by 10% over baseline</p> <p><b>Baseline:</b> Reports generated in DY4</p> <p><b>Numerator:</b> Number of reports generated</p> <p><b>Data Source:</b> Quality Improvement Data System</p>
Milestone 1 Estimated Incentive Payment: \$ 32,498.00		Milestone 2 Estimated Incentive Payment: \$ 35,688.00	Milestone 3 Estimated Incentive Payment: \$ 38,176.00	Milestone 4 Estimated Incentive Payment: \$ 36,887.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$143,249.00				

## **SUMMARY PAGE: Lakes Regional MHMR Pass 1 Category 1 Project/121988304.1.1**

**Project Name:** 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified a needed to the region.-- (Lakes Regional Rockwall Telemedicine/Tele-health Project)

**Unique Project Identifier:** 121988304.1.1

**Provider Name:** Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays.

Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year Over 95% of our consumers are either Medicaid eligible or indigent.

**Intervention(s):** This project will implement telemedicine and telehealth services to provide consultations and increase capacity for behavioral health and other specialty provider services to the Medicaid and indigent target population.

**Need for the project:** There is currently have a lack of provider capacity that will serve the Medicaid and indigent population for these behavioral health and other specialty services. The region is looking for ways to feasibly and effectively improve provider capacity and access to services (specialists) for remote populations/ communities. Our project is focused on the expansion of behavioral health services (psychiatric and behavioral specialists), and health and wellness services for the target population (low income, rural areas of Rockwall County).

**Target population:** The target population are clients needing specialty consultation ( i.e., psychiatry, certified behavioral analysts, counseling, nursing, therapy, and other specialty services consults. Approximately 95% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from the majority of the consults.

**Category 1 or 2 expected patient benefits:** The project seeks to provide 200 telemedicine consults in DY4 and DY5.

**Category 3 outcomes:** IT-10.1 Quality of Life

The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. To demonstrate improvement in symptoms and function, the Quality of Life (QOL) validated assessment tool will be implemented to measure improvement in Quality of Life factors. The projected improvement percentage is 10% for DY-4 and 20% for DY-5

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

**Unique RHP Project Identification Number (new):** 121988304.1.1

**Performing Provider Name:** Lakes Regional MHMR Center/121988304

### **Project Description**

Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.

#### **Core project components:**

- Provide patient consultations by psychiatric specialty staff as well as other types of health professionals using telecommunications.
- Conduct quality improvement activities that include identification of project impacts, “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Rationale** There currently exists a significant gap in behavioral health (psychiatric specialist referral services), and health and wellness services being provided in many Texas counties. As of March 25th, 2011, many counties have been Federally Designated as Mental Health Professional Shortage Areas<sup>2</sup>. Lakes Regional MHMR Center proposes to reduce this gap and significantly improve patient access to these services (identified as needed in the Region for Rockwall County) with the implementation of telemedicine/telehealth technology. This technology uses electronic information and telecommunications to support a wide array of clinical health care services over long distance. These services include specialist referral services such as psychiatric care, patient and professional health-related education, and public health and administration. This approach in providing access to these services is a cost effective alternative to face to face communication, especially for individuals in remote/rural areas where access is difficult and/or unavailable. The planned telemedicine/ network technology for this project will include the deployment of high definition video/audio equipment, Virtual Private Network (VPN) internet cloud based connectivity and server based video session management technology. Server based telemedicine/ telehealth technology will allow for the management of multiple client/specialist sessions and the internet cloud connectivity will enable sessions between many different provider sites and mobile devices. The implementation plan includes quality improvement measures and “lessons learned” approach making corrections to the program. Quality control methodologies and data analysis will be utilized to effectively manage the expansion of the program to the service areas where the population has the greatest need. Successful implementation of this technology will open the door for Lakes Regional to provide more flexible and timely delivery of needed health care and specialist services to individuals in rural areas of Rockwall County.

**Project goals:** Specific goals for this project include: 1.) Successful planning and implementation of a telemedicine/ telehealth infrastructure program to provide and enable expansion of behavioral health services (including psychiatric specialist referral services), and health and wellness services with improved, flexible, and cost effective access to these services needed in Rockwall County. 2.) Continuous improvement in the quality of the technical functionality and processes of the telemedicine/telehealth

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<sup>2</sup> U.S. Department of Health and Human Services Shortage Designation Branch (<http://bhpr.hrsa.gov/shortage/>)

system with a program of monitoring and analysis of the delivery system performance. 3.) Measurable and continuing improvement in the clinical processes of the telemedicine/telehealth program with clinical data tracking and analysis to show the expansion of access to specialty services, improvement in clinical outcomes, increasing patient satisfaction with the services they receive, and a 10 to 15% annual increase trend ( over baseline) for the number of individuals seeing a specialist or using the telemedicine program for the first time.

Lakes Regional MHMR Center would like to significantly improve patient access to these needed services with the implementation of telemedicine/telehealth technology. Lakes Regional is confident that the implementation of telemedicine/telehealth technology will work exceedingly well for the expansion of behavioral health services (including psychiatric specialists), and health and wellness services needed in Rockwall County. A needs assessment/ services gap analysis (our first project process-milestone) will be conducted to provide the information necessary for Lakes Regional to determine infrastructure requirements and the appropriate types and level of services (specialists and others) needed for the region and a successful telemedicine/telehealth start-up and expansion program.

**Challenges:** The use of telemedicine/telehealth technology for the expansion of behavioral health services (including psychiatric specialists), and health and wellness services has not yet been fully explored by Lakes Regional in Rockwall County. The number of individuals in need of specialist psychiatric and other services in the penetration area around current Lakes Regional offices has not been established. A thorough needs assessment/services gap analysis (our first project process-milestone) will be conducted to provide the information necessary to determine infrastructure requirements and the appropriate level and types of services needed from the telemedicine/ telehealth start-up and expansion program. For a portion of the population, many specialist type consultative services and the opportunities for ensuring clinical preparedness in Rockwall County are limited by fiscal, travel time and distance costs. Also, the technology for the data lines currently deployed for the Lakes Regional core network into Rockwall is very limited bandwidth. The data transfer speeds between our headquarters in Terrell Texas and sites in Rockwall are very slow and limited for an effective deployment of high definition, internet cloud and server based telemedicine technology. This project will require infrastructure improvements with the latest advancements in technology for telemedicine/ telehealth hardware and server based software as well as networking improvements to include high speed data transmission through the deployment of VPN internet cloud capabilities and mobility options.

**Five-year expected outcome/s:** Through the implementation of this telemedicine/telehealth project, Lakes Regional expects 5-year outcomes to include: 1.) Expanded access to behavioral health services (including psychiatric specialist referral services), and health and wellness services for the target population (low income, rural areas of Rockwall County). The projected outcome for Year 5 is 25% improvement over baseline in the target population gaining access to a specialist or using the services for the first time; 2) Continuous quality improvement effort in the technical and clinical processes with documented improvement in the satisfaction of individuals receiving services over base-line/ start-up results.

**Relationship to regional goals:** RHP 18 and Rockwall County, are seeking ways to feasibly and effectively increase provider capacity and access to services (specialists) for remote populations/ communities. Our project is focused on the expansion of behavioral health services (psychiatric specialist), and health and wellness services for the target population (low income, rural areas of Rockwall County). By improving this access, the quality of care, and the clinical outcomes, the region

anticipates a reduction in emergency room utilization and an overall cost savings. Our telemedicine/telehealth project will implement a means to move past current barriers towards helping the region achieve these goals. Lakes Regional is successfully improved access and reduced costs by utilizing this technology in some of the larger clinics and with this experience will move the technology into the region for the rural areas of Rockwall County. The application of this technology is very flexible and will provide the means to achieve changing service provider objectives for the region as the current needs for these communities are assessed. The program will allow connectivity between all kinds of service providers including doctors' offices, hospitals, specialty clinics, law enforcement and crisis care providers such as respite clinics with wrap-around services for IDD (another Lakes Regional project). According to several studies,<sup>3</sup> there have been upwards of 50 different medical subspecialties successfully served via telemedicine and the number is growing. These new services will help to reduce emergency room visits and the need for hospitalization by getting crucial crisis care and preventative care where it is needed in the region.

**Baseline:** Lakes Regional has experience with providing services through telemedicine; however we have not implemented or expanded the program into Rockwall County. Providing these telemedicine/telehealth services in the region will be a start-up program and baseline data for the quality of services and the expansion of the kinds of services provided and the number of individuals served will need to be established. As soon as our implementation and assessment phase is completed, we will begin data collection to capture base-line data in many areas of the program. After the first six months, we will have the baseline numbers from which expansion and improvement metrics will be measured against.

**Rationale for options:** One of the biggest challenges facing the U.S. healthcare system is to provide quality care to the areas that are currently underserved and lacking access to specialty physicians due to geographic and socioeconomic conditions. With the implementation of a telemedicine/telehealth infrastructure /program, we are certain that Lakes Regional MHMR Center will be able to close a significant gap in behavioral health (including psychiatric specialist referral services), and health and wellness services being provided for individuals in need in the rural areas Rockwall County. The timeframes for implementation and management of the new telemedicine/telehealth program are well within our capabilities. The project milestones and metrics are based on the telemedicine program infrastructure deployment, the introduction of new and specialty services and the corresponding growth and continuous improvement in the quality of those services (technically and clinically). With successful implementation of the telemedicine/telehealth program, we plan to reach and exceed the goals we have set for the introduction of new services, service locations, and improvement in the quality of our services and the number of individuals served. The technology will provide the needed flexibility with how and where we provide services. This flexibility will contribute to our growth and after metric baselines are established, we intend to have a significant growth rate every year for the number Telemedicine/Telehealth e-consultations/visits for individuals in need while continuously improving the quality of the program.

**Rational for project components:** The selected project components are in line with the 5 year goals we have set and are achievable from our starting point within our planned timeframes. The project will provide access to psychiatric specialty services using telecommunication. In addition, the project plan includes the use of quality improvement methodologies involving: identification of project impacts,

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<sup>3</sup> American Telemedicine Association (<http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333>)



“lessons learned,” key challenges associated with project expansion, and opportunities to scale all or part of the project from dually diagnosed individuals to the broader safety-net population.

**Reasons for selecting the milestones and metrics:** Our project milestones and metrics are based on the telemedicine program infrastructure deployment and the introduction of new and specialty services along with the planned growth and continuous improvement in the quality of those services (technically and clinically). Successful implementation of the telemedicine/telehealth project plan will enable Lakes Regional to reach and exceed the goals we have set for the introduction of new services, new service locations, and improvement in the quality of our services and the number of individuals served.

**Unique CN ID number:** CN.11 Behavioral Health – all components – all ages.

**Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Lakes Regional is currently providing services through telemedicine at some of our larger clinics, but we have not implemented or expanded the program into Rockwall County. Providing these telemedicine/ telehealth services is a new initiative for us in this region and will be a start-up program. Our plan will enable us to significantly enhance our existing services delivery system. Our telemedicine/ telehealth infrastructure system/ program will enable flexible delivery of care and improved delivery times for services. Doctors will be able to connect to individuals in the rural clinics and provide services without needing to be located there (they can be at another clinic or even at their home office). Mobility through I-cloud connectivity will enable Lakes Regional to have the flexibility to provide connectivity to areas where access to services has been difficult for individuals’ in need. Lakes Regional will be able to setup multiple connections to include private physicians, hospitals, other MHMR Centers, and other providers or resources in the community wherever they may be located.

### **Related Category 3 Outcome Measures**

#### **Outcome Measure #1: IT-10.1 Quality of Life (Stand-alone)**

Although this Telemedicine/Telehealth Introduction/Expansion Project will enable services from multiple provider specialties, it will share significant focus with Lakes Regional Behavior Support and Day Programs in the region, as well as other providers of behavioral health services in the region. Within the IDD population, research has shown that there is a much greater instance of health problems;<sup>4</sup> with the help of telemedicine/telehealth technology, program staff will monitor improvement in quality of life status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population. The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population.<sup>5</sup> To demonstrate improvement in symptoms and function, the Quality of Life (QOL) validated assessment tool will be implemented to measure improvement in Quality of Life factors. The sharing of quality of life data (overall health survey results) between agencies and providers in the region will result in a greater awareness of the efficacy of behavioral interventions in improving quality of life satisfaction, following better self-management skills and follow-up to care. Identified within the Behavior Supports project there is significant data analysis planned with encounter based assessments to show and measure improvement in quality of life satisfaction in the target population (children and adults with ASD/IDD).

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<sup>4</sup> Journal of Intellectual Disability Research 48 (2): 93-102, 2004

<sup>5</sup> Journal of Applied Research in Intellectual Disabilities. 19: 214-218.

**Relationship to other Projects:**

There are no other projects proposed by this provider.

**Related Category 1 and 2 projects:** Lakes Regional is contemplating several Pass-2 DSRIP projects. If approved, this project will be linked to one or more such as our Potential Pass-2 Project Intervention: 2.13 -- Early Intervention and Outreach for Autism Spectrum (ASD) and Related Intellectual Developmental Disabilities (IDD) – (Behavior Supports)

**Related Category 4 Population-focused improvements with the unique RHP project identification number based on the requirements above:** N/A

**Relationship to Other Performing Providers' Projects in the RHP:** Lakes Regional has also proposed several Pass-2 Projects that if approved will be linked to this project. (this should be deleted.)

Behavioral Health projects in RHP 18 including those provided by LifePath Systems, Texoma Community Center, and Lakes Regional MHMR are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, and may move across geo-political boundaries in the process of obtaining healthcare services. These local behavioral health services providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region. Additionally, representatives of other providers including UT Southwestern and Children's Medical Center that may also provide behavioral healthcare will be included in the coordination activities that will occur in both scheduled and routine-doing-business venues across RHP 18 and its neighboring counties.

**Plan for Learning Collaborative:** The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

**Project Valuation:** Our telemedicine/telehealth project will provide great flexibility for the type of services and where the connections between providers can be established. With the rural areas of Rockwall County, the internet cloud based implementation planned for the project will open up the area for video communication between doctors' offices, schools, hospitals, jails, behavioral health clinics, and just about anywhere that there is broadband access (providers working out of their homes). The possibilities for expansion of this program are numerous and the services provided will result in overall cost reductions for the region.

This project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing Access to Timely Services Through Telemedicine." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value of \$50,000 per QALY gained. By using multiple studies the research team identified an averaged QALY equal to 0.0245 for their telemedicine intervention value.

The complete description of project research studies are available at the performing provider site. Additional cost effectiveness savings can also be assumed through avoidance of higher cost crisis emergency based services and transportation costs as a result of increased specialty care access due to this project.

121988304.1.1	1.7.1	A, B	IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES	
Lakes Regional MHMR Center			121988304	
IT-10.1	10.1	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)
<p><b>Milestone 1 [P-1]:</b> Conduct needs assessment to identify needed specialties that can be provided via telemedicine.</p> <p><b>Metric 1 [P-1.1]:</b> Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.</p> <p>Baseline/Goal: Personnel needs assessed.</p> <p>Data Source: Needs Assessment</p> <p><b>Milestone 1 Estimated Incentive Payment: \$113,956</b></p> <p><b>Milestone 2 [P-7]:</b> Create plan to monitor and enhance technical properties, bandwidth, or telemedicine/ Telehealth program.</p> <p><b>Metric 1 [P-7.1]:</b> Documentation of bandwidth capacity in relationship to program needs.</p> <p><b>Baseline/Goal:</b> Capacity plan</p>		<p><b>Milestone 3 [P-3]:</b> Implement or expand telemedicine program for selected medical specialties, based upon regional and community need.</p> <p><b>Metric 1 [P-3.1]:</b> Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents.</p> <p>Baseline/Goal: Telemedicine program implemented.</p> <p>Data Source: Program records.</p> <p><b>Metric 2 [P-3.2]:</b> Documentation of the number of consults delivered by each specialty.</p> <p>Baseline/Goal: Number of consults delivered by each specialty documented.</p> <p>Data Source: Clinic log of health services provided via telemedicine.</p>	<p><b>Milestone 5 [I-17]:</b> Improved access to specialists care or other needed services over baseline.</p> <p><b>Metric 1 [I-17.1]:</b> Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time.</p> <p>Goal: 10% improvement over baseline for seeing a specialist.</p> <p>Data Source: Program records.</p> <p><b>Milestone 5 Estimated Incentive Payment: \$127,177</b></p> <p><b>Milestone 6 [I-17]:</b> Improved access to specialists care or other needed services over baseline.</p> <p><b>Metric 1 [I-17.1]:</b> Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time.</p> <p><b>Goal:</b> 15% improvement over</p>	<p><b>Milestone 7 [I-17]:</b> Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc.</p> <p><b>Metric 1 [I-17.1]:</b> Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using for the first time.</p> <p>Goal: 20% improvement over Year 4 for seeing a specialist.</p> <p>Data Source: Program records.</p> <p><b>Milestone 7 Estimated Incentive Payment: \$122,880</b></p> <p><b>Milestone 8 [I-17]:</b> Improved access to specialists care or other needed services over baseline.</p> <p><b>Metric 1 [I-17.1]:</b> Percentage of patients in the telemedicine/ telehealth program that are</p>

121988304.1.1	1.7.1	A, B	IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES	
Lakes Regional MHMR Center			121988304	
IT-10.1	10.1	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)	
completed.  Data Source: Bandwidth assessment and program plan.  Milestone 2 Estimated Incentive Payment: \$113,956	Milestone 3 Estimated Incentive Payment: \$118,885  Milestone 4 [I-17]: Improved access to specialists care or other needed services over baseline established. Metric 1 [I-17-1]: Percentage of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time. Goal: 5% improvement over baseline for seeing a specialist. Data Source: Program records  Milestone 4 Estimated Incentive Payment: \$118,885	baseline for seeing a specialist. Data Source: Encounter records from telemedicine program  Milestone 6 Estimated Incentive Payment: \$127,177	seeing a specialist or using the services for the first time. Goal: 25% improvement over baseline for seeing a specialist. Data Source: Encounter records from telemedicine program.  Milestone 8 Estimated Incentive Payment: \$122,880	
Year 2 Estimated Milestone Bundle Amount: \$227,912	Year 3 Estimated Milestone Bundle Amount: \$237,770	Year 4 Estimated Milestone Bundle Amount: \$254,354	Year 5 Estimated Milestone Bundle Amount: \$245,761	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$965,797				

# **CATEGORY 1**

## **PASS 2 PROJECTS**

For Pass 2, two providers have submitted Category 1 projects:

- One by LifePath Systems
- One by Tenet Centennial Medical Center of Frisco

## **SUMMARY PAGE: LifePath Systems: Pass 2 Category 1 Project/084001901.1.1**

**Provider:** LifePath Systems is the non-profit community center for Collin County. Collin County encompasses 886 square miles, has a population of 840,000 and is one of the fastest growing counties in the United States. LifePath Systems staff provide behavioral health treatment for individuals with mental illnesses and support services for individuals with intellectual or developmental disabilities.

**Intervention(s):** This project will expand behavioral health specialty care capacity throughout Collin County by adding a behavioral health clinic in southeast Collin County (an underserved area), moving our McKinney clinic to a larger space (to accommodate the growing demand for services), updating our communications infrastructure, and opening up eligibility criteria for mental health and substance abuse services to include a broader range of individuals with a behavioral health need.

**Need for the project:** While Collin County has grown 59% over the past 10 years, due to funding restrictions, available behavioral health services has reduced by almost 50% since 1999. Current community behavioral health clinics are over-crowded and larger space is needed to accommodate a growing population. There are a large number of Collin County residents seeking services each month who do not meet the State's current clinical criteria for admission into mental health or substance abuse services. When left with no treatment available, these individuals are showing up in the criminal justice and emergency room settings.

**Target population:** The target population includes those individuals in Collin County with a mental illness or substance use disorder who are currently unable to access services. This project's goal is to serve an additional 5,000 individuals by demonstration year 5. This includes individuals with Medicaid and those who are indigent.

**Category 1 expected patient benefits:** The project seeks to make behavioral health care more accessible to the Collin County population, by opening/expanding clinics in areas of high need and serving a wider range of individuals, including many with a diagnosis of depression which is a common illness, yet can have a severely debilitating effect on an individual's life and ability to be a productive citizen.

**Category 3 outcomes:** IT-1.9 Our goal is to obtain remission on at least 20% of individuals' depression by 12 months into treatment, as measured by a pre- and post-test standardized instrument, the PHQ-9.

**Title of Project:** Expand Behavioral Health Specialty Care Capacity

**Unique RHP Project Identification Number:** 084001901.1.1

**Performing Provider name & TPI:** LifePath Systems/ 084001901

## **Project Description**

The goal of this project is to increase the capacity to provide specialty behavioral healthcare for individuals residing in Collin County in order to better accommodate the high demand for behavioral health care services for low income individuals. This project will assist the region in meeting its goals of decreasing the number of low income individuals being served in higher, more expensive levels of care, by providing an outpatient option for behavioral health services.

This goal will be accomplished by expanding our behavioral health clinic hours, opening a new clinic location in an underserved area (Wylie, TX), moving our McKinney clinic into a larger space to accommodate the increased demand for services in that area, increasing clinical and support staff in each of the behavioral health clinics, and updating our communications infrastructure in order to fully utilize an electronic health record and telemedicine capabilities.

The current challenge is that many Collin County residents do not have access to mental health or substance abuse treatment. Texas ranks 50th in the nation per capita funding for state mental health authority (DSHS) services and supports for people with serious and persistent mental illness and substance use disorders. Medically indigent individuals who are not eligible for Medicaid have no guarantee of access to needed services. This project is aimed at those Collin County residents who may not qualify, clinically &/or financially, for state funded behavioral health services and who are therefore unable to access services.

The 5-year expected outcome is that we will serve 50% more low income individuals each month with behavioral health needs in Collin County. This translates into 1863 unique individuals each month – 621 more people per month than are currently able to access services by year 5. Average duration of treatment is estimated to be 6 to 12 months, resulting in a maximum of 5,000 additional individuals receiving behavioral health treatment over the course of 4 years.

## **Starting Point/Baseline**

Total number of behavioral health clients currently served each month is 1242 (December 2011 baseline number). This represents our baseline number of unique individuals served per month. Additionally, we will increase the number of specialty behavioral health staff by 50%.

## **Rationale**

The project option of improving access to specialty care has been selected as a priority for our region due to the identified high need for access to behavioral health care in our area. Inadequate access to specialty behavioral health care has contributed to the limited scope and size of the safety net health system in our region. To achieve success as an integrated network, these gaps must be assessed and addressed.

While the population in Collin County has grown 59% over the past 10 years, LifePath Systems has not expanded behavioral health clinic size or locations, and due to funding cuts has actually reduced services available by almost 50% from 1999. Additionally, in Collin County over the past decade, the arrest rate for all drug offenses and substance related death rates have both increased, while access to outpatient



substance abuse treatment has decreased. This lack of access to substance abuse treatment was exacerbated in September of 2009, when Value Options, the BHO for the NorthSTAR population, decided to eliminate Supportive Outpatient Therapy as an entry level of care for individuals needing substance abuse treatment. All NorthSTAR individuals seeking substance abuse services are required to meet the higher level of care criteria of Intensive Outpatient Treatment. This has resulted in a large number of individuals needing substance abuse treatment, but unable to access it due to financial hardship. This has resulted in an increase in criminal justice involvement.

Essential components of this project include

- a) Increasing service availability by extended hours at our Plano location and moving our McKinney clinic into a larger space.
- b) Increasing the number of specialty clinic locations by adding a clinic in Wylie, Texas, currently an underserved area of the region.
- c) Implementing transparent, standardized referrals across the system by educating referral sources of the availability of the expanded services.
- d) Conducting quality improvement for the project using the rapid cycle improvement model. Activities will include 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 unique community needs identification number for this project is: CN.11 (Behavioral Health). By expanding services to a greater number of individuals needing behavioral health services, we will address CN.11.

This project significantly enhances the existing delivery system of community behavioral healthcare in Collin County by expanding access to individuals unable to access care through the state's current delivery system.

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

OD-1-Primary Care and Chronic Disease Management; IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone Measure) is the outcome measure we will use to assess this project.

This outcome has been chosen as an appropriate measure for this project due to the fact that depression is a widespread illness that affects millions of adults and children each year. According to the National Institute of Mental Health (NIMH), the lifetime prevalence of major depression in the U.S. population is 16.5% and only 51.7% of those with the disorder receive treatment. Additionally, 38% of those receiving treatment are receiving minimally adequate treatment. This project will open access for many of those individuals to receive appropriate treatment in their community.

The most effective treatment for major depression is a combination of antidepressant medication and psychotherapy. An essential part of this project is increasing the number of clinical staff available to provide these services. Our specialty behavioral health clinics can offer this combination of treatment by a comprehensive treatment team consisting of psychiatrists, psychiatric nurses, and licensed professional counselors. Outcomes will be tracked by assessing each client with a diagnosis of major depression with the PHQ-9 at admission and again at twelve months.

By focusing on improving outcomes for individuals with major depression, this project will ensure not only that access to specialty care has been improved for low income populations, but also that those receiving services have improved in their day to day functioning level.

### **Relationship to other Projects**

LifePath Systems' Project number 084001901.2.1, implementing Integrated Primary and Behavioral Health Care at all our clinic locations, will also benefit from this project, which will expand care to a greater number of individuals in Collin County than what was previously possible under current funding and state eligibility criteria. With increased access to behavioral health care, Collin County individuals will be better able to receive both physical and behavioral health treatment earlier in the phase of the illness. Receiving care at an earlier stage of the illness and having access to on-going psychiatric and primary care services will improve health outcomes across the region and reduce use of emergency rooms and jails for those unable to access care.

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

Lakes Regional MHMR Center.

### **Plan for Learning Collaborative**

Lakes Regional MHMR and LifePath Systems will participate in the RHP Learning Collaborative activities, to review progress, identify challenges and share solutions for working with clients in these clinics. Approaches and treatment modalities with specific difficult-to-serve clients will be shared to improve engagement and effectiveness of the systems.

### **Project Valuation**

The approaches used for valuing this project are a cost-utility analysis and a cost effectiveness/cost savings model as demonstrated in the attached papers ("Valuing the Project to Implement a Chronic Disease Prevention/Management Model" and "Increased Access to Behavioral Healthcare"). In a cost-effectiveness analysis (CEA), cost averted is compared to a common health outcome which in this case is cost per depression-free day. Simon et al. (2001) found that collaborative care yielded 47.7 additional depression free days per year at a cost of \$52 per depression-free day. This projects estimates serving an additional 5,000 individuals over the course of the 4 demonstration years.

$5,000 \text{ individuals} \times \$52 \text{ a day} \times 47.7 \text{ days} = \$12,402,000 \text{ in valuation}$

Cost-utility analysis is a tool for assessing the value of new health service interventions. This type of analysis provides a standard way of valuing multiple types of interventions and programs. In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added. Benefits of a proposed program are then valued based on assigning a monetary value of \$50,000 pre life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature (Brown et al,

2012). The value of providing substance abuse treatment in a collaborative setting has been shown in several studies as adding .11135 quality-adjusted life-years (QALYS). By year 5, our goal is to provide substance abuse treatment to at least one third of the additional 5,000 individuals receiving services (i.e. 1,667) individuals.

$1,667 \text{ individuals} \times .11135 \text{ QALYS} \times \$50,000 = \$9,281,023 \text{ in valuation}$

Total Project Valuation = \$21,683,023

## References

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Project to Implement a Chronic Disease Prevention/Management Model.

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing Increased Access to Behavioral Health.

### Valuing Increased Access to Behavioral Health,

Center for Health Care Services (CHCS) – Bexar County, Region 6 – University Health System; Texas Healthcare Transformation and Quality Improvement Program - (Project Number 11-W-00278/6). H. Shelton Brown, Ph.D., A. Hasanat Alamgir, Ph.D., UT Houston School of Public Health, Thomas Bohman, Ph.D., UT Austin Center for Social Work Research

The Center for Health Care Services proposes to expand the network of neighborhood-based behavioral health service sites throughout Bexar County. The program would increase training to support expanding workforce needs, expand substance abuse treatment resources, increase clinic service hours, and address workforce shortages by using telemedicine. This program meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Category II Program Innovation and Redesign goal. The overall goal of this program is to improve access to behavioral health care and reduce unnecessary hospitalizations resulting from long waits for care.

The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved.

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

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

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

of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

## Cost-Utility Analysis

### Telemedicine

A search of the scientific literature identified the following studies that were used to determine the valuation amount. The first study we identified looking at telemedicine and mental health was done by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico that received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010) examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional gain for intervention was 0.034 QALYs gained. The average of the two estimated QALYs is 0.0245. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

$$\begin{aligned} & 100 \text{ (persons served)} \\ & \times 0.0245 \text{ (QALY gained)} \\ & \times \$50,000 \text{ (life year value)} \\ & = \$122,500 \end{aligned}$$

### Substance Abuse Treatment in a Collaborative Setting

A cost-utility study for substance/alcohol using treatment Buprenorphine (Schackman et al, 2012) that showed 0.22 QALYs gained for those receiving treatment. Drummond et al. (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. The average of these two values is 0.11135. Assuming 100 patients enroll in this program, the total value of this component would be:

$$\begin{aligned} & 100 \text{ (persons served)} \\ & \times 0.11135 \text{ (QALY gained)} \\ & \times \$50,000 \text{ (life year value)} \\ & = \$556,750 \end{aligned}$$

## Summary and Total Valuation

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Assuming that the telemedicine component and the substance abuse component are additive, the total valuation is \$718,750

<b>Service Delivery System</b>	<b>Valuation</b>
Telemedicine	\$122,500
Substance Abuse Treatment in Collaborative Setting	\$556,750
Total Valuation	<u>\$679,250</u>

## References

- Drummond, C., Coulton, S., James, D., Godfrey, C., Parrott, S., Baxter, J., . & Peters, T. (2009). Effectiveness and cost-effectiveness of a stepped care intervention for alcohol use disorders in primary care: pilot study. *Br J Psychiatry*, 195(5), 448-456. doi: 10.1192/bjp.bp.108.056697
- Hollingshurst, S., Peters, T. J., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost- effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomised controlled trial. *Br J Psychiatry*, 197(4), 297-304.
- Pyne, J. M., Fortney, J. C., Tripathi, S. P., Maciejewski, M. L., Edlund, M. J., & Williams, D. K. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Arch Gen Psychiatry*, 67(8), 812-821.
- Schackman, B., Leff, J., Polsky, D. Moore, B., and Fiellin, D. (2012). Cost-effectiveness of long-term outpatient Buprenorphine-Naloxone treatment for opioid dependence in primary care. *Journal of General Internal Medicine*, 27(6), 669-676. doi: 10.1007/s11606-011-1962-8

<b>UNIQUE CATEGORY 1 PROJECT IDENTIFIER:</b> 084001901.1.1	<b>PROJECT OPTION:</b> 1.9.2	<b>PROJECT COMPONENTS:</b> 1.9.2 A, B, C, & D	<b>PROJECT TITLE:</b> EXPAND BEHAVIORAL HEALTH SPECIALTY CARE CAPACITY	
<b>Performing Provider:</b> LifePath Systems				<b>TPI:</b> 084001901
<b>Related Category 3 Outcome Measure:</b> OD- 1-Primary Care and Chronic Disease Management	<b>Unique Category 3 IT identifier:</b> IT- 1.9	<b>Reference number from RHP PP :</b> 084001901.3.2	<b>Outcome Measure (Improvement Target) Title:</b> Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone Measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>Milestone 1 [1.9.2.P-1]: Conduct specialty care gap assessment based on community need.</p> <p>Metric 1 [1.9.2.P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).</p> <p>Baseline/Goal: Completion of needs assessment</p> <p>Data Source: Needs Assessment</p> <p>Milestone 1 Estimated Incentive Payment (maximum amount): \$1,932,576</p> <p>Milestone 2 [1.9.2.P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected specialties</p>	<p>Milestone 3 [1.9.2.P-11]: Launch / expand a behavioral health specialty care clinic.</p> <p>Metric 1 [1.9.2.P-11.1]: Establish/expand behavioral health specialty care clinics a. Number of patients served by specialty care clinic</p> <p>Baseline/Goal: 1242 = baseline / 1366 = goal (10% increase)</p> <p>Data Source: Documentation of new/expanded specialty care clinic &amp;/or expanded hours &amp; staffing</p> <p>Milestone 3 Estimated Incentive Payment: \$2,313,294</p> <p>Milestone 4 [1.9.2.I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [1.9.2.I-23.2]:</p>	<p>Milestone 5 [1.9.2.I-23]: Increase clinic volume of visits and evidence of improved access for patients seeking services.</p> <p>Metric 1 [1.9.2.I-23.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. A. Total number of unique patients encountered in the clinic for reporting period.</p> <p>Goal: 1614 = goal (30% increase over baseline)</p> <p>Data Source: EHR, claims or other Performing Provider source</p> <p>Milestone 5 Estimated Incentive Payment: \$2,321,991</p> <p>Milestone 6 [1.9.2.I-23]: Increase clinic volume of visits and evidence</p>	<p>Milestone 7 [1.9.2.I-23]: Increase clinic volume of visits and evidence of improved access for patients seeking services.</p> <p>Metric 1 [1.9.2.I-23.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. A. Total number of unique patients encountered in the clinic for reporting period.</p> <p>Goal: 1800 = goal (45% increase over baseline)</p> <p>Data Source: EHR, claims or other Performing Provider source</p> <p>Milestone 7 Estimated Incentive Payment: \$2,063,992</p> <p>Milestone 8 [1.9.2.I-23]: Increase clinic volume of visits and evidence</p>	

<b>UNIQUE CATEGORY 1 PROJECT IDENTIFIER:</b> 084001901.1.1	<b>PROJECT OPTION:</b> 1.9.2	<b>PROJECT COMPONENTS:</b> 1.9.2 A, B, C, & D	<b>PROJECT TITLE:</b> EXPAND BEHAVIORAL HEALTH SPECIALTY CARE CAPACITY	
<b>Performing Provider:</b> LifePath Systems			<b>TPI:</b> 084001901	
<b>Related Category 3 Outcome Measure:</b> OD- 1-Primary Care and Chronic Disease Management	<b>Unique Category 3 IT identifier:</b> IT- 1.9	<b>Reference number from RHP PP :</b> 084001901.3.2	<b>Outcome Measure (Improvement Target) Title:</b> Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone Measure)	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
Metric 1 [1.9.2.P-2.1]: Training of staff and providers on referral guidelines, process and technology a. Numerator: Number of staff and providers trained and documentation of training materials b. Denominator: Total number of staff and providers working in specialty care and medical specialty clinics  Baseline/Goal: Completion of training  Data Source: Log of specialty care personnel trained and curriculum used for training.  Milestone 2 Estimated Incentive Payment (maximum amount): \$1,932,577	Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). A. Total number of unique patients encountered in the clinic for reporting period.  Goal: 1490 = goal (20% increase over baseline)  Data Source: EHR, claims or other Performing Provider source  Milestone 4 Estimated Incentive Payment: \$2,313,294	of improved access for patients seeking services.  Metric 1 [1.9.2.I-23.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. A. Total number of unique patients encountered in the clinic for reporting period. Goal: 1738 = goal (40% increase over baseline)  Data Source: EHR, claims or other Performing Provider source  Milestone 6 Estimated Incentive Payment: \$2,321,990	of improved access for patients seeking services.  Metric 1 [1.9.2.I-23.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. A. Total number of unique patients encountered in the clinic for reporting period.  Goal: 1863 = goal (50% increase over baseline)  Data Source: EHR, claims or other Performing Provider source  Milestone 8 Estimated Incentive Payment: \$2,063,991	
<b>Year 2 Estimated Milestone Bundle Amount: \$3,865,153</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$4,626,588</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$4,643,981</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$4,127,983</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$17,263,705</b>				

## **SUMMARY PAGE: Centennial Medical Center Pass 2 Category 1 Project/169553801.1.1.2**

**Provider:** Centennial Medical Center is a 118-bed hospital in Frisco, Texas serving a 25 square mile area and a population of approximately 644,401 PSA.

**Intervention(s):** This project will expand access to primary care through combining the resources of Tenet Healthcare and Centennial Medical Center with Collin County Adult Clinic to provide the “right care at the right place,” which will include expansion of primary care clinic hours and staffing. Specifically, this project will include enhanced diabetes and hypertension management, education and compliance tracking, provision of basic wellness check-ups for women over forty through a new women’s wellness clinic, and seamless referral for HIV/AIDS issues and testing.

**Need for the project:** The primary care services provided by Collin County Adult Clinic almost doubled in size and cost over the past four years. The clinic and the county are seeking ways to expand primary care services in targeted areas to reduce risk for new chronic diseases, and improve the management for diabetes, hypertension, cervical cancer, and HIV/AIDS.

**Target population:** Collin County Adult Clinic patients, who are primarily women and diabetic patients. While CCAC will provide services at both clinics, with CCCHC at the east side seeing Medicare/Medicaid patients, both will see a large majority of patients below 100% of the federal poverty level. Currently, 80% of the 4,200 patients’ visits at CCAC are below 100%, while the remainder are between 100% and 200% of FPL.

**Category 1 or 2 expected patient benefits:** The project seeks to provide improved primary care through expanded primary care hours and staffing, enhanced diabetes and hypertension management and education, wellness check-ups and screening for women, and seamless referral for HIV/AIDS issues and testing. Specifically, this includes metrics and goals of diagnosing, treating, and tracking those with hemoglobin A1c (HbA1c) whose A1c levels are  $\leq 6$ , concentrating on reducing those with A1c levels  $\geq 9$ , “uncontrolled,” by 10%. Patients will also be diagnosed, treated, and tracked for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate. The project will increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. The project also includes increased referrals and support for HIV testing.

### **Category 3 outcomes:**

- IT-1.10 Diabetes Care. Our goal is to increase the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control  $>9.0\%$ .
- IT-12.2 Cervical Cancer Screening. Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.



**Title of Project:** Expand existing primary care capacity  
**Unique RHP project identification number:** 169553801.1.1  
**Performing Provider Name:** Centennial Medical Center/169553801

### **Project Description**

Centennial Medical Center and Collin County Adult Clinic (CCAC) will partner to expand existing primary care capacity. The project will include three distinct components as it expands access through expanded clinic hours and staffing:

- 1) Enhanced Diabetes and Hypertension Management, Education and Compliance Tracking;
- 2) Provision of Basic Wellness Check-ups for Women over forty through a new Women's Wellness Clinic; and
- 3) Seamless referral for HIV/AIDS issues and testing

The enhanced diabetes portion of the project includes support for patients who are seen at the expanded east Collin County Community Health Center (CCCHC) and West Side Clinic (West Side) for free or at low-cost to manage their care for diabetes and or HTN, medications/supplies, ongoing education and compliance tracking, and support for a licensed medical provider.

Collin County Adult Clinics will provide basic wellness check-ups for women over forty through a new Women's Wellness Clinic and at the expanded East clinic (CCCHC) with new hours and days. This new clinic program is a collaboration with area OB/GYN physicians and other hospitals to provide basic wellness checks-ups for women, concentrating on women over 40. This service includes pap smears, breast exams with mammography, if needed, basic check-ups for diabetes and hypertension, medications/supplies, and ongoing education and compliance tracking. It is structured as a free or low cost service for indigent and uninsured women from the target population.

The project contains a seamless referral for HIV/AIDS issues and testing to Health Services of North Texas and referrals back to CCAC for other medical issues with Collin County Adult Clinic at its two clinics, Plano, TX - Collin County Community Health Center (CCCHC) and the West Side Clinic (West Side). This project is in collaboration with Health Services of North Texas (Plano office) and area hospitals, to increase patients from the target population area who will receive HIV testing and HIV/AIDS education and tracking at HSNT, then referred back to CCAC for other health medical issues. This includes reimbursement for patients who are seen for free or at low-cost to manage their care, testing referrals, ongoing education and compliance tracking, and support for a licensed medical provider. This includes additional hours at CCCHC, and new nights at the West Side to achieve goals.

The following core health care indicators including Challenges/Community Need addressed in this project for HIV/AIDS testing and potential corresponding illnesses that will be seen at CCAC clinics in the overall target population are:

**HIV/AIDS** In the target population, 210 persons per 100,000 were infected compared to a state rate of 258 per 100,000. Most of the target population in this survey who are tested for HIV do not do so until they are symptomatic. It is a growing problem and a major concern within the Hispanic population. The issue of HIV testing is especially difficult for this population increasingly affecting the indigent who traditionally have lacked appropriate medical access. Unprotected sex, injection drug use, and the fear of the stigma rather than getting tested are fueling the need to increase the number of indigent who should access these tests. (12)(13)

**DIABETES** The target population has an age-adjusted diabetes prevalence rate of 15.8% compared to the Texas rate of 9.7% and the national rate of 8.2%. In this target population, thus, the rate is twice that of the national average. (8)(14)(15)

**CANCER** In the target population of women over 40, 38% report not having mammograms in the last three years compared to the state average of 29%. Thirty percent (30%) of all women over 18 report not having a pap smear in three years compared to a state average of 20%, with the national benchmark at 25%. Prevention and early detection are critical within the target population. (8)(14)

**CARDIOVASCULAR DISEASE** HTN in the target area is 29.92%, while the state rate is 29.10%, and the U.S. rate is 24.80%. This is a high rate, especially compared to the national average—20% higher. A simple reduction in blood pressure can reduce heart attacks by 21%, strokes by 37%, and overall Cardiovascular Disease by 25%. (8)(16)(17)

**History** Since 2005, CCAC has worked with the Collin County Health Department to provide basic primary care services to the adult indigent and uninsured population of Plano and Collin County. CCAC utilized an all-volunteer workforce that could see over 1,000 patients in 3,500 visits. In 2009, CCAC created a three-year Strategic Plan (2009 to 2012) to review all programs and to look at what these patients needed, not just what CCAC could provide through volunteer efforts and donated goods.

**Goals and Relationship to Regional Goals** CCAC will improve the health of indigent adults by diagnosing and managing Type 1 and Type 2 diabetes increasing the “under control” percentage of adult patients. CCAC will expand hours and days at CCCHC and additional evenings at the West Side to address the target population growth.

CCAC will diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are  $\leq 6$ , concentrating on reducing those with A1c levels  $\geq 9$ , “un-controlled”, by 10%.

#### **Baseline Determination**

**Years Two through Five:** The annual goal is to get 10% of patients at manageable levels. CCAC will work to grow the program to accept the anticipated growth rate.

CCAC will improve the health of adult patients diagnosing and managing those with HTN. CCAC will expand hours and days at CCCHC and additional evenings and Saturdays at the West Side to address the target population growth.

CCAC will diagnose, treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 10% improvement rate.

#### **Baseline Determination**

**Numerator:** Patients 18 to 85 with a diagnosis of HTN with most recent systolic BP measured  $< 140$ mm HG and diastolic BP  $< 90$ mm HG among those patients included in the denominator.

**Denominator:** Patients 18 to 85 who as of Dec. 31 of the measurement year of the diagnoses of HTN who were seen at least twice during the reporting year.

**Key Contributing Factors:** weight, blood pressure, lipid profile, tobacco usage, activity level, and nutritional habits. Patients will be educated by CCAC or referred to community support programs. Patients in the target population have a strong tendency not to take their medication regularly, sometimes even cutting the pills thinking that they last longer (tendency in many population groups)

**Years Two through Five:** The annual goal is to get 10% of the current patients to manageable levels. CCAC anticipates a 25% annual growth rate in numbers of patients.

#### **Increase in Patient Goals for Diabetes and HTN programs (Many patients have both issues)**

Year One: 400 Pts: 200 Pts for Diabetes/200 Pts for HTN; Year Two: 500 Pts: 250 Pts for Diabetes/250 Pts for HTN; Year Three: 625 Pts: 325 Pts for Diabetes/300 Pts for HTN; Year Four: 782 Pts: 375 Pts for Diabetes/407 Pts for HTN; Year Five: 977 Pts: 527 Pts for Diabetes/450 Pts for HTN.

The following core health care indicators including Challenges/Community Need addressed in this project for the overall target population are:

**DIABETES** The target population has an age-adjusted diabetes prevalence rate of 15.8% compared to the Texas rate of 9.7% and the national rate of 8.2%. In this target population, thus, the rate is twice that of the national average. (8)(14)(15)

**CARDIOVASCULAR DISEASE** HTN in the target area is 29.92%, while the state rate is 29.10%, and the U.S. rate is 24.80%. This is a high rate, especially compared to the national average—20% higher. A simple reduction in blood pressure can reduce heart attacks by 21%, strokes by 37%, and overall Cardiovascular Disease by 25%. (8)(16)(17)

The project also focuses on improving the health of indigent women by providing examinations and tests for women who may never have had or have not had in years - opening of a second women's Wellness Clinic, expansion of medical provider base, open more days.

Centennial Medical Center will partner with CCAC to increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year.

### **Baseline Determination:**

**Numerator:** Number of females receiving one or more Pap smears during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.

**Denominator:** Number of females as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by CCAC before their 65<sup>th</sup> birthday.

**Key Contributing Factors:** Working poor female patients routinely do not keep current annual wellness exam appointments, Pap smears, or breast exams. This is true for breast exams and mammography which will be provided for women who are having pap smears. CCAC staff will notify current patients of upcoming due dates for these tests. Staff will review charts to determine testing intervals and target no-shows.

**Years Two through Five:** The annual five-year goal is to increase the number of basic wellness exams by 25% annually with 50% receiving pap smears:

Year One: 300 exams with 150 Pap smears; Year Two: 375 exams with 187 Pap smears; Year Three: 468 exams with 234 Pap smears; Year Four: 586 exams with 293 Pap smears; Year Five: 732 exams with 366 Pap smears.

**GOAL:** CCAC will improve the health of indigent adults by providing a seamless referral program to and from Health Services of North Texas for patient testing, and then provide medical care for other issues at CCAC. Open of additional hours at both clinics and the hire a medical provider (CCCHC) with HIV/AIDS and infectious disease expertise.

**OUTCOME:** Increase the number of patients referred to HSNT for testing by 10%, and referrals to CCAC from HSNT by 10%.

### **Baseline Determination**

**Years Two through Five:** The annual goal is to increase testing by 10% and to work toward addressing the anticipated 25% annual increase in patients.

### **Patient Goals for HIV/AIDS Testing**

Year One: 100 Pts tested; Year Two: 125 Pts tested; Year Three: 156 Pts tested; Year Four: 195 Pts tested; Year Five: 244 Pts tested.

### **Challenges**

**Insurance:** Forty-four percent (44.8%) of the target population is uninsured compared to a state average of 25% and a national adult average of 17%. Even greater still, over 60% of the Hispanic population does not have insurance. Without insurance or assistance, this population goes without healthcare except for

the emergency room when their illness is beyond a critical stage, or simply because there is no other place to go. (4)

**Low Educational Issue:** In the 12 elementary schools just in the MUA, for 2010, eleven were Title I schools. Of the twelve schools (approximately 10,000 students), six schools had over 70% and as high as 89.2% economically disadvantaged students. The remaining six schools are between 23.4% and 50.9% disadvantaged—all in Plano. (3)

**Health Language:** Thirty-three percent (33.6%) of people in this area speak a language other than English. (5)(6)

**Beliefs:** Various cultural backgrounds within this population accept different health care systems and beliefs, many foreign to the rest of the local community. (8)(9)(10)

**Geographical and Transportation:** Plano has good transportation, but those in the target population have no transportation except through a friend. CCAC is in the midst of the MUA, so many are able just to walk. Many CCAC clients, however, walk for up to two miles to get their care, and decide not to come in mildly inclement weather. (7)

**Closing of Clinics in Collin County:** Within the last ten months two major women's clinics providing pap smears, etc. closed: McKinney Family Planning Clinic and Presbyterian Hospital Dallas' Plano Women's Clinic. (4) (11)

### **Five-year Expected Outcomes**

Collin County Adult Clinic will diagnose, treat, and track those with hemoglobin A1c (HbA1c) whose A1c levels are  $\leq 6$ , concentrating on reducing those with A1c levels  $\leq 9$ , "uncontrolled" by 10% per year.

The Clinic will diagnose, treat, and track adult patients for HTN reducing BP from their most recent reading to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate.

Collin County Adult Clinic will increase the percentage of indigent women aged 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year.

The Clinic will increase the number of patient referrals for HIV/AIDs testing by 10%.

Achieve TBD "x%" improvement compared to baseline, with x determined in Year 2 based on baseline data.

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).

Achieve TBD "x%" improvement compared to baseline, with x determined in Year 2 based on baseline data.

c. Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

d. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

### **Starting point/baseline**

The baselines for this project will be established in DY2.

**Rationale** The Collin County Adult Clinic had a Health Care Needs Assessment (July 2012) completed for the area, targeting the local Medically Underserved Area (MUA). This project specifically addresses diabetes in Collin County, and the Needs Assessment states that of PPAs for Diabetes (short-term), 26% are uninsured, and there were 819 cases with an average charge of \$27,950. Eleven percent are uninsured related to PPAs for long-term Diabetes, and there were 1639 cases (per year) with an average charge of \$42,276. (Pages 5-6). Rationale for the cervical screenings and HIV/AIDs testing are laid out in previous paragraphs related to the projects. This project will address these growing challenges in the community.

Community Needs Addressed: Access to health services, Clinical preventive services and Nutrition, Physical Activity and Obesity.

### **Project Enhances an Existing Delivery System**

The project enhances delivery through establishment of improved outcomes, supplying resources and quality measures through Centennial Medical Center and Tenet Healthcare to Collin County Adult Clinic, and through new learning collaborative opportunities through the anchor, Tenet Healthcare, Centennial Medical Center, and clinics including Collin County Adult Clinic.

### **Related Category 3 Outcome Measure and Rationale for Selecting Outcome Measure**

IT-1.10 Diabetes Care. Our goal is to increase the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control >9.0%. Explain how it ties to Category 1 project

IT-12.2 Cervical Cancer Screening. Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Explain how it ties to Category 1 project

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

#### **Plan for Learning Collaborative:**

Collin County Adult Clinic, Centennial Medical Center, and Tenet Healthcare will partner in regular meetings of clinic, clinical, IT, and other leaders to determine processes and objectives that will reach metrics and milestones.

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

#### **Project Valuation:**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria: Meets Waiver Goals, Addresses Community Needs, Project Scope, Project Investment and Value Weight of the Project.

While CCAC will provide services at both clinics, with CCCHC at the east side seeing Medicare/Medicaid patients, both will see a large majority of patients below 100% of the federal poverty level. Currently, 80% of the 4,200 patients' visits at CCAC are below 100%, while the remainder are between 100% and 200%. Whether in the CCCHC setting or at the West Side, those under 100% must be seen for free per FQHC and CCAC guidelines. With the extensive change to CCAC's programs, the new Women's Clinic expenses, the need to provide free care at both clinic sites to those below 100% of the poverty level, medications including insulin and supplies, and the hiring of paid medical staff to see patients free of charge, patient care through CCAC, costs between \$125 and \$200 per visit (average cost \$162) depending upon whether they are seen by the CCCHC medical staff or the West Side medical staff.

This includes the patient visit, medications, testing, administrative expenses, etc. with program costs at 75% of the total. For those under 100% of the federal poverty level, there is no reimbursement by any source including Medicare and Medicaid, except for the requested \$20 co-pay, which is forgiven if the patient does not have it. The project costs for Collin County Adult Clinic, including expanded hours and staffing, enhanced diabetes and hypertension management and education, wellness check-ups and screening for women, and seamless referral for HIV/AIDS issues and testing are also including in the project valuation.

**(References in Addendum.)**

<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p><b>P-1. Milestone:</b> CCAC will improve the health of indigent adults by diagnosing and managing Type 1 and Type 2 diabetes increasing the “under control” percentage of adult patients. CCAC will expand hours and days at the East Clinic (CCCHC) and additional evenings and Saturdays at The West Side Clinic and hire medical staff...P-4 and P-5.</p> <p>Related Category 3: Improved outcomes for disparity group, improved clinical outcomes, and reduced ED utilization.</p> <p><b>P-1.1. Metric:</b> CCAC will diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data.</p>	<p><b>4. Milestone:</b> Increase number of diabetes and HTN care patients being served by 25% over Year 2. Enhance ability to accept urgent care in this area. Open additional hours into the evenings with another provider. <u>Maintain and track current patient load.</u> I-12, I-13 and I-15</p> <p><b>Metric 4A.</b> Expand services by the expected 25% increase in patients from Year 2 to diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data. Estimated Incentive</p> <p><b>Baseline Determination</b> <b>Numerator:</b> Number of adults 18 to 75 with a diagnosis of Type 1 or 2 diabetes whose most recent A1c level during the measurement year is &lt;=9 and whose patients are</p>	<p><b>Milestone:</b> Increase number of diabetes and HTN care patients being served by another 25% over Year 3. Provide urgent care. Hire another medical provider. <u>Maintain and track current patient load.</u> I-12, I-13, I15</p> <p><b>Metric 5A:</b> Expand services by the expected 25% increase in patients from Year 3 to diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data.</p> <p><b>Estimated incentive \$73,587.</b></p> <p><b>Metric 5B:</b> Expand services by 25% from Year 3 to Treat and track adult Patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG,</p>	<p><b>Milestone:</b> Increase number of diabetes and HTN care patients being served by another 10% over Year 4. Provide urgent care. <u>Maintain and track current patient load.</u> I-12, I-13, I-15</p> <p><b>Metric 6A:</b> Expand services by the expected 25% increase in patients from Year 4 to diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data.</p> <p><b>Estimated Incentive \$81,874.</b></p> <p><b>Metric 6B:</b> Treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 10%</p>	

<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>
<i>Centennial Medical Center</i>			<b>169553801</b>
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<p>Estimated Incentive: <b>\$40,000.</b></p> <p><u>Process Milestone Two:</u> CCAC will improve the health of adult patients diagnosing and managing those with HTN. CCAC will expand hours and days at the East Clinic (CCCHC) and additional evenings and Saturdays at The West Side Clinic...P-4</p> <p><u>Metric 2.</u> CCAC will diagnose, treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Estimated incentive: \$20,000.</b></p> <p><u>Milestone:</u> Provision of basic wellness check-ups for women over forty through the new Women's Wellness Clinic, and at the expanded East</p>	<p>included in the denominator. <u>Denominator:</u> Number of adults 18 to 75 as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen at the clinic at least twice during the reporting year and do not meet any of the exclusion criteria.</p> <p><b>Estimated Incentive \$47,520.</b></p> <p><u>Metric 4B.</u> Expand services from Year 2 to treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Baseline Determination</b> <u>Numerator:</u> Patients 18 to 85 with a diagnosis of HTN with most recent systolic BP measured &lt;140mm HG and diastolic BP</p>	<p>with an expected 10% improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Baseline Determination</b> Same as previous Year for 5A&amp;B</p> <p><u>Milestone:</u> Increase the number of patients receiving pap smears, mammograms and regular check-ups over Year 3 by 50% within the current population, and address the number of new patients, expected to be 25%, as well.</p> <p>I-12 and I-15</p> <p><u>Metric 5:</u> CCAC will increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. Data source is CCAC's EMR system.</p>	<p>improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Baseline Determination</b> Same as previous year for 6A&amp;B</p> <p><u>Milestone:</u> Increase the number of patients receiving pap smears, mammograms and regular check-ups over Year 4 by 50% within the current population, and address the number of new patients, expected to be 25%, as well.</p> <p>I-12 and I-15</p> <p><u>Metric 6:</u> CCAC will increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. Data source is CCAC's EMR system.</p>



<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>Clinic hours and day. This new clinic program is collaboration with area OB/GYN's, THR Presbyterian Hospital Plano, and other hospitals to provide basic wellness checks-ups for women, concentrating on women over 40. This service includes pap smears, breast exams with mammography, if needed, basic check-ups for diabetes and hypertension, medications/supplies, and ongoing education and compliance tracking. It is structured as a free or low cost service for indigent and uninsured women from the target population. P-1, P-4.1, P.5</p> <p><u>Metric 1:</u> CCAC will increase the Percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. Data source is CCAC's EMR system.</p> <p><b>2. Process Milestone:</b> N/A</p> <p><b>Metric 2.</b></p>	<p>&lt;90mm HG among those patients included in the denominator. <u>Denominator:</u> Patients 18 to 85 who as of Dec. 31 of the measurement year of the diagnoses of HTN who were seen at least twice during the reporting year.</p> <p>Estimated Incentive <b>\$24,480.</b></p> <p><u>Milestone:</u> Increase the number of patients receiving pap smears, mammograms and regular check-ups over Year 2 by 50% within the current population, and address the number of new patients, expected to be 25%, as well. Will continue to expand hours, days, and provide additional providers, as needed.</p> <p>I-12 and I-15</p> <p><u>Metric 4.</u> CCAC will increase the Percentage of indigent women 21 to 64, concentrating on Women over 40 in the target population, who received one or more Pap smears by 50% and to</p>	<p><u><b>Baseline Determination</b></u> Same as previous year</p> <p><b>Estimated DSRIP Funding: \$57,747</b></p> <p><u>Milestone:</u> Continue to provide seamless referrals for eligible patients. Maintain and track patients referred back to CCAC.</p> <p><u>Metric 5:</u> Increase referrals by 10% and growth expectations of 25% over Year Three. I-12 and I-15</p> <p><u><b>Baseline Determination</b></u> <u>Numerator:</u> Total number of patients who receive HIV testing during the measurement year among those who are included in the denominator. <u>Denominator:</u> Number of patients by December 31 of the previous year who were seen for a medical encounter at least once during the measurement year.</p> <p><b>Estimated DSRIP Funding:</b></p>	<p><b>Baseline Determination</b> Same as previous year</p> <p><b>Estimated DSRIP Funding: \$62,866</b></p> <p><u>Milestone:</u> Continue to provide seamless referrals for eligible patients. Maintain and track patients referred back to CCAC.</p> <p><u>Metric 6:</u> Increase referrals by 10% and growth expectations of 25% over Year Four.  I-12 and I-15</p> <p><u><b>Baseline Determination</b></u> <u>Numerator:</u> Total number of patients who receive HIV testing during the previous year among those who are included in the denominator. <u>Denominator:</u> Number of patients by December 31 of the previous year who were seen for a medical encounter at least once during the measurement year.</p>	

<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>N/A</p> <p><b>Estimated DSRIP Funding (Max) : \$49,000</b></p> <p><b><u>Milestone:</u></b> Seamless referral for HIV/AIDS issues and testing to Health Services of North Texas and referrals back to CCAC for other medical issues. This project is in collaboration with Health Services of North Texas (Plano office) and area hospitals, if needed, to increase patients from the target population area who will receive HIV testing and HIV/AIDS education and tracking at HSNT, then referred back to CCAC for other health medical issues. This includes reimbursement for patients who are seen for free or at low-cost to manage their care, testing referrals, ongoing education and compliance tracking, and support for a licensed medical provider with HIV/AIDS experience. CCAC will expand hours and days at the East Clinic (CCCHC) and additional evenings and Saturdays at The West Side Clinic.</p>	<p>increase the number served by 25% each year. Data sources is CCAC's EMR system.</p> <p><b><u>Baseline Determination</u></b> <u>Numerator:</u> Number of females receiving one or more Pap smears during the measurement year or during the two years prior to the measurement year, among those women included in the denominator. <u>Denominator:</u> Number of females as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by CCAC before their 65<sup>th</sup> birthday.</p> <p><b>Estimated DSRIP Funding : \$58,800</b></p> <p><b><u>Milestone</u></b> Continue to provide seamless referrals for eligible patients. Maintain and track patients referred back to CCAC. Will continue to expand hours, as needed. I-12 and I-15</p>	<b>\$10,226</b>	<b>Estimated DSRIP Funding: \$5,840</b>	

169553801.1.1	1.1.2		EXPAND EXISTING PRIMARY CARE CAPACITY	
Centennial Medical Center			169553801	
			EXPAND EXISTING PRIMARY CARE CAPACITY	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
P-4 and P-5  <b><u>Metric 1:</u></b> Increase the number of patients referred to HSNT for testing by 10%, and referrals to CCAC from HSNT by 10% with a baseline of 1,000 regular patients in Year One. CCAC will include the growth of the population, expected to be 25% annually. Will refer 100 to HSNT—125 in Year Two.  <b>Estimated DSRIP Funding (Max): \$19,700</b>	<b><u>Metric 4:</u></b> Using Year Two as the baseline, increase referrals by 10% and growth expectations of 25%.  <b><u>Baseline Determination</u></b> <u>Numerator:</u> Total number of patients who receive HIV testing during the measurement year among those who are included in the denominator. <u>Denominator:</u> Number of patients by December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year.  <b>Estimated DSRIP Funding: \$18,088</b>			
Year2 Estimated Milestone Bundle Amount: \$128,700	Year3 Estimated Milestone Bundle Amount: \$148,888	Year4 Estimated Milestone Bundle Amount: \$141,560	Year5 Estimated Milestone Bundle Amount: \$150,580	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$569, 528				

## **CATEGORY 1**

### **PASS 3 PROJECTS**

In Pass 3, one provider has proposed a Category 1 Project:

Lakes Regional MHMR

## **SUMMARY PAGE: Lakes Regional MHMR Pass 3 Category 1 Project/121988304.1.2**

**Provider Name:** Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays.

Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year. Over 95% of our consumers are either Medicaid eligible or indigent.

**Intervention(s):** This project will create a clinic in RHP 18 for provision of evidence based services for individuals who suffer from depression or trauma related disorders not meeting the state mandated diagnostic criteria for eligibility for state funded behavioral health services.

**Need for the project:** There are currently no services available for low income and Medicaid populations defined above who have diagnosable symptoms or a behavioral health crisis other than reporting to the hospital emergency department or driving out of the Region a prohibitive distance. Rockwall County is in need of a source for referral from hospital, physicians and public servants for services for the target population (low income or Medicaid eligible of Rockwall County) that is not cost prohibitive.

**Target population:** The target population to be served is estimated at 100-150 patients per year for DY-4 and DY-5, needing access to depression or trauma related behavioral health services that are without alternative providers (i.e., high cost private providers or state funded services restricted to Major Depression, Bipolar, Schizo-Affective, or Schizophrenic disorders).

**Category 1 or 2 expected patient benefits:** The project seeks to provide access to screening, referral and therapeutic services in individual, family and groups which are evidence-based leading to recovery and increased quality of life, satisfaction with care, reduced likelihood for need of higher level of care and avoidance of emergent or intervention services.

**Category 3 outcomes:** IT-10.1 Quality of Life The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. To demonstrate improvement in symptoms and function, the quality of life (SF-36) validated assessment tool will be implemented to measure improvement in quality of life mental and physical functioning factors. The projected aggregate improvement percentage is 10% for DY4 and continuing for DY-5.

**Project Intervention Title:** 1.12 Enhance service availability

**Performing Provider Name:** Lakes Regional MHMR Center/121988304.1.2

**Project Option:** 1.12.2 Expand number of community based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression/Trauma Counseling Center).

**Project Description:**

Rural communities are underserved in behavioral health (Hogg Foundation, 2010). This is true for Rockwall County where Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) provides Mental Health (MH) and Intellectually Developmentally Delayed (IDD) services in RHP 18. The National Association of State Mental Health Program Directors (NASMHPD) estimated that states have cut \$3.4 billion in mental health funding since FY 2009, while the demand for services has increased during this time period (since FY 2009, demand for community-based services has increased by 56 percent, and the demand for emergency room (ER), state hospital, and emergency psychiatric care has climbed 18 percent) (Womble, N., 2012). The State of Texas funded services are restricted to the severely mentally ill (SMI) population by diagnostic code. Others in the community who do not meet the state criteria for supported services other than the local hospital emergency department (ED) need an appropriate place to obtain effective depression and trauma services to lower the overall cost of health care in the county by providing the proper care in the proper context.

LRMHMRC will develop and establish a behavioral health Depression/Trauma Clinic for individuals with a primary need for MH screening and treatment for symptoms of depression and mental anguish or trauma. Members of the community similarly affected who do not meet State criteria for SMI services will be able to access the appropriate level of service without engaging the local hospital ED. The Screening – Brief Intervention Referral and Treatment (S-BIRT) evidence-based tools to screen and intervene for substance abuse will be used as well. Screening services will be able to identify and link clients who present with co-morbid substance use disorders for effective treatment. Evidence-based individual and group counseling services will be rendered by personnel prepared specifically for Depression and Trauma screening and interventions. Clients with the need for prescription and monitoring of depression medications by an appropriate prescriber will have it available through another waiver project.

**Describe the project Goals:**

The goal for the citizens not eligible for State supported behavioral health services due to diagnostic restrictions is to have an available clinic to provide evidence-based screening and/or treatment services for the array of depression, substance abuse and trauma related anxiety concerns. Greater satisfaction with appropriate and effective services is a goal for all community participants.

**Describe any challenges or issues:**

Access to state supported mental health services is restricted to those individuals with SMI and the service array narrow in scope around the restricted diagnostic criteria. Members of the broader community in mental and emotional distress due to symptoms related to moderate depression or trauma and who do not have financial resources for private care seek relief assistance through the ER at local hospitals increasing the overall cost of services to the community. Local hospitals seek a solution to the pressure on the ER to serve what are regarded as psychologically related symptom driven presentations. There is no apparent mental health trauma treatment available to indigent populations in this RHP area as an alternative to the current pattern of ER usage. RHP 18 has recognized the communities-at-large dearth of MH service in the Community Needs Assessment (CAN) as (CN.11) Insufficient access to mental and behavioral health

services. This contributes to inappropriate ED utilization and (CN.7) High costs due to potentially preventable hospitalizations.

**The 5-year expected outcome:**

The five year expected outcome of the project is clinic resources in the rural underserved county providing outpatient evidence-based screening, counseling and prescription services to community members thereby contributing to the overall health delivery system by appropriately and effectively addressing mental health concerns which at present contribute to inefficiencies, possibly preventable hospitalizations and inappropriate ER utilization increasing the cost of health care in the community. Individuals served will experience a greater level of satisfaction and improved personal efficacy from their state of entry into services. There will be measureable improvement in quality and life from program participation.

**Describe how the project is related to regional goals:**

The project relates to the Region 18 goal to improve access to behavioral health services (CN.11) and to reduce the preventable acute care admissions (CN.7).

**Starting Point/Baseline:**

While the local hospital personnel in the communities served by LRMHMRC have urged the development of a referral resource for their ED patients that present with behavioral health driven complaints, no such low-cost solution exists. The program will have to be developed from the point of researching all aspects and creating an operational plan: community resources, selection parameters, protocols, evidence-based programming choices, location, hiring and training qualified staff. However, LRMHMRC is well familiar with the community and will be able to extend the services of the Information Technology (IT) and business departments to support accounting, reporting, quality improvement, electronic medical records and telemedicine to cover prescriber service access. Following these DY2 preparations and staffing selections, provider competence in the chosen intervention models will be trained and services initiated in DY3. Continuous improvement strategies will guide the refinement of operations and services from DY3 through DY5. LRMHMRC will seek to collaborate with Primary Care providers for more integration of care where possible.

**Rationale-- Describe the reason(s) for selecting this project option:**

Category 1.12, [Option 1.12.2 Expand the number of community based settings where behavioral health services] seemed the most descriptive menu item for the project. Rural communities need adequately trained resources to respond to the demand for care for trauma recovery and depression for populations where those services do not currently exist. LRMHMRC chose this project category and due to the restrictions in state budgeted mental health services and the obvious access needs of the un-served populations in the RHP 18 counties. The vast majority of patients with behavioral health problems go without care, visit the ER in emotional/somatic crisis or visit primary care providers without behavioral health specialty care, either because the patient doesn't meet entry criteria into the mental health system (limited to the severely mentally ill) or because the patient refuses behavioral health specialty care due to the stigma attached; thus, the requirements of the State services viewed as cumbersome and private care is too costly. Adults with mental illnesses were more likely to use an ER or be hospitalized in the past year (at least one visit) than adults without mental illnesses. Compared with adults without mental illness, adults with SMI were more likely to use an ER (38.8 vs. 27.1 percent) in the past year and to be hospitalized (15.1 vs. 10.1 percent) (SAMHSA, 2012).

**Describe the reason(s) for selecting these project components:**

Having a clinic in the community available with trained personnel in appropriate service delivery for these concerns will be a new addition to overall community health resources. Many primary care providers feel poorly equipped to handle significant behavioral health issues by themselves. “The impact of psychological interventions on the use of medical services was evaluated by examining the outcome of 91 studies published between 1967 and 1997 using meta-analytic techniques and percentage estimates. Results provided evidence for a medical cost-offset effect, specifically in the domain of behavioral medicine. Average savings resulting from implementing psychological interventions was estimated to be about 20%. About one third of the articles demonstrated that dollar savings continued to be substantial even when the cost of providing the psychological intervention was subtracted from the savings.” (Chiles, J. et.al., 1999).

LRMHMRC currently serves individuals who receive only medication prescription services for their depressive symptoms and are not interested in other required services under State protocols for enrolled participants accounting for a large portion of serial failed appointments and wasted professional man-hours. Treatment in this type of clinic will allow greater satisfaction with the level of care desired by clients, and the existing SMI clinics to better serve individuals in need of more intense services.

**Reasons for selecting the milestones and metrics:**

The milestones and metrics chosen for the introduction of a new clinic serving a niche unavailable in the current health delivery system are in keeping with the Community Needs Assessment item “CN.11 Behavioral Health – All Components”. Category 1.12, Option 1.12.2. “Expand the number of community based settings where behavioral health services” seemed the most descriptive menu item for the project. Thus the milestones chosen to inform and prepare the project are P-3. Process Milestone: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols and clinical guidelines), P-4. Process Milestone: Hire and train staff to operate and manage projects selected and P-6. Process Milestone: Establish behavioral health services in new community-based settings in underserved areas. Once services are initiated, the milestone to expand the community presence and access will be I-11 Improvement Milestone: Increased utilization of community behavioral healthcare and the impact on the participant’s milestone will be I-14 Improvement Milestone: Improved Consumer satisfaction with Access.

**Specify the unique community need identification number the project addresses:**

Community Need Identification Number:

CN.7 Preventable acute care admissions.

CN.11 Behavioral Health – all components

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

The Depression/Trauma Clinic provides a needed level of care in the continuum filling an important gap. The milestones and metrics chosen for the introduction of a new clinic serving a niche unavailable in the current health delivery system are in keeping with the Community Needs Assessment item ‘CN.11 Behavioral Health – all components’.

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

**OD- 10** LRMHMRC chose the outcome domain OD- 10 Quality of Life/ Functional Status and the Improvement target IT-10.1

**Relationship to other Projects:**

**Describe the related Category 1 and 2 projects:**

121988304.1.1 Introduce, Expand or Enhance Telemedicine / Telehealth



**b. Describe the related Category 4 Population-focused improvements:**

(N/A)

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

Behavioral Health projects in RHP 18 including those provided by LifePath Systems, Texoma Community Center, and Lakes Regional MHMR are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, and may move across geo-political boundaries in the process of obtaining healthcare services. These local behavioral health services providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region. Additionally, representatives of other providers including UT Southwestern and Children's Medical Center that may also provide behavioral healthcare will be included in the coordination activities that will occur in both scheduled and routine-doing-business venues across RHP 18 and its neighboring counties.

**Plan for Learning Collaborative:**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

**Project Valuation:**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- \* Meets Waiver Goals
- \* Addresses Community Needs
- \* Project Scope
- \* Project Investment
- \* Value Weight of the Project

Rural communities need adequately trained resources to respond to the demand for care for trauma recovery and depression for populations where those services do not currently exist. LRMHMRC chose this project category and option due to the restrictions in state budgeted mental health services and the obvious access needs of the un-served populations in the counties. The scope of this project could impact a potential of at least 100 patients in a largely rural medically underserved geographic area. In addition this project was valued based upon three (3) valuation research studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research:

- *Valuing the Program to Expand Behavioral Health Outpatient Capacity (ATCIC) –Travis County Region 7, Central Health (2012)*
- *Valuing the Youth Counseling Program (BTCS) – Fayette County Region 7, Central Health (2012)*
- *Valuing the Substance Abuse Treatment Program (BTCS) – Guadalupe County Region 6 , University Health System (2012)*

These valuation studies used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value of \$50,000 per QALY gained due to the intervention multiplied by number of participants. A complete write-up of project will be available at performing provider site.

Total Five Year Valuation: **\$2,588,626**

**References:**

Womble, K, Budget Cuts For State Mental Health Programs Lead To Crowded Emergency Rooms, Think Progress Health, 2012, [thinkprogress.org/health](http://thinkprogress.org/health).

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (April 5, 2012). *The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses*. Rockville, MD.

Jeremy A. Chiles et al. The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review *Clinical Psychology: Science and Practice*, June 1999, Vol. 6.

Pallak, M. S., et al., "Medical costs, Medicaid, and managed mental health treatment: the Hawaii study", **Managed Care Q**, 1994 Spring; 2 (2).

121988304.1.2	<b>1.12.2</b>	N/A	Expand number of community based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression / Trauma Counseling Centers)	
Lakes Regional MHMR Centers				121988304
<b>Related Category 3 Outcome Measure(s):</b> OD-10		IT-10.1	121988304.3.3	<b>Quality of Life</b>
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1 [P-3]:</b> Develop administrative protocols and clinical guidelines for projects selected.</p> <p><b>Metric 1 [Manual of operations for the project detailing administrative protocols and clinical guidelines – P-3.1]:</b> <b>Baseline/Goal:</b> Project Plan -Stakeholder survey data gathered. Data gathered on Treatment models. EMR reports for client transfer eligibility. Software options gathered. Location information for real estate/leasing agents gathered. <b>Data Sources:</b> Program Plan and files. Survey data pool. HR records.</p> <p><b>Milestone 1 Estimated Incentive Payment (maximum amount):</b> <b>\$305,156</b></p> <p><b>Milestone2 [P-4]:</b> Train existing staff to operate and manage project selected.</p> <p><b>Metric 2 [Number of staff secured and trained – P-4.1]:</b></p>	<p><b>Milestone 3 [P-4]:</b> Hire and train counseling staff.</p> <p><b>Metric 3 [Number of staff secured and trained – P-4.1]:</b> <b>Goal:</b> Hire and train counseling staff in basic requirements of operational and clinical software. Clinicians are additionally trained in chosen evidence-based therapy models, screening and referral. <b>Data Sources:</b> HR records, training certificates.</p> <p><b>Milestone 3 Estimated Incentive Payment (maximum amount):</b> <b>\$318,382</b></p> <p><b>Milestone 4 [P-6]:</b> Establish behavioral health services in new community-based setting in underserved area.</p> <p><b>Metric 4 [Number of new community-based settings where behavioral health services are delivered – P-6.1]:</b></p>	<p><b>Milestone 5 [I-11]:</b> Increased utilization of community behavioral healthcare.</p> <p><b>I-11.1. Metric 5 [Percent utilization of community behavioral healthcare services – I-11.1]:</b> <b>Goal:</b> Expansion of population target of 20% met. PDSA cycle complete with report and improvement targets. <b>Data Source:</b> Schedules, client rosters, chart reviews. PDSA document.</p> <p><b>Milestone 5 Estimated Incentive Payment (maximum amount):</b> <b>\$306,156</b></p> <p><b>Milestone 6 [I-14]:</b> Improved Consumer satisfaction with Access</p> <p><b>Metric 6 [ &gt;40% of people reporting satisfaction with access to care – I-14.1]:</b> <b>Goal:</b> Satisfaction scores on participant surveys using the MHSIP</p>	<p><b>Milestone 7 [I-11]:</b> Increased utilization of community behavioral healthcare.</p> <p><b>I-11.1. Metric 7 [Percent utilization of community behavioral healthcare services – I-11.1]:</b> <b>Goal:</b> Expansion of population target of 20% met. PDSA cycle complete with report and improvement targets. <b>Data Source:</b> Schedules, client rosters, chart reviews. PDSA document.</p> <p><b>Milestone 7 Estimated Incentive Payment (maximum amount):</b> <b>\$329,619</b></p> <p><b>Milestone 8 [I-14]:</b> Improved Consumer satisfaction with Access</p> <p><b>Metric 8 [ &gt; 60% of people reporting satisfaction with access to care – I-14.1]:</b> <b>Goal:</b> Satisfaction scores on</p>	

<b>Goal:</b> Support staff and management hired and trained in new employee orientation and state requirements. <b>Data Source:</b> HR records  <b>Milestone 2 Estimated Incentive Payment: \$305,156</b>	<b>Goal:</b> Open and provide services rendered. Enhanced professional training accomplished. Target number of clients served (TBD by Plan DY2). PDSA process cycles in place to inform project development, efficiency and effectiveness. <b>Data Source:</b> Client records, schedules Reports of PDSA reviews.  <b>Milestone 4 Estimated Incentive Payment: \$318,382</b>	instrument. PDSA cycle improvements. <b>Data Source:</b> Participant surveys and reports. PDSA improvement reports.  <b>Milestone 6 Estimated Incentive Payment (maximum amount): \$306,156</b>	participant surveys using the MHSIP instrument. PDSA cycle improvements. <b>Data Source:</b> Participant surveys and reports. PDSA improvement reports.  <b>Milestone 8 Estimated Incentive Payment (maximum amount): \$329,619</b>
Year 2 Estimated Milestone Bundle Amount: <b>\$610,312</b>	Year 3 Estimated Milestone Bundle Amount: <b>\$636,764</b>	Year 4 Estimated Milestone Bundle Amount: <b>\$682,312</b>	Year 5 Estimated Milestone Bundle Amount: <b>\$659,238</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$2,588,626</b>			

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

Section D of the RHP 18 Plan contains the following material.

### **PASS 1 contains three projects in Category 2.**

These are, presented in the following order:

- One from Children's Medical Center in Plano,
- One from LifePath Systems,
- One from Texoma Community Center.

### **PASS 2 includes three Category 2 projects:**

- One from LifePath Systems
- One from Texoma Community Center
- One from Lakes Regional MHMR

### **PASS 3 includes three Category 2 projects:**

- LifePath Systems 084001901.2.3
- Texoma Community Center: 084434201.2.3
- Lakes Regional MHMR: 121988304.2.2

### ***Areas of need addressed in Category 2 projects include:***

***Centralization of services via medical home models, improved IT systems, health promotion and education, effective provision of combined and blended behavioral health and medical care to prevent exacerbation of co-morbid chronic conditions and unnecessary use of higher levels of more expensive care. This category also contains innovations in collaborative care project for referrals, case management, and point of care interventions. Special populations are addressed in these Category 2 projects including adults and children at risk for incarceration or hospitalization related to chronic health or behavioral health conditions negatively affecting daily function and quality of life.***

***Metrics associated with these projects include measures of improvement in health awareness, self-management, quality of life, functional status, and patient satisfaction. Tracking of duplication of services will be monitored and corrected via learning collaboratives and interinstitutional consultations. Monitors also include cases resolved without use of higher levels of care, and full utilization of new innovations.***

## **CATEGORY 2**

### **Nine total projects**

### **PASS 1 PROJECTS (3)**

- One from Children's Medical Center in Plano,
- One from LifePath Systems,
- One from Texoma Community Center.

#### **In pass 2 we added three projects:**

- One from LifePath Systems
- One from Texoma Community Center
- One from Lakes Regional MHMR

#### **In pass 3 we added three projects:**

- LifePath Systems 084001901.2.3
- Texoma Community Center: 084434201.2.3
- Lakes Regional MHMR: 121988304.2.2

#### **Each project includes a one-page abstract per instructions of the Texas HHSC 11-2012.**

Provider: Brief description of the provider organization

Hospital ABC is a 40-bed hospital in CDF Town serving a 25 square mile area and a population of approximately 21,000.

Intervention(s): This project will implement telemedicine to provide patient consultations by a pharmacist after hours and on weekends to reduce medication errors.

Need for the project: We currently only have a pharmacist onsite 40 hours per week and have noticed an increase in inpatient admissions, many of which are related to medication errors.

Target population: The target population is our patients that need medication consults after hours.

Approximately 50% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the consults.

Category 1 or 2 expected patient benefits: The project seeks to provide 200 telemedicine consults in DY4 and 400 in DY5.

Category 3 outcomes: IT-X.X Our goal is to reduce the 30-day potentially preventable all-cause readmission rate from X% currently to X% by DY5. *(If more than one outcome, use sub-bullets.)*

## **SUMMARY PAGE: LifePath Systems: Pass 1 Category 2 Project/138910807.2.1**

### Expand Pediatric Primary Care

**Provider:** Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Children's has approximately 600,000 patient contacts a year.

Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

**Intervention(s):** The purpose of this project is to transform the MyChildren's primary care offices into a NCQA-certified medical homes. Providing primary care and preventive care services to children in the medical home setting allows for better coordination care, improved health outcomes and improved satisfaction for children and their families. Access to care delivered in a medical home environment should reduce both the use of the ED for inappropriate reasons as well as reduce overall use of the ED for patients receiving care in a medical home setting.

**Need for the project:** Providing care in a medical home setting has been shown to improve overall health of the population receiving care in the medical home setting, reduce overall costs and improve patient satisfaction.

**Target population:** The target population is children in RHP 18 covered by Medicaid and CHIP.

**Category 1 or 2 expected patient benefits:** Providing primary care and preventive care services to children in the medical home setting allows for better coordination care, improved health outcomes and improved satisfaction for children and their families

**Category 3 outcomes:** OD-9 Preventive and Primary Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure) This measure was selected because the project is designed to support appropriate utilization of ED services and reduce the inappropriate use of ED services.

**Title of Project: Enhance/Expand Medical Homes****Unique RHP project identification number:** 138910807.2.1**Performing Provider name/TPI:** Children's Medical Center/13890807**Project Description:**

- Develop, implement and spread across all Collin County Children's Medical Center (CMC) pediatric primary care centers a medical home team-based approach to care, transforming the existing fee-for-service delivery system from a reactive, fragmented approach to a proactive, comprehensive approach to improving the health of a population
- Expand staff roles to ensure that all staff are practicing at the top of their license; redesign processes in the CMC primary care centers to effectively use technology and staff to take responsibility for the health of a defined population and improve cost, quality, health and satisfaction outcomes
- Implement the effective use of IT systems, including patient identification, risk adjustment/analysis/scoring, predictive modeling, data warehousing, gaps in care alert system, provider profiling, outcomes measurement and reporting system capable of aggregating data at the individual patient level, chronic disease, pediatric physician panel, clinic and system-wide level
- Build, implement and spread a pediatric patient/family care coordination system across Collin County CMC primary care centers
- Build, implement and spread a health promotion and education program through the establishment of health resource centers

**Goal and Relationship to Regional Goals**

The goal of the project is to build infrastructure to expand the CMC primary care medical home capability and perform extensive innovation and redesign to achieve the outcome of NCQA Primary Care Medical Home recognition. This five-year project will involve capacity to manage chronic diseases, increase screening for potentially treatable and preventable conditions, and contribute to reduction in avoidable ED care and avoidable admissions/readmissions.

The expansion of a pediatric medical home approach complements and leverages the expansion of CMC's primary care centers such that the incremental primary care centers will be able to achieve a higher level of comprehensive, coordinated care and better quality, cost, health and satisfaction outcomes. By spreading the medical home model to all of our primary care centers in order to be able to empanel thousands of patients comprehensively and systematically, we can make a measureable difference in the experience, results and costs of health care.

Expanded prevention, wellness and patient/family education programs also feeds into the expansion of medical homes and more organized care delivery, better prevention and wellness programs specific to immunizations and well-child care, better prevention and management of chronic conditions, integrated physical-behavioral health care and better utilization of health care resources. Patients and families have better access to care, better access to behavior change programs, better access to social support networks and better access to health education. All of which is delivered in a patient/family-focused approach and in a culturally appropriate manner.

The medical home model increases opportunities to prevent disease and treat it early, where patients and families, upon patient discharge, can be scheduled for follow-up appointments at a medical home, thereby reducing the risk and consequences of worsening health conditions. Additionally, staff take responsibility



for proactively reaching out to high risk patients, patients transitioning from one care setting to another and patients due for preventive services.

**Challenges:**

A major challenge will be the thoughtful and careful redesign of care delivery and communications processes resulting in a team approach to patient/family centered care, requiring a formally structured, inclusive project management approach. This project will use proven process improvement methodologies to guide the redesign as well as use “lessons learned” from providers who have successfully redesigned care delivery in their practices.

**Five Year Expected Outcomes for Provider and Patients**

Five-year expected outcomes include increased access to care, improved patient and family satisfaction, increased patient navigation and care coordination services for patients with chronic diseases, increased availability of information on healthy lifestyle choices and self-management through new community resource centers and decreased low complexity Emergency Department visits.

The project is related to the regional goals of increased access to medical homes and improved patient and family satisfaction with services.

**Starting point/baseline:**

Baseline measurements will be established using DY1 data.

**Rationale:**

The demand for both primary and specialty care services exceeds that of available physicians in Collin County for children covered by Medicaid and CHIP, thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Additionally, many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit more severe complications. Finally, emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, re-admissions are higher than desired, particularly for those with severe chronic diseases or behavioral health.

The impact of the limited primary and specialty care is significantly profound for children and families in the region. With the current pediatric need being more than 80% of the current supply, in rural and urban areas the demand for primary care services is much higher than the current supply. In the North Texas Corridor, almost 40% of children were either uninsured or enrolled in Medicaid or CHIP in 2010, exacerbating the issue of availability of primary care access and treatment. Additionally, data indicates that many of the pediatric specialists are limited, creating a backlogged pipeline for those needing specialty services after seeking primary care.

As we seek to develop pediatric medical homes through National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition, MyChildren’s will have the opportunity to provide better care through improved prevention screenings and routine primary and chronic care. The majority of the MyChildren’s primary care providers are still functioning in a more traditional fee for service approach. We want to make sure the pediatric medical home model is embedded within the care delivery model at MyChildren’s so that all patients can receive the right care in the right place at the right time. This is a strategic priority for MyChildren’s because by providing more patients with family-

centered, culturally appropriate coordinated care services grounded in their primary care medical homes, children can stay healthier and families can take better care of their children, thereby reducing avoidable ED visits, specialty visits, admissions and readmissions. Children will be identified via the IT support systems and then receive this care in a proactive, planned manner so that they can receive evidence-based interventions across the care continuum. The staff will be complemented to include nutritionists, social workers, community health workers and therapists as part of the family-focused patient care teams. Services will include group visits, care management, chronic care management, telephone outreach and home health care. Heavy emphasis will be placed on a patient/family-focused approach that incorporates evidence-based clinical protocols, and is applied in a consistent and documented manner. Rigorous measurement of both processes of care and pediatric outcomes will ensure continuous improvement and sustainability over time.

MyChildren's will utilize the IT support systems to track and monitor prevention and wellness programs, with targeted improvements in key quality indicators, such as well-child visits, immunizations and potentially preventable acute care services. Currently, primary care capacity, resources, infrastructure and technology are severely limited. Our goal is to better treat the volume of patients who need preventive and wellness interventions in addition to chronic care management. The IT support systems will promote tracking, trending timely intervention and also support patient/family education.

### **Project Components:**

All of the project components of 2.1 will be included in this project:

- a. Utilize a gap analysis to assess and/or measure the primary care providers' readiness for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) status
- b. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
- c. Conduct educational sessions for primary care physician offices, hospital board of director, medical staff and senior leadership on the elements of PCMH, its rationale and vision
- d. Conduct quality improvement for the project using methods such as rapid cycle improvement

All milestones and metrics are based on the relevancy to RPH IX's population, community needs, RHP priorities and the starting point for the project.

### **Community Needs Addressed:**

- CN 2 Primary Care-Children
- CN 4 Urgent and Emergency Care
- CN 5 Co-morbid and Behavioral Health
- CN 7 Preventable Acute Care Conditions
- CN 11 Behavioral Health – All Components, All Ages

### **Project Represents a New Initiative:**

This project represents a new initiative for Children's and its system of primary care providers: MyChildren's. Significant changes to practice, staffing, process and productivity will be reflected in the process of becoming qualified medical homes.

### **Related Category 3 Outcome Measure and Rationale for Selection**

OD-9 Preventive and Primary Care IT-9.2 ED appropriate utilization. (Stand-alone measure)

Access to care delivered in a medical home environment should reduce both the use of the ED for inappropriate reasons as well as reduce overall use of the ED for patients receiving care in a medical home setting.

#### **Relationship to other projects:**

- 1.1. Expand Primary Care Capacity
- 1.2. Expand Primary Care Hours
- 1.3. Implement Disease Management
- 1.4. Expand Pediatric Behavioral Health
- RD-1. Potentially Preventable Admissions
- RD-2. 30-day readmissions
- RD-3. Potentially Preventable Complications
- RD-4. Patient-centered Healthcare
- RD-5. Emergency Department
- RD-6. Initial Core Set of Health Care Quality Indicators

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

Expand Primary and Specialty Care Capacity (UT Southwestern) and Establish More Primary Care Clinics (Grayson County Health Clinic)

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

### **References**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>

Nashmia Qamar, Andrea A Pappalardo, Vineet M Arora, and Valerie G Press . Patient-centered care and its effect on outcomes in the treatment of asthma. *Patient Relat Outcome Meas*. 2011 July; 2: 81–109.

Reid A, Baxley E, Stanek M, Newton W. Practice transformation in teaching settings: lessons from the I<sup>3</sup> PCMH collaborative. *Fam Med*. 2011 Jul-Aug;43(7):487-94.

Mangione-Smith R, Schiff J, Dougherty D. Identifying children's health care quality measures for Medicaid and CHIP: an evidence-informed, publicly transparent expert process. *Acad Pediatr*. 2011 May-Jun;11(3 Suppl):S11-21.

13890807.2.1	2.1.	2.1.1 A, B, C, D	ENHANCE/EXPAND MEDICAL HOMES	
Children's Medical Center			13890807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary Care	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p>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. 63</p> <p>P-2.1. Metric: Performing Provider policies on medical home</p> <p>a. Data Source: Performing Provider's "Policies and Procedures" documents</p> <p>b. Rationale/Evidence: Operationalizing the work as part of the "Policies and Procedures" for an organization will make the work the "norm" or expectation for the organization and its employees.</p> <p>c. Goal: Policies and systems in</p>	<p>P-1. Milestone: Implement the medical home model in primary care clinics</p> <p>P-1.1. Metric: Increase number of primary care clinics using medical home model</p> <p>a. Numerator: Number of primary care clinics using medical home model</p> <p>b. Denominator: Total number of eligible primary care clinics</p> <p>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.<sup>62</sup> In addition to reductions in ED utilization, the medical home model has helped improve the delivery and quality of primary</p>	<p>I-18. Milestone: Obtain medical home recognition by a nationally recognized agency 82(e.g., NCQA, RAC, AAHC, etc.). The level of medical home recognition will depend on the practice baseline and accrediting agency.</p> <p>I-18.1. Metric: Medical home recognition/accreditation</p> <p>a. Numerator: number of sites or clinics receiving recognition/accreditation</p> <p>b. Denominator: total number of sites or clinics eligible for recognition/accreditation.</p> <p>c. Data Source: Documentation of recognition/accreditation from nationally recognized agency (e.g., NCQA)</p> <p>d. Rationale/Evidence: It is important to validate the medical home service being provided by seeking and</p>	<p>I-16. Milestone: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home</p> <p>I-16.1. Metric: Percent of primary care visits at medical home</p> <p>a. Numerator: Number of enrolled patients' primary care visits with medical home primary care provider/team</p> <p>b. Denominator: Total number of enrolled patients' primary care visits within the Performing Provider</p> <p>c. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider</p> <p>d. Rationale/Evidence: Patients know the professionals on their care team and establish trusting,</p>	

13890807.2.1	2.1.	2.1.1 A, B, C, D	ENHANCE/EXPAND MEDICAL HOMES	
Children's Medical Center			13890807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)	
place by 9/30/13  <b>Milestone P-2.1 Estimated Incentive Payment (<i>maximum amount</i>): \$542,831</b>  P-4. Milestone: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members. <sup>66</sup> P-4.1. Metric: Expanded primary care team member roles; a. Data Source: Revised job descriptions 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	care and reduce costs. d. Goal: 50% of eligible clinics implemented with medical home model by 9/30/14. <b>Milestone P-1.1 Estimated Incentive Payment (<i>maximum amount</i>): \$555,188</b>  P-7. Milestone: Track the assignment of patients to the designated care team P-7.1. Metric: Tracking medical home patients a. Data Source: Submission of tracking report. Can be tracked through the practice management system, EHR, or other documentation as designated by Performing Provider b. Rationale/Evidence: Review panel status (open/closed) and panel fill rates on a monthly basis for equity to be able to adjust to changing environment	receiving recognition/accreditation. Some safety net sites that have attained NCQA accreditation “reported that they have become far more sophisticated as a result of the application effort and have invested in quality improvement efforts that might otherwise have gone unrealized”. e. Goal: 50% of eligible clinics receive medical home certification by 9/30/15 Milestone I-18 Estimated Incentive Payment ( <i>maximum amount</i> ): \$297,500.00 I-12. Milestone: Based on criteria, improve the number of eligible patients <sup>80</sup> that are assigned to the medical homes. I-12.1. Metric: Number or percent of eligible patients assigned to medical homes,	ongoing relationships to reinforce continuity of care. Medical home model should enhance continuity. E. Goal: 50% increase over baseline  <b>Milestone I-16: Estimated Incentive Payment (<i>maximum amount</i>): \$447,593</b>  I-17. Milestone: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care I-17.1. Metric: Reminders for patient preventive services 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	

13890807.2.1	2.1.	2.1.1 A, B, C, D	ENHANCE/EXPAND MEDICAL HOMES	
Children's Medical Center			13890807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)	
multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions. <sup>67</sup> It is clear that primary care physicians in the 15-minute visit can no longer do what their patients expect and deserve.” c. Goal: Staffing plan developed by 9/30/13  <b>Milestone P-4.1 Estimated Incentive Payment (maximum amount): \$542,831</b>	(e.g., patient preference, extended provider leave). c. Goal: Tracking report developed by 9/30/14  <b>Milestone P-7.1. Estimated Incentive Payment (maximum amount): \$555,188</b>	where “eligible” is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients  c. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider d. Rationale/Evidence: Murray M, Davies M, Boushon B, Panel Size: How Many Patients Can One Doctor Manage? <i>Fam Pract Manag.</i> 2007 Apr;14(4):44-51 e. Goal: 50% of eligible patients in MyChildren's in Collin County assigned a medical home by 9/30/15  <b>Milestone I-12.1 Estimated</b>	have been contacted to come in for service b. Denominator: Total number of 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. This approach has been used with good effect in state and federal health disparity collaborative. The care team assesses the patient's overall health and co-develops a health care plan with the patient, including health goals, ongoing management, and future visits. e. Goal: 50% of patients receive information regarding	

13890807.2.1	2.1.	2.1.1 A, B, C, D	ENHANCE/EXPAND MEDICAL HOMES	
Children's Medical Center			13890807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)	
		<b>Incentive Payment (maximum amount): \$369,551</b>  I-13. Milestone: New patients assigned to medical homes receive their first appointment in a timely manner I-13.1. Metric: Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days a. Numerator: Number of new patients contacted within specified days b. Denominator: Total number of new patients c. Data Source: Practice management or scheduling systems, registry, EHR, or other documentation as designated by Performing Provider	preventive services by 9/30/16  <b>Milestone 11 Estimated Incentive Payment (maximum amount): \$447,593</b>	

13890807.2.1	2.1.	2.1.1 A, B, C, D	ENHANCE/EXPAND MEDICAL HOMES	
Children’s Medical Center			13890807	
OD 9	IT-3.9.2	P-1, I-1; P-2, I-1; P-3, I-1; P-4, I-1; P-5, I-1	Preventive and Primary 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)	
		d. Rationale/Evidence: It is important to get new patients into the medical home in a timely manner. e. Goal: 50% of new patients in medical home models in MyChildren’s in Collin County receive first appointment within or before 60 to 120 days  Milestone I-13 Estimated Incentive Payment (maximum amount): \$369,551		
Year 2 Estimated Milestone Bundle Amount: \$1,085,663	Year 3 Estimated Milestone Bundle Amount: \$1,110,375	Year 4 Estimated Milestone Bundle Amount: \$1,108,654	Year 5 Estimated Milestone Bundle Amount: \$895,186	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$4,199,877				



## **SUMMARY PAGE: LifePath Systems: Pass 1 Category 2 Project/084001901.2.1**

**Provider:** LifePath Systems is the non-profit community center for Collin County. Collin County encompasses 886 square miles, has a population of 840,000 and is one of the fastest growing counties in the United States. LifePath Systems staff provide behavioral health treatment for individuals with mental illnesses and support services for individuals with intellectual or developmental disabilities.

**Intervention(s):** This project will implement primary care services into existing behavioral health outpatient clinics and behavioral health services into existing indigent primary care clinics in Collin County. We plan to hire a primary care physician and support staff to provide services at the outpatient behavioral health clinics. Additionally, a behavioral health counselor will be placed at the indigent primary care clinic. By demonstration year 5, we plan to reach the maximum level of collaboration in a fully integrated system where providers are part of the same treatment team, using the same electronic medical record, and the patient experiences primary care as part of their mental health treatment and vice versa.

**Need for the project:** We do not currently have integrated care in Collin County. Many individuals with chronic mental illnesses also have untreated physical health conditions, such as heart disease, diabetes, and obesity. About 35% of the clients served in our behavioral health clinics have Medicaid and have difficulty finding a Medicaid provider who is accepting new patients. The remaining clients are unable to access medical care due to lack of finances. By providing primary care and behavioral health care in one location, these individuals will have greater access to care.

**Target population:** The target population is chronically mentally ill individuals seen in our community behavioral health clinics and individuals identified in the indigent care clinics in Collin County with behavioral health needs. We currently serve over 1200 individuals a month in the behavioral health clinics. We plan to provide ongoing primary care services to at least 15% of those served, including both Medicaid and indigent individuals.

**Category 2 expected patient benefits:** The project seeks to provide ongoing integrated care to at least 479 individuals annually by year 5. Additional patient benefit lies in the close coordination of primary and behavioral health care, with a fully integrated electronic medical record by year 5.

**Category 3 outcomes:** IT-10.1 Our goal is to improve the quality of life for at least 20% of the individuals receiving integrated care by DY5, by improving the physical health of individuals with chronic mental illness.

**Title of project:** Integrate Primary and Behavioral Health Care

**Unique RHP Project Identification Number:** 084001901.2.1

**Performing Provider name/TPI:** LifePath Systems/084001901

## **Project Description**

Our goal is to improve the physical health of individuals with chronic mental illnesses, and to improve the mental health of individuals with chronic physical illnesses. It has been demonstrated that individuals with behavioral health issues have significant chronic physical health conditions that go untreated, and that these individuals suffer increased morbidity, poorer quality of life, and earlier mortality (up to 29 years) than individuals without behavioral diagnoses. Our goal is to establish physical health care services in all of the LifePath Systems behavioral health clinics and place a behavioral health provider in community health clinics, specifically the Collin County Community Health Center, a Federally Qualified Health Clinic Look-a-Like applicant.

Our goal by year 5 is to reach the maximum level of close collaboration in a fully integrated system where providers are part of the same team and system and the patient experiences mental health treatment as part of their regular primary care and vice versa. Additionally, by year 5, we plan to have at least 15% of the behavioral health individuals served also receiving ongoing integrated primary care at our clinic locations.

**Expected results for this project** include improving the overall health of the seriously mentally ill population that is served in our BH clinics by offering primary health care services in each BH clinic and by adding behavioral health services in non-profit/indigent Collin County primary care clinics.

Finally, given the ever-increasing cost of transportation, a “one stop shopping” approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions.

## **Starting Point/Baseline**

Currently, our baseline is 0. There is no level of integrated services currently in our area.

## **Rationale**

Our project will focus on the design, implementation, and evaluation of projects that provide integrated primary and behavioral health care services in Collin County.

Essential components of this project include:

- Identifying sites for integrated care projects, which will have the potential to benefit a significant number of patients in the community. Examples of selection criteria include proximity/accessibility to target population, physical plant conducive to provider interaction; ability/willingness to integrate and share data electronically; receptivity to integrated team approach.
- Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers can be facilitated.
- Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.
- Recruit a number of specialty providers (physical health, mental health, substance abuse, etc.) to provide services in the specified locations.
- 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: regular consultative meetings between physical health and behavioral health practitioners; case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or shared treatment plans co-developed by both physical health and behavioral health practitioners.

- Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic Medical Record system.
- Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
- Arrange for utilities and building services for these settings.
- Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as health care outcomes of individuals treated in these integrated service settings.
- Conduct quality improvement for project using methods such as rapid cycle improvement. Activities include indentifying 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 unique community need identification numbers this project addresses are: CN.1 (Primary Care – Adults), CN.5 (Co-morbid Medical and Behavioral Health Conditions), CN.8 (Diabetes), CN.9 (Cardiovascular Disease), and CN.14 (Obesity and its Co-morbid Risk Factors). By focusing on providing primary care to adults with chronic mental illness, we expect to address not only these co-morbid illnesses, but also address the treatment of diabetes, cardiovascular disease, and obesity in this specialized population.

The research literature on mortality of individuals with serious mental illnesses is clear: serious mental illnesses are directly tied to a significantly shorter life. 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. Cardiovascular diseases are also very prevalent among people with mental illnesses. 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. As a long term provider to Collin County residents with serious mental illnesses, the impact of poor physical health on the lives and longevity of our clients is seen every day. We recognize that for many of our clients the psychiatric and nursing services they receive through LPS constitute almost 100% of the medical care they receive, for a variety of reasons.

### **Related Category 3 Outcome Measure**

OD- 10 Quality of Life/ Functional Status; IT-10.1 Quality of Life (Standalone measure) is the outcome measure we will use to assess this project.

This outcome is a priority for our community due to the lack of access to affordable healthcare for the low income populations and the increasingly shorter lifespan of individuals with chronic mental illness due to untreated medical conditions.

Implementing integrated primary and behavioral health care in numerous clinics throughout Collin County will help to achieve this outcome of improved quality of life for individuals in the low income populations who otherwise do not have access to care. Research has shown that serious mental illness is tied to a significantly shorter life expectancy - as much as 29 years shorter in the state of Texas.

By focusing on improving outcomes for individuals with physical and behavioral health conditions, this project will ensure not only that access to specialty care has been improved for low income populations, but also that those receiving services have improved in day to day functioning level of this population.

### **Relationship to other Projects**

LifePath Systems Project 084001901.1.2 - Expanding Behavioral Health Specialty Care (Pass 2) will expand office hours, open a clinic in an underserved area, and open eligibility criteria for individuals to receive behavioral health services and allow space to be designed in the clinics for this project. By having access to a larger number of individuals receiving services in the behavioral health clinics, more clients will have access to primary care through this project.

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

Behavioral Health projects in RHP 18 including those provided by LifePath Systems, Texoma Community Center, and Lakes Regional MHMR are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, and may move across geo-political boundaries in the process of obtaining healthcare services. These local behavioral health services providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region. Additionally, representatives of other providers including UT Southwestern and Children's Medical Center that may also provide behavioral healthcare will be included in the coordination activities that will occur in both scheduled and routine-doing-business venues across RHP 18 and its neighboring counties.

### **Plan for Learning Collaborative:**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

**Project Valuation:** Cost-utility analysis is a tool for assessing the value of new health service interventions. This type of analysis provides a standard way of valuing multiple types of interventions and programs. In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added. Benefits of a proposed program are then valued based on assigning a monetary value of \$50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature (Brown et al, 2012). The value of providing integrated primary and behavioral care has been shown in several studies. By year 5, our goal is to serve 279 clients a year in an integrated primary and behavioral health clinic. A cost-utility analysis (Brown et al, 2012) for 279 individuals with SMI seen by PCPs in LifePath's clinics results in a total potential valuation of \$4,680,787. Another 200 individuals at least will be seen in the recently opened Collin County Community Health Center, almost doubling that valuation total to over \$9 million in valuation. Local funding is estimated to be \$3,000 from a small co-pay charge for each client.

<i>084001901.2.1</i>	<i>2.15.1</i>	<i>2.15.1 A, B, C, D, E, F, G, H, I &amp; J</i>	<i>INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE</i>	
<i>LifePath Systems</i>			<i>084001901</i>	
<i>OD-10 Quality of Life / Functional Status</i>	<i>IT-10.1</i>	<i>084001901-IT-10.1</i>	<i>Quality of Life (Standalone measure)</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p><b>Milestone 1</b> [2.15.1.P-2]: Identify existing health clinics or other community-based settings where integration can be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, and that behavioral health staff will be located in at least one physical health clinic.</p> <p><b>Metric 1</b> [2.15.1.P-2.1]: Discussions/interviews with community healthcare providers (such as Collin County Adult Clinic).</p> <p><b>Baseline/Goal:</b> completion of interviews</p> <p><b>Data Source:</b> Information from persons interviewed</p>	<p><b>Milestone 3</b> [2.15.1.P-6]: Develop integrated behavioral health and primary care services within co-located sites.</p> <p><b>Metric 1</b> [2.15.1.P-6.1]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).</p> <p><b>Baseline/Goal:</b> Achieve Level 4 coordination</p> <p><b>Data Source:</b> Project data</p> <p><b>Milestone 3 Estimated Incentive Payment: \$803,498</b></p> <p><b>Milestone 4</b> [2.15.1.I-8]: Integrated Services.</p> <p><b>Metric 1</b> [2.15.1.I-8.1]: 5% of Individuals receiving both physical and behavioral health care at the established locations.</p>	<p><b>Milestone 5</b> [2.15.1.P-6]: Develop integrated behavioral health and primary care services within co-located sites.</p> <p><b>Metric 1</b> [2.15.1.P-6.1]: Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system)</p> <p><b>Baseline/Goal:</b> Achieve Level 5 coordination</p> <p><b>Data Source:</b> Project data</p> <p><b>Milestone 5 Estimated Incentive Payment: \$803,498</b></p> <p><b>Milestone 6</b> [2.15.1.I-8]: Integrated Services</p> <p><b>Metric 1</b> [2.15.1.I-8.1]: 10% of Individuals receiving both physical and behavioral health care at the established locations.</p>	<p><b>Milestone 7</b> [2.15.1.P-7]: Evaluate and continuously improve integration of primary and behavioral health services.</p> <p><b>Metric 1</b> [2.15.1.P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</p> <p><b>Goal:</b> use results of evaluations to adjust services as needed</p> <p><b>Data Source:</b> Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement</p> <p><b>Milestone 7 Estimated Incentive Payment: \$714,221</b></p> <p><b>Milestone 8</b> [2.15.1.I-8]: Integrated Services.</p>	

<i>084001901.2.1</i>	<i>2.15.1</i>	<i>2.15.1 A, B, C, D, E, F, G, H, I &amp; J</i>	<i>INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE</i>	
<i>LifePath Systems</i>			<i>084001901</i>	
<i>OD-10 Quality of Life / Functional Status</i>	<i>IT-10.1</i>	<i>084001901-IT-10.1</i>	<i>Quality of Life (Standalone measure)</i>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<b>Milestone 1 Estimated Incentive Payment (maximum amount): \$892,775</b>  <b>Milestone 2</b> [2.15.1.P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project:  <b>Metric 1</b> [2.15.1.P-5.2]: Number of primary care providers newly located in behavioral health settings.  <b>Baseline/Goal:</b> personnel records  <b>Data Source:</b> Project data  <b>Milestone 2 Estimated Incentive Payment: \$892,776</b>	<b>Numerator:</b> Number of individuals receiving both physical and behavioral health care in project sites <b>Denominator:</b> Number of individuals receiving services in project sites.  <b>Goal:</b> 5% of clients receive integrated services  <b>Data Source:</b> Project data; claims and encounter data; medical records  <b>Milestone 4 Estimated Incentive Payment: \$803,498</b>	<b>Numerator:</b> Number of individuals receiving both physical and behavioral health care in project sites <b>Denominator:</b> Number of individuals receiving services in project sites.  <b>Goal:</b> 10% of clients receive integrated services  <b>Data Source:</b> Project data; claims and encounter data; medical records  <b>Milestone 6 Estimated Incentive Payment: \$803,498</b>	<b>Metric 1</b> [2.15.1.I-8.1]: 15% of Individuals receiving both physical and behavioral health care at the established locations.  <b>Numerator:</b> Number of individuals receiving both physical and behavioral health care in project sites <b>Denominator:</b> Number of individuals receiving services in project sites.  <b>Goal:</b> 15% of clients receive integrated services  <b>Data Source:</b> Project data; claims and encounter data; medical records  <b>Milestone 8 Estimated Incentive Payment: \$714,220</b>	

084001901.2.1	2.15.1	2.15.1 A, B, C, D, E, F, G, H, I & J	INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE	
LifePath Systems			084001901	
OD-10 Quality of Life / Functional Status	IT-10.1	084001901-IT-10.1	Quality of Life (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Year 2 Estimated Milestone Bundle Amount: \$1,785,551	Year 3 Estimated Milestone Bundle Amount: \$1,606,996	Year 4 Estimated Milestone Bundle Amount: \$1,606,996	Year 5 Estimated Milestone Bundle Amount: \$1,428,441	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$6,427,984				

## **SUMMARY PAGE: Texoma Community Center: Pass 1 Category 2 Project/084434201.2.1**

**Provider Description:** Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County with a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics treating over 1,200 adults, children and families ranging in age from zero to death. Staff provide an average of 10,226 face to face patient contacts per month. Less than 1% of TCC's patients have private insurance, between 38-40% have Medicaid on average, and 88.05% of children and 81.34% of adult patients are at or below the federal poverty level.

**Interventions:** Project 084434201.2.1 will implement a new initiative for TCC by incorporating a primary health care provider into the TCC behavioral health system to create a "medical home" for the most "at risk" patients with mental illness and co-occurring chronic physical diseases, and who also have no primary care physician. The intervention will be at ½ day per week or approximately 12 patients per week to start.

**Need for the Project:** TCC selected this project to expand and improve medical and behavior health services in Grayson County. Grayson County is identified by HRSA as an underserved behavioral health provider area. (1b) This project is essential to enhance access to comprehensive services. The WHO (2003) commented on blending primary and mental health care saying: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." (1h)

**Target Population:** The target population for Project 084434201.2.1 is patients that need psychiatric care and a primary care provider to address both mental and chronic physical illnesses. Approximately 38-40% of our patients are Medicaid eligible and almost 100% are low-income or completely indigent, so we expect 100% of the patients receiving these blended services will fit this criteria.

**Category 2 Expected Patient Benefits:** This project will identify three community agencies for relevant data and the most "at risk" patients will be identified in DY 2. Protocols will be established in DY 3 along with hiring and training the appropriate staff, and routine preventative and primary care will be increased by 5% in DY 4 and 10% in DY 5. This project is expected to benefit 47 patients for a \$441,259 value.

**Category 3 Outcomes:** TCC's Category 3 goal is to improve the quality of life for TCC's most "at risk" patients with co-occurring mental and physical health problems reducing the use of more expensive health services. QALY improvement targets will be determined in DY 3 after establishing a baseline in DY 2 but it is expected that the savings to the regional health care community will be significant based on research documented in the project narrative.



**Title of project:** Develop Care Management Function that integrates primary and behavioral health needs of individuals

**Unique RHP Project Identification Number:** 084434201.2.1

**Performing Provider name/TPI:** Texoma Community Center/084434201

**Required core project components:**

- Conduct data matching to identify individuals with co-occurring disorders who are:
  - not receiving routine primary care, not receiving specialty care according to professionally accepted practice guidelines,
  - over-utilizing ER services based on analysis of comparative data on other populations
  - over-utilizing crisis response services
- Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.
- Review chronic care management best practices such as Wagner’s Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation.
- Identification of BH case managers and disease care managers to receive assignment of these individuals.
- Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders.
- Train staff in protocols and guidelines.
- Develop registries to track client outcomes.
- Review the intervention(s) impact on quality of care and integration of care and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

**Project Description:** Texoma Community Center (TCC) intends to implement a care management system that will integrate the primary physical health and behavioral health care for individuals served by TCC and to broaden the services array. By providing physical health care to those patients receiving behavior health treatment, TCC will address regional needs (CN.4, CN.5, CN.6, CN.11, CN.12) and enhance regional goals to improve the health of populations in the region, reduce the cost of health care in the region, and improve access to health care in the region. TCC intends to do this by contracting with 1 primary care physician and 1 nurse for four hours per week specifically to treat chronic physical health issues that are co-occurring with TCC’s most “at risk” patients. In doing so, TCC commits to researching, establishing protocols, supporting and providing the physical health treatment alongside the psychiatric treatment in an enhanced care management model. To do so, TCC will also need to additionally employ one full-time clerk to manage the medication acquisition through Patient Assistance Applications and other related duties. Providing this service will improve outcomes for behavioral health patients who have complications due to chronic conditions and insufficient insurance coverage and insufficient support to meet those physical health needs. TCC patients have significant barriers and limited access to primary care physicians (CN.1) and case managers frequently have trouble finding physicians to prescribe physical health medications for Medicaid or low-income patients, at times putting patients at risk of not having essential medication. Integrating physical health care in this mental and behavioral health clinic will help solve this access problem and contribute to the regional goals to improve quality of care, reduce the cost of health care, prevent hospitalizations and improve access to all health care services. To accomplish these goals, TCC will implement the core components including data matching to identify individuals with co-occurring disorders, as the core components describe:

- not receiving routine primary care, not receiving specialty care according to professionally accepted practice guidelines,
- over-utilizing ER services based on analysis of comparative data on other populations
- over-utilizing crisis response services
- becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

TCC will further explore and implement a chronic care management best practices protocol that is compatible with organizational readiness. BH case managers will be identified in order to receive assignment of these individuals. Plans will be implemented to improve access to primary care, reduce over-utilizing the emergency departments, stabilize individuals to reduce crisis response needs, and reduce criminal justice involvement. Protocols for coordinating care will be written and implemented and community resources and services that are available for supporting people with co-occurring disorders will be identified. Staff will be trained in protocols and guidelines and a registry to track client outcomes will be developed. As part of the continuing quality improvement strategies, intervention impact on quality of care and integration will identify the “lessons learned,” explore opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety-net populations.

It is specifically noted that one of the “Core Components” for this Project Option (2.19.1) has been omitted from TCC’s Project Plan. The component omitted was “(e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression and asthma.” The reason for this omission is that TCC’s medical staff’s area of practice is specifically psychiatry and it is believed that trying to implement physical health guidelines at this point is beyond the scope of practice. While it is the purpose and intent of this project to expand the scope of practice to treating physical health issues “in house,” it is further believed that initially, it will be important for the treatment primary care physician and nurse to have time to integrate into a new environment and treatment model and to focus the limited available hours to seeing patients rather than implementing new disease management guidelines. It is believed that in hiring a well-qualified primary care physician and nurse, the ability to adequately address disease management issues will be within their expertise brought to the center. This is not to diminish the value of developing evidence-based practices and implementing those best-practices guidelines in any way, but simply to be successful over time in making a paradigm shift away for a specialty practice of psychiatry to a more blended “whole person” treatment utilizing ALL best-practices guidelines. It is expected that as this blending of primary care and behavioral health care services is established and then expands, and potentially increasing physician and nurse time, then it will be the time to focus on identifying and implementing more refined disease management guidelines and protocols. It is believed that by adopting and implementing all of the other Core Components, the groundwork will be established and supported for then incorporating more refined disease management protocols. TCC is committed to breaking new ground into this area of blending primary care and specialty care, and to researching best-practices guidelines in all areas of treatment. By implementing the other Core Components in this project, this lays the groundwork for further growth into the identification and implementation of additional disease management guidelines as well as venturing into chronic disease registry data sharing in the future.

The five-year expected outcome is that current and new patients served by TCC will have quick access to both physical health treatment and psychiatric and behavioral health treatment at this center such that the most “at risk” patients will experience a quality of life improvement, improve their overall health and stabilize to reduce unnecessary emergency department visits and hospitalizations.

**Baseline Data and Project Starting Point:** Currently TCC does not provide any physical health treatment except for vital sign monitoring at the time of psychiatrist visits, with the exception of the ACT patients,

who have access to a RN at all times for assessing physical problems. However, when physical health issues are evident, the actual treatment must be referred out to area physicians who are rapidly opting out of providing services to Medicaid patients and more often don't provide services to indigent patients. Therefore, the initial baseline for treating physical health issues that are co-occurring with psychiatric issues for TCC's high utilizer patients would be zero. Being able to quickly and efficiently coordinate physical and psychiatric health care within the same facility for even a few "at risk" TCC patients, and establish that medical home, would be a significant improvement in service quality, accessibility and improve outcomes.

**Rationale:** Individuals with severe and persistent mental illness have difficulty accessing resources for all of their needs, including their basic health care needs. They encounter transportation problems, organizational problems and communication problems. They often have chronic medical conditions along with their mental illness; therefore their health and psychiatric stability is easily compromised. Coordinating and providing primary physical health care at the same facility where their behavioral health needs are treated will increase the care they receive for physical health issues as well. Individuals who are the most "at risk," where both the psychiatric issues and chronic physical issues are concerned tend to be high utilizers of emergency rooms, psychiatric hospitals and physical, acute care hospitals. Their overall level of functioning tends to be lower than the general population. Therefore, offering and supporting physical health treatment simultaneously with their psychiatric needs at TCC's behavioral health clinic would significantly reduce their risk factors and increase their overall stability, thus reducing their use of high dollar facilities. Texoma Community Center has already provided evidence and data with our own ACT patients showing increased support reduces hospitalizations and ER visits. The reduction of psychiatric hospitalization of these high utilizer patients from 1.8% being hospitalized in 2007 down to 0% in 2010 was in part due to the ACT team model including physical health awareness by: (1) having an RN on the case load who knows all ACT patients and regularly evaluates their physical health needs; (2) case manager's being made aware of physical health issues and supporting these clients in addressing physical health issues in addition to their psychiatric needs and then ensuring that they are transported to physical health appointments as needed. (32) The "wraparound" style of services for the ACT team has improved the psychiatric and physical health of these patients and supports the evidence that this ACT model of service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar utilization of ERs and hospitals. Having the opportunity through this Project to further broaden this style of service delivery to additional patients utilizing TCC's services would refine and enhance the cost reduction for area hospitals and improve patient outcomes, as well as overall global functioning and quality of life.

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status  
IT-10.1 Quality of life- (standalone measure)

- a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
- b. Data source: Assessment of Quality of Life Tool Data Results
- c. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this Quality Improvement project because TCC recognizes that the success of all of the other TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the other projects are expected to have on patient care and on using the data to improve outcomes. Quality of Life (QOL) and functional status are a key element in

assessing project impact results which will direct future expansion of services. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually enhancing all of the programs in the Center of which all are aimed at improving the functional abilities and Quality of Life status of the target populations served. As HHSC has identified, improving symptoms and function are two essential components of health-related quality of life. This Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

The Quality of Life/Functional Status outcome domain is appropriate for this projects because, again, mental/behavioral health is adversely impacted by physical health issues, and vice versa. Both reduce a patient's ability to function which adversely affects quality of life issues. Both physical and mental health problems negatively impact a person's independent living, relationships, sense of self-worth and lead to costly emergency treatment. By focusing on assessment of QOL and functional status, we will be able to determine the efficacy of combining primary care and behavioral health care treatment at one facility. The World Health Organization (WHO) issued a report called "Integrating mental health into primary care: A global perspective" and pointed out that by blending mental health treatment and primary care treatment, patients "avoid indirect costs associated with seeking specialist care in distant locations..... [and] integrating mental health services into primary care generates good health outcomes at reasonable costs."(33) Improving access to primary physical health while simultaneously providing mental health services will, indeed, help the low-income population served in Grayson County by TCC achieve a better quality of life, reduce high dollar hospital costs and achieve positive patient outcomes.

**Relationship to other Projects:** This project relates to expanding telehealth services (084434201.1.1), expansion of substance abuse services (084434201.1.2) , and expanding counseling services to non-priority populations (084434201.1.3) in an integral way. Adding primary physical care to a more comprehensive behavioral health treatment program will create a complete wellness opportunity for those served. Successful development and implementation of this project will be facilitated by the other projects through streamlining information exchange and collaboration between the proposed projects. This will allow for a multi-modal approach to comprehensive healthcare for unfunded, underfunded and underserved members of our community (CN.4, CN.5, CN.6, CN.11, and CN.12) which will assist in meeting the regional health care goals to improve quality of care, improve patient satisfaction, improve the health of populations, reduce the cost of health care and improve access to health care services. Integrating primary and behavioral health care facilitates preventive treatment and a reduction in more costly and inefficient repetition of services.

**Relationship to Other Performing Providers' Projects in the RHP:** The primary relationship this Project will have to the other Projects in RHP 18 is one of collaboration, sharing of data and information, and referrals as appropriate. While there are no specific TCC projects that are combined in implementation with other providers in the region, this project specifically lends itself to future collaboration as the potential to work with physical health providers blends into a holistic, patient-centered care model. Discussion has already begun with several health care providers in RHP 18, including health clinics and hospitals participating in the DSRIP service enhancement program, and a more formal collaboration is in the future. TCC will, indeed, be a part of collaboration and sharing data, knowledge and experiences with other with other stakeholders and providers in RHP 1 in order to enhance best practice models is a definite TCC goal. The need (CN.6) for additional behavioral health providers allows for service expansion, along with physical health providers, without duplicating services or even meeting the need fully.

**Plan for Learning Collaborative:** RHP 18 plans to implement a Learning Collaborative within the region. Texoma Community Center will participate in the learning collaborative meetings with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. Part of TCC's goal is to gather information and bring new knowledge back to the management table to help direct TCC's growth and expansion toward sound, cost-effective, evidence-based practices. Focus in the learning collaborative will be to identify project impacts, what has been learned from other entities, and expanding the projects to a broader patient population. In the case of this project, TCC will be expanding, learning and growing into an entirely new territory of combining physical health care with behavioral health care. Addressing key challenges will be done internally and as part of the learning collaborative within the region because TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences. It is important to look for solid solutions that are backed up by evidence-based research, especially in a new area for this center, so that positive outcomes can spread across the region.

**Project Valuation:** According the World Health Organization/Organization of Family Doctors, 2000 publication entitled Integrating Mental Health and Primary Care: A Global Perspective, the lack of coordination of treatment on a world-wide scale is regretful because: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." (34) The article also points out that: "Primary care for mental health forms a necessary part of comprehensive mental health care, as well as an essential part of general primary care. However, in isolation, it is never sufficient to meet the full spectrum of mental health needs of the population." (35) As documented in the American Journal of Psychiatry, June 1, 2008, medical costs are approaching 20% of the nation's Gross National Product, and 6.2% of those costs are directly related to mental health issues. (36) Persons with severe mental illness often have addictions, such as consuming 44% of all cigarettes smoked, that shorten their lifespan by 13 to 35 years. (37) The absence of integrated primary and medical care takes a toll on individuals, their families, their communities, and results in cost are greatly reduced if preventative medical treatment was used to avoid progression of illnesses to an acute care stage.

Approximately 40% of the people served by TCC are without a third-party payer source for medical care, leaving them to manage illnesses through expensive "band aide" treatment in emergency rooms. (38) Additionally, many of the people receiving psychiatric services are placed on powerful psychotropic medications, and are at risk for adverse effects. Although the psychiatric staff do a good job in screening for critical conditions, such as pulmonary and circulatory problems, it is the absence of preventative or stabilizing primary medical care that prompts emergency room visits and hospital care at its highest cost end. TCC's employment of primary medical care staff to treat the most medically "at risk" individuals will create a community value that by far exceeds its cost.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** The following resources were instrumental in supporting this valuation methodology. One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained. **(9g)** Likewise, Dewa et al. (2009) found that collaborative care saved \$503 per patient in disability benefits. **(9h)** Two additional studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. **(9e)** Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. **(9f)** The average of these two values is 0.11135. The project value is \$441,259.00 and the project is expected to benefit a minimum of 47 people in the region.

084434201.2.1	2.19.2	2.19.2.A.C.D.F.G.H	DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS	
Texoma Community Center			084434201	
OD-10	IT-10.3	P-1, P-2, P-3, P-5	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)	
<b>Milestone 1: P-2</b> Identify 3 community agencies that have relevant data to identify the service utilization patterns of persons with co-occurring disorders. <b>P-2.1. Metric-</b> List relevant agencies and the data elements each has available. <b>Data Source:</b> Records of lead organization <b>Milestone 1 Estimated Incentive Payment:</b> <b>\$50,052.00</b>  <b>Milestone 2: P-5</b> BH case managers are identified & trained for blended care coordination for “at risk” patients with co-occurring mental/physical health needs. <b>P-5.1 Metric:</b> Number of staff identified with the capacity to support the target population will be determined after number of “at risk” patients in mental health program is known.	<b>Milestone 3: P-6</b> Care coordination protocols are developed. <b>P-6.1 Metric -</b> Written protocols are in place and easily available to staff. <b>Data Source:</b> Written protocols <b>Milestone 3 Estimated Incentive Payment:</b> <b>\$54,966.00</b>  <b>Milestone 4: P-8</b> 1 physician, 1 nurse, and 1 clerical staff are hired, trained & providing services. <b>P-8.1 Metric:</b> Percent of staff hired/trained/working. <b>Baseline:</b> zero staff hired/trained <b>Goal:</b> 100% staff hired/ trained <b>Data Source:</b> HR records/Training records  <b>Milestone 4 Estimated Incentive Payment:</b> <b>\$54,965.00</b>	<b>Milestone 5: I-21</b> -Increase use of routine preventive and primary care by 5% for identified “at risk” patients. <b>I-21.1 Metric -</b> 5% increase in routine visits <b>Baseline:</b> zero routine visits <b>Goal:</b> 5%+ increase in routine visits <b>Data Source:</b> Encounter/claims data <b>Milestone 5 Estimated Incentive Payment:</b> <b>\$117,599.00</b>	<b>Milestone 6: I-21</b> --Increase use of routine preventive and primary care by 10% for identified “at risk” patients. <b>I-21.1 Metric -</b> 10% increase in routine visits <b>Baseline:</b> zero routine visits <b>Goal:</b> 10%+ increase in routine visits <b>Data Source:</b> Encounter/claims data <b>Milestone 6 Estimated Incentive Payment:</b> <b>\$113,625.00</b>	

084434201.2.1	2.19.2	2.19.2.A.C.D.F.G.H	DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS	
Texoma Community Center			084434201	
OD-10	IT-10.3	P-1, P-2, P-3, P-5	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 Source: Staff rosters and documents of caseloads/training rosters.  Milestone 2 Estimated Incentive Payment: \$50,052.00				
Year 2 Estimated Milestone Bundle Amount: \$100,104.00	Year 3 Estimated Milestone Bundle Amount: \$109,931.00	Year 4 Estimated Milestone Bundle Amount: \$117,599.00	Year 5 Estimated Milestone Bundle Amount: \$113,625.00	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 441,259.00				



## **PASS 2**

### **CATEGORY 2**

Three Pass 1 participating providers have submitted projects in Category 2 for Pass 2 of the planning process:

- One from LifePath Systems
- One from Texoma Community Center
- One from Lakes Regional MHMR.

## **SUMMARY PAGE: LifePath Systems: Pass 2 Category 2 Project/084001901.2.2**

**Provider:** LifePath Systems is the non-profit community center for Collin County. Collin County encompasses 886 square miles, has a population of 840,000 and is one of the fastest growing counties in the United States. LifePath Systems staff provide behavioral health treatment for individuals with mental illnesses and support services for individuals with intellectual or developmental disabilities.

**Intervention(s):** This project will provide targeted behavioral health interventions to three identified populations in Collin County. Individuals with mental health &/or substance abuse needs who are involved in the new Mental Health or Veterans Courts will receive intensive field-based services. Young children who have been abused or neglected, yet remain in the home with the perpetrator, will receive intensive field-based family counseling. Individuals with a dual diagnosis of intellectual or development disability along with a mental illness will receive specialized behavioral health services.

**Need for the project:** Collin County does not currently have a jail diversion program. The creation of the Mental Health and Veterans Courts allows for an opportunity to divert those identified individuals from jail by receiving appropriate community-based services. However, there is currently no funding for this project. Additionally, young children who have been abused or neglected yet remain in the home with the perpetrator are not currently eligible for services through Child Protective Services. Finally, there is a high need for experienced psychiatric providers for those with dual MR/BH diagnoses. It is currently very difficult to find a Medicaid provider who will agree to serve this population.

**Target population:** The target population includes those individuals in Collin County with a mental illness or substance use disorder who are involved in the Mental Health or Veterans Courts. We plan to serve at least 90 individuals in this jail diversion program by demonstration year 5. We plan to serve at least 170 young children referred by Child Protective Services by demonstration year 5. We plan to serve at least 105 individuals with intellectual or developmental disability along with a mental illness by demonstration year 5.

**Category 1 expected patient benefits:** The project seeks to provide behavioral health care to 3 groups of the Collin County population who are currently not able to access specialized behavioral health services. We plan to serve both Medicaid and indigent individuals in these projects.

**Category 3 outcomes:** IT-9.1 Our goal is to decrease mental health admissions and readmissions to the criminal justice and Child Protective Services settings.

**Title of project:** Intervention for Targeted BH Population to Prevent Unnecessary Use of Higher LOC

**Unique RHP Project Identification Number:** 084001901.2.2

**Performing Provider name/TPI:** LifePath Systems/084001901

## **Project Description**

The goal of this project is to provide specialized services to targeted populations who have complex and severe behavioral health needs.

One group is comprised of individuals with mental health/substance abuse treatment needs who are involved in the newly established Mental Health and Veterans Courts in Collin County. It has been recognized that some individuals in the court system may be successful in the community if given adequate behavioral supports. A Forensic Assertive Community Treatment (FACT) team combines behavioral health treatment, rehabilitation, and supportive services in a self-contained clinical team made up of a mix of disciplines including psychiatry, nursing, addiction counseling, and vocational rehabilitation. The team provides intensive services in the community and focuses on 1) preventing arrest and incarceration, 2) preventing psychiatric hospitalization, 3) and accepting the majority of referrals from criminal justice agencies. Recent studies on Forensic Assertive Community Treatment teams have shown a significant reduction in jail days, arrests, hospital days, and an associated reduction in jail and hospital costs for individuals receiving FACT services. It is expected that as a result of immediate access to this intensive level of field-based services, 1) individuals being released or diverted from jail with mental health needs will stabilize rapidly due to the increased effort of a FACT team to bring the services to the client and 2) recidivism rates for this population will be reduced, thereby reducing the costs to the criminal justice system and the county. After stabilization on the FACT team and the resolution of the criminal justice involvement, individuals will be stepped down into lower levels of care in the existing behavioral health clinics. This project would ensure access to care for all identified individuals in these diversion programs. We plan to serve at least 20 clients by year 3 in this intensive field based service. We plan to increase this number served to 30 in year 4 and 40 individuals in year 5, for a total of at least 90 individuals during the 4 year period.

The second target group are young children who have been abused or neglected but remain in the home. Of the 718 child abuse reports a day in Texas, over half stay in the home with a majority of the perpetrators being parents. Family Counseling is not available to these individuals through Child Protective Services. The long term consequences for the child if treatment (primarily counseling) is not provided is significant on both physical and psychological health. This project would provide in-home counseling for those identified in this target population. Expected outcomes include an improvement in functioning level of the child and family with associated reduction of new reports to CPS for those individuals served. We plan to serve at least 50 children in year 3. The number of children served will increase by 20% each year, resulting in 60 served in year 4 and 72 served in year 5 with a minimum of 170 total children served at the end of year 5.

The final target group is individuals with a dual diagnosis of intellectual or developmental disability (IDD) along with mental illness diagnosis. The project will add qualified clinical staff to provide services for this underserved population. A psychiatrist who has access to specialized training for working with

individuals with this dual diagnosis will be provided along with a psychiatric registered nurse for medication monitoring and provision of injectable medications. Additionally, the evidenced-based practice of Applied Behavior Analysis (ABA), which includes interventions based on the principles of learning and motivation, will be used to significantly improve behaviors and reduce the severity of the symptoms associated with both diagnoses. We plan to serve at least 25 clients by year 3 in this specialized service program. We plan to increase this number served to 35 in year 4 and 45 individuals in year 5, for a total of at least 105 individuals during the 4 year period. It is expected that services will be intensive for the first 6-12 months of treatment and then once stabilized, individuals will be stepped down from ABA to psychiatric services only.

### **Starting Point/Baseline**

The Mental Health and Veterans Courts are newly established in Collin County, therefore we do not currently have a FACT team, we do not serve infant/young children who are abused/neglected and remain in the home, and we do not have specialized IDD/BH services available, therefore the baseline is 0.

### **Rationale**

The project option of targeting behavioral health services to individuals with complex needs has been selected as a priority for our region due to the identified high need of access to behavioral health care in our area. Inadequate access to specialty behavioral health care has contributed to the limited scope and size of the safety net health system in our region. To achieve success as an integrated network, these gaps must be assessed and addressed.

This project will design, implement, and evaluate research supported and evidence based interventions tailored towards individuals in our identified target populations.

Essential project components include:

- Assess size, characteristics and needs of target populations (jail diversion for veterans and the seriously mentally ill, abused or neglected infants/young children, and dually diagnosed IDD/BH population);
- Review literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric treatment, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes/quality of life.
- Develop a project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- Design models which include an appropriate range of community-based services and residential supports.
- Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA); medical, prescription

drug and claims/encounter records; participant surveys; provider surveys. Identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

The unique community needs identification numbers the project addresses are CN.11 (Behavioral Health) and CN.6 (Health Professions Shortage).

Currently, individuals who need behavioral health services in the NorthSTAR area must meet strict clinical and financial eligibility criteria in order to gain access to outpatient behavioral health care. These access requirements present a barrier to individuals with complex behavioral health needs who are involved in the criminal justice setting. Additionally, NorthSTAR’s open access also has had an unintended consequence of certain services (for example jail diversion, veterans services, mobile crisis team, supported housing, after hours clinics) being centralized in Dallas County rather than distributed more evenly throughout the region. To further complicate matters, if an individual is incarcerated during care, NorthSTAR will no longer cover behavioral health services for the individual, thereby disrupting the continuity of care for this population.

Access to specialized behavioral health care for individuals with a dual diagnosis of IDD/BH has barriers associated with it due to the lack of experienced and trained providers in our area. Individuals with a mental retardation or autism spectrum diagnosis often experience difficulty accessing physical and behavioral health services due to a scarcity of providers who accept Medicaid. If a provider can be located, there is often a lack of providers across funding sources who are formally trained to treat individuals with IDD/BH diagnoses. When individuals do receive services, they tend to receive assistance later in the course of the disease process and tend to receive medication for sedating purposes and not in accordance with the individual’s mental illness. Additionally, NorthSTAR will not cover psychiatric services for individuals who have behaviors that are directly related to the mental retardation or autism diagnosis.

### **Related Category 3 Outcome Measure**

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) has been chosen as the outcome measure for this project.

This outcome has been chosen as an appropriate measure for this project due to the fact that a majority of the referrals into this project will come from the criminal justice setting (i.e. the Mental Health and Veterans Courts or Child Protective Services). Reducing the strains placed on the criminal justice system by an increasing number of individuals with behavioral health needs will assist our RHP in managing costs and improving access to care.

An evidenced based treatment for individuals with complex behavioral health disorders and high needs is the Assertive Community Treatment team (ACT). This project will utilize this evidenced based treatment on a forensic/criminal justice population.

Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, and 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 or low income and high risk populations.

### **Relationship to other Projects**

In addition to the intensive services available to these target populations identified in this project, these individuals will also have access to primary health care as part of their behavioral health treatment through LifePath's project 084001901.2.1 - Integrated Primary and Behavioral Health Care. Access to basic health care will assist this project in being successful in reducing use of higher levels of care not only due to behavioral health crises, but also physical health issues.

**Relationship to Other Performing Providers' Projects in the RHP** Not applicable

### **Plan for Learning Collaborative**

As in other projects, LifePath Systems staff will participate in the RHP 18 Learning Collaborative.

**Project Valuation** The approaches for valuing this project are a cost-utility analysis and a cost effectiveness/cost savings model. Cost-utility analysis provides a standard way of valuing multiple types of interventions and programs. In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added. Benefits of a proposed program are then valued based on assigning a monetary value of \$50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. Based on the research referenced in the paper, "Valuing the Youth Counseling Program" by Brown, Alamgir, & Bohman, an average of .07725 quality-adjusted life years (QALYs) is gained by providing counseling services to an at-risk youth population. We plan to serve at least 170 children over the 4 years of this project.

$170 \text{ children} \times .07725 \text{ QALYs} \times \$50,000 = \$656,625 \text{ in valuation}$

In the paper, "Valuing the Community Behavior Support Program," researchers compared the cost-effectiveness of access to specialized behavioral health care for individuals with a dual diagnosis of IDD/BH to the cost savings of ACT services. Research examining the cost-effectiveness of ACT versus standard care and found that the overall average cost per ACT client was \$15,732 less than the cost per client for treatment as usual. Valuing the dual diagnosis IDD/BH treatment program with and expectation of serving at least 105 individuals results in the following valuation:

$105 \text{ individuals} \times \$15,732 = \$1,651,860 \text{ in valuation}$

Cost-savings studies for jail diversion for persons with mental and behavioral issues show an average of \$3.18 benefit value for each dollar spent, according to Brown, Alamagir, & Bohman in their paper "Valuing the Jail Diversion Program". This project has an annual jail diversion budget of \$647,424 per year for a total of 4 years.

$\$3.18 \times \$804,983 \times 4 \text{ years} = \$10,239,383 \text{ in valuation}$

Additionally, Brown, Alamagir, & Bohman reported in their paper, "Valuing the Expansion of Crisis Intervention Project", intensive wraparound services add an average of .335 quality-adjusted life-years

(QALYs) to each individual served. We plan on providing intensive wraparound services (FACT team services) to a minimum of 260 individuals during the 4 years of this project

$270 \text{ individuals} \times .335 \text{ QALYs} \times \$50,000 = \$4,355,000$  in valuation

The total valuation for this project is estimated at \$16,902,868.

## **References**

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Youth Counseling Program.

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Jail Diversion Program.

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Expansion of Crisis Intervention Project.

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Community Behavior Support (CBS) Program.

<b>UNIQUE CATEGORY 2 PROJECT IDENTIFIER:</b> 084001901.2.2	<b>PROJECT OPTION:</b> 2.13.1	<b>PROJECT COMPONENTS: 2.13.1</b> A, B, C, D, E	<b>PROJECT TITLE: INTERVENTION FOR TARGETED BH POPULATION TO PREVENT UNNECESSARY USE OF HIGHER LOC</b>	
<b>Performing Provider: LifePath Systems</b>				<b>TPI: 084001901</b>
<b>Related Category 3 Outcome Measure: OD- 9 Right Care, Right Setting</b>	<b>Unique Category 3 IT identifier: IT-9.1</b>	<b>Reference number from RHP PP:</b> 084001901.3.3	<b>Outcome Measure (Improvement Target) Title: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Standalone measure)</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>Milestone 1 [2.13.1.P-1]: Conduct needs assessment of complex behavioral health populations in the targeted groups who are frequent users of community public health and criminal justice resources.</p> <p>Metric 1 [2.13.1.P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, criminal justice utilization</p> <p>Baseline/Goal: Completion of needs assessment</p> <p>Data Source: Project documentation; Inpatient, discharge and ED records; State psychiatric facility records; survey of stakeholders (inpatient providers, mental health providers, social services, criminal justice, and Child Protective Services); literature review</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>):</p>	<p>Milestone 3 [2.13.1.P-3]: Enroll and serve individuals with targeted complex needs.</p> <p>Metric 1 [2.13.1.P-3.1]: Number of targeted individuals enrolled/served in the project.</p> <p>Baseline/Goal: Counseling: baseline=0 / goal=25 FACT team: baseline=0 / goal=10 IDD/BH: baseline=0 / goal = 10</p> <p>Data Source: Project documentation</p> <p>Milestone 3 Estimated Incentive Payment: \$1,986,040</p> <p>Milestone 4 [2.13.1.P-3]: Enroll and serve individuals with targeted complex needs.</p> <p>Metric 1 [2.13.1.P-3.1]: Number of targeted individuals enrolled/served in the project.</p> <p>Baseline/Goal: Counseling: baseline=0 / goal=50</p>	<p><b>Milestone 5 [2.13.1.I-5]: Improved Functional Status</b></p> <p>Metric 1 [2.13.1.I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) Numerator: The percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. Denominator: The number of individuals receiving specialized interventions.</p> <p>Goal: at least 20% of individuals served demonstrate an improved assessment score</p> <p>Data Source: Standardized functional assessment instruments (e.g. ANSA, CANS, etc.)</p> <p>Milestone 5 Estimated Incentive Payment: \$1,993,507</p>	<p>Milestone 7 [2.13.1.P-3]: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness &amp;/or substance abuse who is involved in the Mental Health or Veteran's Court or abused/neglected children involved with Child Protective Services).</p> <p>Metric 1 [2.13.1.P-3.1]: Number of targeted individuals enrolled/served in the project.</p> <p>Goal: Family Counseling = 140 FACT team = 75</p> <p>Data Source: Project documentation</p> <p>Milestone 7 Estimated Incentive Payment: \$1,772,006</p> <p>Milestone 8 [2.13.1.P-3]: Enroll and serve individuals with targeted complex needs.</p> <p>Metric 1 [2.13.1.P-3.1]: Number of targeted individuals enrolled/served in the project.</p>	



<b>UNIQUE CATEGORY 2 PROJECT IDENTIFIER:</b> 084001901.2.2	<b>PROJECT OPTION:</b> 2.13.1	<b>PROJECT COMPONENTS: 2.13.1</b> A, B, C, D, E	<b>PROJECT TITLE: INTERVENTION FOR TARGETED BH POPULATION TO PREVENT UNNECESSARY USE OF HIGHER LOC</b>	
<b>Performing Provider: LifePath Systems</b>				<b>TPI: 084001901</b>
<b>Related Category 3 Outcome Measure: OD- 9 Right Care, Right Setting</b>	<b>Unique Category 3 IT identifier: IT-9.1</b>	<b>Reference number from RHP PP:</b> 084001901.3.3	<b>Outcome Measure (Improvement Target) Title: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Standalone measure)</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
\$1,659,182  Milestone 2 [2.13.1.P-2]: Design community-based specialized interventions for target populations. Interventions may include (but are not limited to) Assertive Community Treatment Teams, ABA, and Family Counseling  Metric 1 [2.13.1.P-2.1]: Project plans which are based on evidence/experience and which address the project goals  Baseline/Goal: Completion of project plans  Data Source: Project documentation  Milestone 2 Estimated Incentive Payment (maximum amount): \$1,659,181		FACT team: baseline=0 / goal=20 IDD/BH: baseline=0 / goal = 25  Data Source: Project documentation  Milestone 4 Estimated Incentive Payment: \$1,986,041	Milestone 6 [2.13.1.P-3]: Enroll and serve individuals with targeted complex needs.  Metric 1 [2.13.1.P-3.1]: Number of targeted individuals enrolled/served in the project.  Goal: Counseling = 110 FACT team = 50 IDD/BH = 55  Data Source: Project documentation  Milestone 6 Estimated Incentive Payment: \$1,993,507	Goal: Counseling = 170 FACT team = 90 IDD/BH = 105  Data Source: Project documentation  Milestone 8 Estimated Incentive Payment: \$1,772,006
<b>Year 2 Estimated Milestone Bundle Amount: \$3,318,363</b>		<b>Year 3 Estimated Milestone Bundle Amount: \$3,972,081</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$3,987,014</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$3,544,012</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$14,821,470</b>				

## **SUMMARY PAGE: Texoma Community Center: Pass 2 Category 2 Project/084434201.2.2**

**Provider Description:** Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County which has a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics treating over 1,200 adults, children, and families ranging in age from zero to death. Staff provide an average of 10,226 face to face patient contacts per month. Less than 1% of TCC's patients have private insurance, between 38% and 40% have Medicaid on average and 88.05% of children and 81.34% of adult patients are at or below the federal poverty level.

**Interventions:** This project is going to: "Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population," and represents both new initiatives and expanded current services for Texoma Community Center. The goals are to develop and provide a comprehensive treatment modality that includes twelve different community-based intervention options to substantially stabilize the mentally ill, functionally impaired and homeless individuals in Grayson County in order to reduce unnecessary use of emergency departments, physical and psychiatric hospitals and the criminal justice system. TCC has an excellent track record in accomplishing these type of goals already, as outlined in the project narrative. TCC is poised to expand these outcome successes exponentially with this extensive project. The treatment components will be integrated into a SAMHSA-guided toolkit for permanent supported housing with all other components acting as a "Wraparound" style of comprehensive interventions based on individual patient need.

**Need for the Project:** TCC selected this project to address a growing community problem of homelessness among mentally ill individuals. The county population is growing and there is a significant need to address a broader patient base with more severe functional impairments. The goal is to comprehensively meet a full spectrum of needs for mentally ill patients in Grayson County. Grayson County is identified by HRSA as an underserved behavioral health provider area (1c) and therefore, this project is essential to stabilize and improve additional mentally ill, homeless and/or "at-risk" individuals.

**Target Population:** Project 084434201.2.2 targets Medicaid eligible and indigent individuals with mental illness, challenging functional impairments and significant community needs.

**Category 2 Expected Patient Benefits:** Project 084434201.2.2 will provide comprehensive community-based interventions as outlined in the narrative for between 1,380 and 3,148 mentally ill homeless individuals between DY 3 and DY 5 who exhibit functional status improvements of 5% in DY 4 and 10% in DY 5.

**Category 3 Outcomes:** The quality improvement outcome for this project is to significantly reduce crisis events and emergency room visits by the homeless and/or functionally-impaired mentally ill with outcome targets to be determined in DY 2.

**Title of Project:** Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.).  
**Unique RHP Project Identification number:** 084434201.2.2  
**Provider:** Texoma Community Center/084434201

**Project Option:** 2.13.1 -- Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

Required core components:

- a) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. 201 Lewis, D., Corporation for Supportive Housing, Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010.) Retrieved from <http://www.caction.org/homeless/documents/AustinModelPresentation.pdf>. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
- b) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes/quality of life.
- c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- d) Design models which include an appropriate range of community-based services and residential supports.
- e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

**Project Goal:** Texoma Community Center (TCC) will provide specialized services to complex behavioral health populations, specifically people in Grayson County, Texas, with severe mental illnesses and/or a combination of behavioral and physical health issues in order to avert potentially avoidable inpatient admissions and readmissions to a more restrictive and expensive setting such as acute and/or psychiatric hospitals or the criminal justice system. The goal is to proactively promote wellness, medication compliance, improved functioning and recovery. TCC recognizes that the required core components will facilitate success. Therefore, the target population size, characteristics and needs will be assessed, a relative literature review will be conducted and a project evaluation plan will be developed that utilizes both qualitative and quantitative metrics. The outcome goals will be accomplished by developing and providing a comprehensive treatment modality that includes but is not limited to the following community-based interventions tailored to meet a patient’s needs: (1) Integrated medical and psychiatric care; (2) Assisted living; (3) Psychosocial Rehabilitation; (4) Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens, etc; (5) Transportation to appointments and community-based activities; (6) Specialized

behavioral therapies such as Cognitive Behavioral Therapy (an empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking) or Cognitive Processing Therapy (an empirically supported treatment developed by the Veterans Administration that focuses on recovery from trauma-based injuries such as Post-Traumatic Stress Disorder and other related conditions); (7) Prescription medications; (8) Peer support service that models successful health and mental health behaviors provided by peer specialists who are in recovery from mental illness or substance use disorders and are supervised by mental health professionals; (9) Respite care (short term); (10) Substance abuse services; and (11) Employment supports. These treatment components will be integrated into a system guided by the SAMHSA evidence-based toolkit for permanent supported housing. (1) The primary goal is to significantly expand and enhance the assisted living and respite care facility in order to divert mentally ill individuals in this region who are homeless and in crisis from high-cost, publicly-funded systems. As evidenced by the following chart outlining TCC internal data (see reference 5), TCC's original 16 bed contracted facility has been extraordinarily successful in accomplishing previous diversion goals. The intent is to broaden the scope of these services to facilitate the regional goals. The impact of the interventions will be assessed relative to the target population using research-based criteria.

TCC will develop initiatives based on process improvement methodologies related to rapid communication, integrated system workflows, providing data to providers and patients, eliminating waste, enhancing provider performance and improving patient-centered care. TCC will use protocols and tools presented in the RHP Planning Protocol Manual (p. 301) designed to identify project impacts, and understand what "lessons have been learned" in order to "solve key challenges that address the special considerations for these target populations. (2)

TCC will accomplish the core components by coordinating with stakeholders in the community impacted by this population. TCC will provide the required training and education to staff on the component elements to facilitate patient recovery. TCC will continue to address issues of safety, quality, and efficiency through continuous quality improvement. This will contribute to the overarching regional (RHP 18) goals of improving quality of patient care, reducing the cost of health care, and enhancing access to health services while improving preventive care. (RHP 18 Anchor Plan) TCC recognizes that project success requires essential quality improvement elements such as being open to change, problem solving, soliciting stakeholder feedback and engaging in continuous monitoring of performance in order to report and use those findings to direct and improve services.

The expected five-year outcome is to have a thriving, adaptive, well-organized, evidenced-based, comprehensive program that provides both transitional services from homelessness or crisis to independent living as well as supported assistive living for those in the community with more profound disabilities. This program will allow for the greatest measure of independence and self-direction possible for each individual. It is also expected that in five years the program will reduce health care costs, incarcerations and produce significant positive outcomes for the target populations. (CN.1, CN.5, CN.6, CN.7, CN.11, CN.12).

**Starting Point/Baseline:** While TCC continuously provides appropriate interventions for patients with severe and persistent mental illness and has diligently worked to stabilize behavioral health patients in order to reduce hospitalizations and emergency department visits and increase recovery, it is recognized that expanding and refining these efforts will have a much greater positive impact on community health resources. Utilizing Quality Improvement process tools along with expanded intervention strategies will lay the foundation for a project baseline to be established in DY 2.

**Rationale:** TCC selected this project in order to impact the homeless mentally ill (target population) in Grayson County, Texas and expand positive interventions across the region to further reduce unnecessary use of more expensive health services. TCC is starting this project with an established "track record" of stabilizing high-utilizer patients in the area's medical community. The following "look back" at what

TCC has accomplished during the past six years is only to exemplify what can be accomplished if these efforts are refined and expanded to a regional level. Since 2006, TCC's management team has made comprehensive changes through an on-going process of consistent communication with patients and staff, soliciting stakeholder feedback and through use of solutions-focused problem-solving responses. The changes and collaborations had a significant impact on improving the Center's financial stability and contributed to positive outcomes. TCC intends to continue this improvement by expanding the intervention base, improving the range of community-based services and by engaging in performance improvement to reduce inefficiencies, waste, and barriers.

The first major change occurred with the Assertive Community Treatment Program (ACT) for those with the most severe and persistent mental illness. The result was a reduction of average psychiatric hospitalizations for this discreet population over a four-year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. (3) Also, other "high utilizer" patients are in TCC's out-patient psychosocial rehabilitation program. This group showed a reduction in crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, to 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (4) The following table exemplifies how TCC already has expertise in reducing costs while improving services and TCC is poised to continue these accomplishments as shown below.

	FY06	FY 07	FY 08	FY 09	FY 10	FY 11	%
MEDICATION COSTS	\$905,652	\$191,491	\$152,257	\$132,072	\$93,355	\$72,511	-92%
HOSPITAL COSTS	\$346,530	\$126,575	\$64,929	\$40,197	\$18,375	\$12,600	-97%
OUTREACH EFFORTS	Began jail diversion; began med formulary	Began mobile crisis team & CRU; trained Judges; ↑PAP	Mental Health Court in 1 county	Drug Court involvement & enhanced community training	Began telemed services in all counties & in 1 jail	Continued outreach efforts & trainings	

(5)

Medication costs were reduced by addressing prescribing practices and adhering to a medication formulary and by aggressively pursuing Patient Assistance Program medications. This improvement trend has continued into 2012. Increased intervention by the Mobile Crisis Outreach Team (MCOT) in the five area emergency departments (EDs) has resulted in more appropriate dispositions of crisis events and fewer overall hospitalizations. There was a critical need in the community for an alternative to hospitalization for individuals in crisis but who did not REQUIRE hospitalization. It was determined that a 16-bed crisis residential unit (CRU) would be the most cost-effective option for TCC and this was implemented in 2007. When the TCC Crisis Team is called for an assessment, local psychiatric hospitalizations were dramatically reduced. It is important to note, that an identified barrier to hospital cost reduction was the need to educate local ED doctors to allow TCC crisis staff to make the outcome determination during a crisis. Internal data showed that when ED doctors dictated the outcome as was done prior to 2007, hospitalizations were excessive, but when TCC crisis staff made the determination for the least restrictive environment (LRE), patients were effectively stabilized in less costly environments, with continued follow up, and no increase in negative patient outcomes. This collaborative initiative resulted in state-funded local hospital costs being reduced to zero for the past 18 months. (6) The TCC internal data is consistent with research conducted by Scott (2000) who stated: ".....patients using MCOT

versus normal care were 27 percentage points less likely to be hospitalized and had \$443 lower expenses.” (9c) The “2012 County Health Rankings” shows that Grayson County residents have “5.8 poor mental health days” compared to the Texas average of “3.3 poor mental health days.” (CN.4, CN.5, CN.6).” Furthermore, Grayson County shows to have identified “73 preventable hospital stays, compared to the national average of 49 hospital stays.”(7) Reducing just 5% or 10% of these preventable hospital stays will have a significant positive impact on health care costs in this region.

As demonstrated above, enhancing the intervention strategies to the target populations, as well as refining quality improvement and data management strategies, will significantly enhance health transformation goals to reduce high dollar hospitalizations and incarcerations. This enhancement is essential to continue TCC intervention endeavors, support the regional goals, and address the identified regional needs (CN.4, CN.5, CN.6, CN.11, and CN.12).

**Related Category 3 Outcome Measure(s):** OD-9 Right Care, Right Setting; IT-9.2 ED Appropriate utilization (standalone measure)

d. Reduce Emergency Department visits for target conditions

- Behavioral Health//substance Abuse

The Right Care, Right Setting Outcome Domain was selected by TCC in order assess service delivery impact specific to target population who are individuals with mental illness, emotional disturbance and substance abuse issues who live within the region. This Project will exemplify the impact that interventions have in relation to reducing emergency department visits, incarcerations and hospitalizations for the patients served. It is recognized that positive improvement requires relentless focus on patient outcomes.

While the Right Care, Right Setting Domain seems to be a simple and single evaluation focus, directing attention and tracking the data for related hospitalizations and incarcerations will provide a more complete picture of the intervention impact on the behavioral health status of Grayson county’s low-income population. Focus on tracking the reduction in hospitalizations is particularly important in reducing overall health-related costs. Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment if they lack health insurance and tend to use the ED as a primary care clinic for minor medical issues. They also are often incarcerated for minor infractions that do not occur when they are kept stable in adequate housing. With dedicated intervention strategies such as those described in this project, TCC will be able to focus on tracking, assessing and reducing emergency department use, hospitalizations, incarcerations and urgent care use. This focus will help accomplish the desired Category 3 goals for this underserved area (CN.5, CN.6, CN.11).

**Relationship to other Projects:** This intervention project will contribute data relative to other projects submitted by TCC for health care transformation. Community –based interventions designed to stabilize additional low-income, mentally ill individuals in this region will impact the success of ALL other Pass 1 TCC projects (084434201.1.1, 084434201.1.2, 084434201.1.3, 084434201.2.1) as well as reduce health care costs and further regional health care goals.

**Relationship to Other Performing Providers’ Projects in the RHP:** Several performing providers in this region are expanding their intervention strategies, therefore, collaborating on experiences and processes will improve all outcomes. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 18 is a definite TCC goal. Lakes Regional MHMR Center and LifePath Center plan to expand behavioral health care within this region so it is expected that strategy-sharing, data sharing and collaboration will occur. The need for behavioral health providers and additional

services (CN.6) allows for all RHP 18 LMHA's to expand behavioral health services without duplicating services or even fully meeting the need.

**Plan for Learning Collaborative:** The RHP 18 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. TCC will participate in the learning collaborative meetings in order to share knowledge, experience and outcomes across the region for quality improvement purposes. TCC will share expansion experiences as well as bring learned information back to the management table to help direct future growth toward even more cost-effective, evidence-based practices to further reduce health care costs.

**Project Valuation:** Providing community-based interventions for the targeted health population is consistent with the U.S. Department of Health and Human Services' objective to "Reduce the growth of healthcare costs while promoting high-value effective care. "(8) Providing stabilizing services to a broader patient population who have severe and persistent mental illness will reduce high-cost hospital or jail interventions and save the health-care resources within the region. TCC recognize that: "From the perspective of a service provider or program manager, quality ensures effectiveness and efficiency. Quality and access are the keys to improving the mental health population and for ensuring value for money expended with accountability." (9)

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are value based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A cost-utility analysis by Holtgrave, (2012) was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is \$62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life. (9a, 9b) A study by Jones, et. al. (2003) show that participants receiving the critical care intervention had 58 fewer homeless nights, compared with standard treatment participants. A night of homelessness was valued at \$152.00 using a societal perspective which results in a value gain of \$8,816 per participant. (9j) For supportive housing, Larimer, et. al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost offset of \$2,449 per month per individual. (9k) Utilizing this methodology, this project's value will be \$5,100,000.00 and benefit a minimum of 3,148 (1,000 per year) low-income individuals in this region who will receive combination of recommended community-based interventions depending on individual need during DY3, DY4 and DY5.

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).			
Texoma Community Center					084434201	
Related Category 3 Outcome Measure(s): OD-9		084434201.3.6	IT-9	ED appropriate utilization (Standalone measure)		
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)		Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-2 Design community-based specialized interventions for target populations, including significantly expanded respite & residential facility with following interventions included: Assisted living; Psychosocial rehabilitation; supported employment; transition assistance; transportation options; specialized behavioral therapies; prescription medications; peer support; respite care; substance abuse services, crisis services & respite. P-2.1. Metric- Project plans which are based on evidence/experience, interventions, including staff hired and in place, and needs identified which address the project goals Data Source: Project Documentation, HR records, Expansion Plan records.  Milestone 1 Estimated Incentive Payment (maximum amount): \$1,020,655.00		Milestone 2: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric – Residential/respite facility secured. Baseline: Current 16 bed facility in place. Goal: Minimum 8 additional bed spaces secured. Data Source: Related financial documents/lease agreements/contracts in place.		Milestone 4: I-5 Functional Status P-4.1 Metric - 20% of individuals receiving specialized interventions demonstrate improved functional status on ANSA assessment Baseline: zero improved individuals Numerator: Percent of individuals receiving specialized interventions demonstrating improvement from baseline on functional assessment. Denominator: The number of individuals receiving specialized interventions  Data Source: ANSA scores for target population  Milestone 4 Estimated Incentive Payment (maximum		Milestone 5: I-5 – Functional Status P-5.1Metric - 30% of individuals receiving specialized interventions demonstrate improved functional status on ANSA assessment Baseline: zero improved individuals Numerator: Percent of individuals receiving specialized interventions demonstrating improvement from baseline on functional assessment. Denominator: The number of individuals receiving specialized interventions  Data Source: ANSA scores for target population  Milestone 5 Estimated Incentive Payment (maximum



084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).			
Texoma Community Center			084434201			
Related Category 3 Outcome Measure(s): OD-9		084434201.3.6	IT-9	ED appropriate utilization (Standalone measure)		
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
		P-3.2 Metric –Number of targeted individuals enrolled / services in the project.  Data Source: Project documentation/encounter data. Milestone 2 Estimated Incentive Payment (maximum amount): \$560,410.00  Milestone 3: P-4- Evaluate and continuously improve interventions P-4.1 Metric – Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Data Source: Project reports including examples of how real- time data is used for rapid-cycle improvement to guide continuous		amount): \$1,199,021.00	amount): \$1,158,420.00	

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).		
Texoma Community Center			084434201		
Related Category 3 Outcome Measure(s): OD-9		084434201.3.6	IT-9	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)
	quality  Milestone 3 Estimated Incentive Payment (maximum amount): \$560,410.00				
Year 2 Estimated Milestone Bundle Amount: \$1,020,655.00	Year 3 Estimated Milestone Bundle Amount: \$1,120,820.00		Year 4 Estimated Milestone Bundle Amount: \$1,199,021.00	Year 5 Estimated Milestone Bundle Amount: \$1,158,420.00	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$4,498,916.00					

## **SUMMARY PAGE: Lakes Regional MHMR Pass 2 Category 1 Project/121988304.2.1**

**Project Name:** 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting.-- (Lakes Regional MHMR Center In SHAPE Project)

**Unique Project Identifier:** 121988304.2.1

**Provider Name:** Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays.

Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year. Over 95% of our consumers are either Medicaid eligible or indigent.

**Intervention(s):** This project will implement a research supported physical health and nutrition awareness and improvement program for individuals with medication stabilized schizophrenia. The program In SHAPE has been demonstrated to provide substantial increases in health and quality of life in the population through individualized health action plans under the guidance of a Health Mentor.

**Need for the project:** The effects of antipsychotic medications is a devastating weight gain that results in major cardiovascular and endocrine system problems in a majority of individuals treated. These life altering and in many life threatening side effects compound the difficulties of those in treatment in self-esteem and social inclusion. It is incumbent upon the systems that treat with these medications to do what is possible to manage these effects. This project is focused on the expansion of behavioral health services into health and wellness services for the target population (low income individuals with Schizophrenia related disorders of Rockwall County).

**Target population:** The target population are clients needing specialty services for improving personal physical health and nutrition through semi-weekly guidance consults. Approximately 95% of our patients are either Medicaid eligible or indigent.

**Category 1 or 2 expected patient benefits:** The project seeks to provide individualized health mentoring for approximately 6 months for 80 to 100 individuals in DY 3, DY4 and DY5 with resulting improvements in monitored health status indicators, community social engagement and mental functioning assessments.

**Category 3 outcomes:** IT-6.1 Patient Satisfaction

The projected outcomes relate to an improvement in standardized patient satisfaction surveys over baseline studies. Patient satisfaction will be a strong component in the maintenance of physical and life style gains made in the program. The projected improvement percentage is 10% for DY-4 and for DY-5.

**Title of Project:** Expand Capacity of Behavioral Health Services

**Unique RHP project identification number:** 121988304.2.1

**Performing Provider name/TPI:** Lakes Regional MHMR Center/121988304

**Project Intervention Title:** 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting.

**Project Option:** 2.13.1 Design, implement, and evaluate research – supported and evidence-based interventions tailored towards individuals in the target population. Required core components: a) through e). (Lakes Regional MHMR Center In SHAPE).

**Unique RHP Project Identification Number:** 121988304.2.1

### **Project Description**

Lakes Regional MHMR Center (LRMHMRC) proposes to affect the negative trend in Rockwall County (that the seriously mentally ill (SMI) population, especially those in rural and poverty stricken areas, have dramatically shortened life expectancy) by implementing the wellness program Individualized Self Health Action Plan for Empowerment (In SHAPE) researched and promoted by the “Prevention Research Center at Dartmouth” which is part of The Dartmouth Institute. The heart of the program is an individualized physical health care program for people with SMI developed with a specially trained Health Mentor for one-on-one education, planning, coaching, training and measuring progress toward goals with reflection on the benefits and appreciation of accomplishment. Health Mentor is a designation developed by In SHAPE that requires additional training to that required to be a “Certified Personal Trainer” by the Aerobics and Fitness Association of America. One Health Mentor can work with up to 16 individuals at a time for the first 6 months in program; therefore, a six month commitment by participants to the program is desired. The Health Mentor meets with individuals 1 or 2 times per week, but the program is designed to be highly individualized with a focus on designing exercise and nutrition plans that are sustainable in a more health directed lifestyle. It is obvious that community partners are critical in providing these services in community sites like the YMCA.

### **Project Goals**

Expand the capacity of behavioral health services to better meet the needs of the patient population and community so that care can be better coordinated and the participant can be treated as a whole person, potentially leading to better outcomes and experience of care. The program is aimed directly at improving physical health, personal health knowledge and quality of life of participants thereby reducing the risk of preventable diseases, lowering health care costs and enhancing the life expectancy of individuals with SMI.

### **Challenges**

It has well established that the SMI population especially those in rural and poverty stricken areas have dramatically shortened life expectancy fraught with physical health difficulties from medication side effects such a morbid obesity, diabetes, and heart disease as well as high instances of preventable diseases from smoking, diet and other life style choices. They have been called the most disadvantaged group in the U.S. in terms of life expectancy 15 to 30 years less than the rest of the population (Lunardini, R., 2011).

### **Five-Year Expected Outcome**

The Five year expected outcome will be participants’ physical health awareness, health status indicators and physical functioning will show measureable improvements leading to corresponding cognitive improvements. Participants will also show consistent compliance with their medication regimen with

related improvements in mental functioning as tracked through the waiver period. Participants learn through close mentoring, instruction and planning how they individually can adopt healthier choices and behaviors, gain control over weight problems and increased energy. With this comes a sense of mastery and self-direction rare to this population. Patient satisfaction and medication compliance will increase and health status indicators will improve. In a nine month pilot study, significant level outcomes were increases in vigorous activity and walking, readiness to reduce caloric intake, reduction in waist circumference, satisfaction with fitness, mental health functioning improved, and severity of negative symptoms decreased (Van Citters, AD, et. Al., 2009). Decreases in medications may occur as physiological processing becomes more efficient and increases in social activity, personal efficacy and purpose can lead to increased employment and quality of life.

### **Describe how the project is related to regional goals**

In keeping with regional goals the project is to avert outcomes such as potentially avoidable inpatient admission and readmission in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community as articulated the RHP protocol page 300.

### **Starting Point/Baseline**

This will be a new addition to the LRMHMRC array of services of a tested and proven program design (Van Citters, AD, et. Al., 2009). The program will be new to the area and the population to be served as well. Consultation and guidelines in keeping with the replication of the program in other mental health centers will be followed (Crum, 2009). As a result, the community resources in each of the planned areas will need to be surveyed and assess for possible partnership and facility appropriateness. Health Mentors will need to be identified from available certified personal trainers (hired or contracted) and trained further. Their initial pool of clients to start the program will need to be identified through a systematic surveying of the client population to establish baseline data and selection criteria.

### **Rationale**

The project option of 2.13.1: Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. People with SMI often have multiple concomitant such as substance abuse, traumatic injuries, cognitive challenges and lack of daily living skills or natural supports. To advance from mere stabilization, this population requires individualized services which serve the whole persons need for physical, mental and community social improvements. In SHAPE is just such a program that is research supported and has proven effective in achieving these gains for this population.

### **Project Components**

All of the required project components of 2.13.1 will be met including:

- a). Assess size, characteristics and needs of target population- this is to be determined through gap analysis/baseline surveying in DY2.
- b). Review literature- DY2 will also be a period to review the relevant literature and engage consultant services in project development.
- c). Develop project evaluation plan- a plan, do, study, act (PDSA) approach will be instituted for continuous evaluation and quality improvement; the Adult Needs and Skills Assessment (ANSA)

scores taken quarterly along with the SF-36 responses and in program functional testing will be used in the evaluation process.

d). Design models- In SHAPE is a research supported program and consultation will advise the adaptations to the current context.

e). Assess the impact of interventions- as above, continuing evaluation of client improvement on several dimensions with standardized instruments will inform personal impact and across participants indicate programmatic impact and PDSA cycles.

### **Reasons for selecting the Milestones and Metrics**

DY2 and DY3 Process Milestones enable the project start-up. Milestones 1 and 2 will prepare the base of the program by [P-1] conducting needs assessment and hire and train personnel [P-X]. Enrollment to serve 16 to 20 individuals with SMI [P-3] after selection from DY2 data and PDSA cycles [P-4] will allow continuous evaluation moving into the improvement target years DY4 and DY5. Milestones 5 and 7 [I-3] will track improvement from the electronic medical record (EMR) the compliance with prescribed anti-psychotic medication; Milestones 6 and 8 [I-5] functional status will inform on improvements in standard measures using the ANSA and physical health measurements (ie. BMI, HBP, Ha1c) quarterly.

### **Specify the unique community need identification number the project addresses**

- CN.5 Co-morbid medical and behavioral health conditions – all ages.
- CN.14 Obesity and its co-morbid risk factors.

### **Describe how the project represents and new initiative or significantly enhances an existing deliver system reform initiative**

LRMHMRC and Texas community centers generally have not entered the realm of physical activity services to SMI clients. This new venture from a proven model provides great potential for improvement in the condition of individuals with schizophrenia which is likely to provide a positive influence on family, peers and staff members as well.

### **Related Category 3 Outcome Measure(s): OD – 6: Patient Satisfaction**

#### **Relationship to other Projects:**

##### **Describe the related Category 1 and 2 projects**

- 121988304.1.1 – Introduce, Expand or Enhance Telemedicine / Telehealth.
- 121988304.2.2 – Autistic Spectrum Disorder Day Treatment Outreach
- 121988304.1.2 Depression Trauma Counseling Center

### **Describe the related Category 4 Population focused improvements N/A**

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

Behavioral Health projects in RHP 18 including those provided by LifePath Systems, Texoma Community Center, and Lakes Regional MHMR are all naturally interrelated in that the general populations of persons with behavioral health conditions in these counties are the same, and may move across geo-political boundaries in the process of obtaining healthcare services. These local behavioral health services providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid

medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region. Additionally, representatives of other providers including UT Southwestern and Children's Medical Center that may also provide behavioral healthcare will be included in the coordination activities that will occur in both scheduled and routine-doing-business venues across RHP 18 and its neighboring counties.

### **Plan for Learning Collaborative**

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

### **Project Valuation**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

In addition, this project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: The studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided).

The complete description of project research studies are available at the performing provider site. Additional cost effectiveness savings can also be assumed through avoidance of higher cost crisis emergency based services and transportation costs as a result of increased specialty care access due to this project. **Total Five Year Valuation: \$863,421**

### **References**

- Luarndini, R., In SHAPE: Local Pilot Becomes National Model, Dartmouth Medicine, Winter 2011.
- Van Citters, A. D., Pratt, S. I., Williams, G., Miller, P. T., Xie, H., and Bartels, S. J., A Pilot Evaluation of the In SHAPE Individualized Health Promotion Intervention for Adults with Mental Illness. *Community Mental Health Journal*, 46(6): 540-552, 2010.
- Crum, R., Business Planning to Replicate In SHAPE, a Program Promoting Health for People with Mental Illness, Robert Woods Johnson Foundation Grant Results Report, June, 2009.
- Barr, B. M., Adults with Severe Mental Illness Get In SHAPE, Robert Woods Johnson Foundation Grant Results Report, Grant Id: 51433, January 14, 2011.

121988304.2.1	2.13	2.13.1 a-e	IN SHAPE	
Lakes Regional MHMR Center			121988304	
Related Category 3 Outcome Measure(s): OD-6	121988304.3.4	IT – 6.1	Patient Satisfaction 6.1	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1 P-1.</b> Milestone: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources create inclusion criteria and program protocol.</p> <p><b>P-1.1. Metric:</b> Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ER utilization.</p> <p><b>Data Source:</b> Project documentation; Inpatient, discharge and ER and HMO records; State psychiatric facility records; survey of stakeholders (inpatient providers, mental health)</p> <p><b>Milestone 1 Estimated Incentive Payment: \$93,856</b></p> <p><b>Milestone 2 [P-X]:</b> Hire and train certified personal trainer to become health mentor.</p> <p><b>Metric 2 [P-X.1]:</b> Trainer is hired and trained through LRMHMRC NEO and health mentor certified</p>	<p><b>Milestone 3 [P-3]:</b> Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities.)</p> <p><b>Metric 3 [P-3.1]</b> Number of targeted individuals enrolled / served in the project is 16 to 20.</p> <p><b>Baseline/Goal:</b> 16 to 20 individuals enrolled and served.</p> <p><b>Data Source:</b> Project documentation</p> <p><b>Milestone 3 Estimated Incentive Payment: \$105,545</b></p> <p><b>Milestone 4 [P-4]:</b> Evaluate and continuously improve interventions</p> <p>RHP Planning Protocol Category 1</p> <p><b>Metric 4 [P-4.1]:</b> Project planning and implementation</p>	<p><b>Milestone 5 [I-3]:</b> Adherence to Antipsychotics for Individuals with Schizophrenia.</p> <p><b>Metric 5[I-3.1]:</b> The percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months).</p> <p>a. Numerator: The TBD percentage of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.</p> <p>b. Denominator: The TBD number of individuals at the end of the measurement period with schizophrenia with at least two claims for an antipsychotic during the measurement period.</p> <p><i>This would be measured at specified time intervals throughout the project to determine if there was a decrease.</i></p> <p><b>Data Source:</b> Claims and Encounter Data</p>	<p><b>Milestone 7 [I-3]:</b> Adherence to Antipsychotics for Individuals with Schizophrenia.</p> <p><b>Metric 7 [I-3.1]:</b> The percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months).</p> <p>a. Numerator: The TBD percentage of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.</p> <p>b. Denominator: The TBD number of individuals at the end of the measurement period with schizophrenia with at least two claims for an antipsychotic during the measurement period.</p> <p><i>This would be measured at specified time intervals throughout the project to determine if there was a decrease.</i></p> <p><b>Data Source:</b> Claims and Encounter Data</p>	



121988304.2.1	2.13	2.13.1 a-e	IN SHAPE	
Lakes Regional MHMR Center			121988304	
Related Category 3 Outcome Measure(s): OD-6	121988304.3.4	IT – 6.1	Patient Satisfaction 6.1	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
<p><b>Baseline/goal:</b> One certified trainer / provider as a health mentor</p> <p><b>Data Source:</b> HR records and HM certification.</p> <p><b>Milestone 2 Estimated Incentive Payment: \$93,857</b></p>	<p>documentation demonstrates plan, do, study, act quality improvement cycles.</p> <p><b>Data Source:</b> Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.</p> <p><b>Milestone 4 Estimated Incentive Payment: \$105,545</b></p>	<p><b>Milestone 5 Estimated Incentive Payment: \$116,263</b></p> <p><b>Milestone 6 [I-5]:</b> Functional Status <b>Metric 6 [I-5.1]:</b> The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) a. Numerator: The 40 percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. b. Denominator: The number of individuals receiving specialized interventions. <b>Data Source:</b> Standardized functional assessment instruments (e.g. ANSA, CANS, etc.)</p> <p><b>Milestone 6 Estimated Incentive Payment: \$116,262</b></p>	<p><b>Milestone 7 Estimated Incentive Payment: \$116,047</b></p> <p><b>Milestone 8 [I-5]:</b> Functional Status <b>Metric 8 [I-5.1]:</b> The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) a. Numerator: The 40 percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. b. Denominator: The number of individuals receiving specialized interventions. <b>Data Source:</b> Standardized functional assessment instruments (e.g. ANSA, CANS, etc.)</p> <p><b>Milestone 8 Estimated Incentive Payment: \$116,046</b></p>	
Year 2 Estimated Milestone Bundle Amount: \$187,713	Year 3 Estimated Milestone Bundle Amount: \$211,090	Year 4 Estimated Milestone Bundle Amount: \$232,525	Year 5 Estimated Milestone Bundle Amount: \$232,093	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$863,421				

**SUMMARY PAGE: Centennial Medical Center Pass 2 Category 1 Project/169553801.1.1**

***NOTE THIS PROJECT NARRATIVE WAS REPLACED IN THE FINAL DOCUMENT***

**Provider:** Centennial Medical Center is a 118-bed hospital in Frisco, Texas serving a 25 square mile area and a population of approximately 644,401 PSA.

**Intervention(s):** This project will expand access to primary care through combining the resources of Tenet Healthcare and Centennial Medical Center with Collin County Adult Clinic to provide the “right care at the right place,” which will include expansion of primary care clinic hours and staffing. Specifically, this project will include enhanced diabetes and hypertension management, education and compliance tracking, provision of basic wellness check-ups for women over forty through a new women’s wellness clinic, and seamless referral for HIV/AIDS issues and testing.

**Need for the project:** The primary care services provided by Collin County Adult Clinic almost doubled in size and cost over the past four years. The clinic and the county are seeking ways to expand primary care services in targeted areas to reduce risk for new chronic diseases, and improve the management for diabetes, hypertension, cervical cancer, and HIV/AIDS.

**Target population:** Collin County Adult Clinic patients, who are primarily women and diabetic patients. While CCAC will provide services at both clinics, with CCCHC at the east side seeing Medicare/Medicaid patients, both will see a large majority of patients below 100% of the federal poverty level. Currently, 80% of the 4,200 patients’ visits at CCAC are below 100%, while the remainder are between 100% and 200% of FPL.

**Category 1 or 2 expected patient benefits:** The project seeks to provide improved primary care through expanded primary care hours and staffing, enhanced diabetes and hypertension management and education, wellness check-ups and screening for women, and seamless referral for HIV/AIDS issues and testing. Specifically, this includes metrics and goals of diagnosing, treating, and tracking those with hemoglobin A1c (HbA1c) whose A1c levels are  $\leq 6$ , concentrating on reducing those with A1c levels  $\geq 9$ , “uncontrolled,” by 10%. Patients will also be diagnosed, treated, and tracked for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate. The project will increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. The project also includes increased referrals and support for HIV testing.

**Category 3 outcomes:**

- IT-1.10 Diabetes Care. Our goal is to increase the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control  $>9.0\%$ .
- IT-12.2 Cervical Cancer Screening. Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

**Title of Project:** Expand existing primary care capacity  
**Unique RHP project identification number:** 169553801.1.1  
**Performing Provider Name:** Centennial Medical Center/169553801

### **Project Description**

Centennial Medical Center and Collin County Adult Clinic (CCAC) will partner to expand existing primary care capacity. The project will include three distinct components as it expands access through expanded clinic hours and staffing:

- 4) Enhanced Diabetes and Hypertension Management, Education and Compliance Tracking;
- 5) Provision of Basic Wellness Check-ups for Women over forty through a new Women's Wellness Clinic; and
- 6) Seamless referral for HIV/AIDS issues and testing

The enhanced diabetes portion of the project includes support for patients who are seen at the expanded east Collin County Community Health Center (CCCHC) and West Side Clinic (West Side) for free or at low-cost to manage their care for diabetes and or HTN, medications/supplies, ongoing education and compliance tracking, and support for a licensed medical provider.

Collin County Adult Clinics will provide basic wellness check-ups for women over forty through a new Women's Wellness Clinic and at the expanded East clinic (CCCHC) with new hours and days. This new clinic program is a collaboration with area OB/GYN physicians and other hospitals to provide basic wellness checks-ups for women, concentrating on women over 40. This service includes pap smears, breast exams with mammography, if needed, basic check-ups for diabetes and hypertension, medications/supplies, and ongoing education and compliance tracking. It is structured as a free or low cost service for indigent and uninsured women from the target population.

The project contains a seamless referral for HIV/AIDS issues and testing to Health Services of North Texas and referrals back to CCAC for other medical issues with Collin County Adult Clinic at its two clinics, Plano, TX - Collin County Community Health Center (CCCHC) and the West Side Clinic (West Side). This project is in collaboration with Health Services of North Texas (Plano office) and area hospitals, to increase patients from the target population area who will receive HIV testing and HIV/AIDS education and tracking at HSNT, then referred back to CCAC for other health medical issues. This includes reimbursement for patients who are seen for free or at low-cost to manage their care, testing referrals, ongoing education and compliance tracking, and support for a licensed medical provider. This includes additional hours at CCCHC, and new nights at the West Side to achieve goals.

The following core health care indicators including Challenges/Community Need addressed in this project for HIV/AIDS testing and potential corresponding illnesses that will be seen at CCAC clinics in the overall target population are:

**HIV/AIDS** In the target population, 210 persons per 100,000 were infected compared to a state rate of 258 per 100,000. Most of the target population in this survey who are tested for HIV do not do so until they are symptomatic. It is a growing problem and a major concern within the Hispanic population. The issue of HIV testing is especially difficult for this population increasingly affecting the indigent who traditionally have lacked appropriate medical access. Unprotected sex, injection drug use, and the fear of the stigma rather than getting tested are fueling the need to increase the number of indigent who should access these tests. (12)(13)

**DIABETES** The target population has an age-adjusted diabetes prevalence rate of 15.8% compared to the Texas rate of 9.7% and the national rate of 8.2%. In this target population, thus, the rate is twice that of the national average. (8)(14)(15)

**CANCER** In the target population of women over 40, 38% report not having mammograms in the last three years compared to the state average of 29%. Thirty percent (30%) of all women over 18 report not having a pap smear in three years compared to a state average of 20%, with the national benchmark at 25%. Prevention and early detection are critical within the target population. (8)(14)

**CARDIOVASCULAR DISEASE** HTN in the target area is 29.92%, while the state rate is 29.10%, and the U.S. rate is 24.80%. This is a high rate, especially compared to the national average—20% higher. A simple reduction in blood pressure can reduce heart attacks by 21%, strokes by 37%, and overall Cardiovascular Disease by 25%. (8)(16)(17)

**History** Since 2005, CCAC has worked with the Collin County Health Department to provide basic primary care services to the adult indigent and uninsured population of Plano and Collin County. CCAC utilized an all-volunteer workforce that could see over 1,000 patients in 3,500 visits. In 2009, CCAC created a three-year Strategic Plan (2009 to 2012) to review all programs and to look at what these patients needed, not just what CCAC could provide through volunteer efforts and donated goods.

**Goals and Relationship to Regional Goals** CCAC will improve the health of indigent adults by diagnosing and managing Type 1 and Type 2 diabetes increasing the “under control” percentage of adult patients. CCAC will expand hours and days at CCCHC and additional evenings at the West Side to address the target population growth.

CCAC will diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are  $\leq 6$ , concentrating on reducing those with A1c levels  $\geq 9$ , “un-controlled”, by 10%.

#### **Baseline Determination**

**Years Two through Five:** The annual goal is to get 10% of patients at manageable levels. CCAC will work to grow the program to accept the anticipated growth rate.

CCAC will improve the health of adult patients diagnosing and managing those with HTN. CCAC will expand hours and days at CCCHC and additional evenings and Saturdays at the West Side to address the target population growth.

CCAC will diagnose, treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 10% improvement rate.

#### **Baseline Determination**

**Numerator:** Patients 18 to 85 with a diagnosis of HTN with most recent systolic BP measured  $< 140$ mm HG and diastolic BP  $< 90$ mm HG among those patients included in the denominator.

**Denominator:** Patients 18 to 85 who as of Dec. 31 of the measurement year of the diagnoses of HTN who were seen at least twice during the reporting year.

**Key Contributing Factors:** weight, blood pressure, lipid profile, tobacco usage, activity level, and nutritional habits. Patients will be educated by CCAC or referred to community support programs. Patients in the target population have a strong tendency not to take their medication regularly, sometimes even cutting the pills thinking that they last longer (tendency in many population groups)

**Years Two through Five:** The annual goal is to get 10% of the current patients to manageable levels. CCAC anticipates a 25% annual growth rate in numbers of patients.

#### **Increase in Patient Goals for Diabetes and HTN programs (Many patients have both issues)**

Year One: 400 Pts: 200 Pts for Diabetes/200 Pts for HTN; Year Two: 500 Pts: 250 Pts for Diabetes/250 Pts for HTN; Year Three: 625 Pts: 325 Pts for Diabetes/300 Pts for HTN; Year Four: 782 Pts: 375 Pts for Diabetes/407 Pts for HTN; Year Five: 977 Pts: 527 Pts for Diabetes/450 Pts for HTN.

The following core health care indicators including Challenges/Community Need addressed in this project for the overall target population are:

**DIABETES** The target population has an age-adjusted diabetes prevalence rate of 15.8% compared to the Texas rate of 9.7% and the national rate of 8.2%. In this target population, thus, the rate is twice that of the national average. (8)(14)(15)

**CARDIOVASCULAR DISEASE** HTN in the target area is 29.92%, while the state rate is 29.10%, and the U.S. rate is 24.80%. This is a high rate, especially compared to the national average—20% higher. A simple reduction in blood pressure can reduce heart attacks by 21%, strokes by 37%, and overall Cardiovascular Disease by 25%. (8)(16)(17)

The project also focuses on improving the health of indigent women by providing examinations and tests for women who may never have had or have not had in years - opening of a second women's Wellness Clinic, expansion of medical provider base, open more days.

Centennial Medical Center will partner with CCAC to increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year.

### **Baseline Determination:**

**Numerator:** Number of females receiving one or more Pap smears during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.

**Denominator:** Number of females as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by CCAC before their 65<sup>th</sup> birthday.

**Key Contributing Factors:** Working poor female patients routinely do not keep current annual wellness exam appointments, Pap smears, or breast exams. This is true for breast exams and mammography which will be provided for women who are having pap smears. CCAC staff will notify current patients of upcoming due dates for these tests. Staff will review charts to determine testing intervals and target no-shows.

**Years Two through Five:** The annual five-year goal is to increase the number of basic wellness exams by 25% annually with 50% receiving pap smears:

Year One: 300 exams with 150 Pap smears; Year Two: 375 exams with 187 Pap smears; Year Three: 468 exams with 234 Pap smears; Year Four: 586 exams with 293 Pap smears; Year Five: 732 exams with 366 Pap smears.

**GOAL:** CCAC will improve the health of indigent adults by providing a seamless referral program to and from Health Services of North Texas for patient testing, and then provide medical care for other issues at CCAC. Open of additional hours at both clinics and the hire a medical provider (CCCHC) with HIV/AIDS and infectious disease expertise.

**OUTCOME:** Increase the number of patients referred to HSNT for testing by 10%, and referrals to CCAC from HSNT by 10%.

### **Baseline Determination**

**Years Two through Five:** The annual goal is to increase testing by 10% and to work toward addressing the anticipated 25% annual increase in patients.

### **Patient Goals for HIV/AIDS Testing**

Year One: 100 Pts tested; Year Two: 125 Pts tested; Year Three: 156 Pts tested; Year Four: 195 Pts tested; Year Five: 244 Pts tested.

### **Challenges**

**Insurance:** Forty-four percent (44.8%) of the target population is uninsured compared to a state average of 25% and a national adult average of 17%. Even greater still, over 60% of the Hispanic population does not have insurance. Without insurance or assistance, this population goes without healthcare except for

the emergency room when their illness is beyond a critical stage, or simply because there is no other place to go. (4)

**Low Educational Issue:** In the 12 elementary schools just in the MUA, for 2010, eleven were Title I schools. Of the twelve schools (approximately 10,000 students), six schools had over 70% and as high as 89.2% economically disadvantaged students. The remaining six schools are between 23.4% and 50.9% disadvantaged—all in Plano. (3)

**Health Language:** Thirty-three percent (33.6%) of people in this area speak a language other than English. (5)(6)

**Beliefs:** Various cultural backgrounds within this population accept different health care systems and beliefs, many foreign to the rest of the local community. (8)(9)(10)

**Geographical and Transportation:** Plano has good transportation, but those in the target population have no transportation except through a friend. CCAC is in the midst of the MUA, so many are able just to walk. Many CCAC clients, however, walk for up to two miles to get their care, and decide not to come in mildly inclement weather. (7)

**Closing of Clinics in Collin County:** Within the last ten months two major women's clinics providing pap smears, etc. closed: McKinney Family Planning Clinic and Presbyterian Hospital Dallas' Plano Women's Clinic. (4) (11)

### **Five-year Expected Outcomes**

Collin County Adult Clinic will diagnose, treat, and track those with hemoglobin A1c (HbA1c) whose A1c levels are  $\leq 6$ , concentrating on reducing those with A1c levels  $\leq 9$ , "uncontrolled" by 10% per year.

The Clinic will diagnose, treat, and track adult patients for HTN reducing BP from their most recent reading to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate.

Collin County Adult Clinic will increase the percentage of indigent women aged 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year.

The Clinic will increase the number of patient referrals for HIV/AIDs testing by 10%.

Achieve TBD "x%" improvement compared to baseline, with x determined in Year 2 based on baseline data.

e. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control  $>9.0\%$ .

f. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).

Achieve TBD "x%" improvement compared to baseline, with x determined in Year 2 based on baseline data.

g. Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

h. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

### **Starting point/baseline**

The baselines for this project will be established in DY2.

**Rationale** The Collin County Adult Clinic had a Health Care Needs Assessment (July 2012) completed for the area, targeting the local Medically Underserved Area (MUA). This project specifically addresses diabetes in Collin County, and the Needs Assessment states that of PPAs for Diabetes (short-term), 26% are uninsured, and there were 819 cases with an average charge of \$27,950. Eleven percent are uninsured related to PPAs for long-term Diabetes, and there were 1639 cases (per year) with an average charge of \$42,276. (Pages 5-6). Rationale for the cervical screenings and HIV/AIDs testing are laid out in previous paragraphs related to the projects. This project will address these growing challenges in the community.

Community Needs Addressed: Access to health services, Clinical preventive services and Nutrition, Physical Activity and Obesity.

### **Project Enhances an Existing Delivery System**

The project enhances delivery through establishment of improved outcomes, supplying resources and quality measures through Centennial Medical Center and Tenet Healthcare to Collin County Adult Clinic, and through new learning collaborative opportunities through the anchor, Tenet Healthcare, Centennial Medical Center, and clinics including Collin County Adult Clinic.

### **Related Category 3 Outcome Measure and Rationale for Selecting Outcome Measure**

IT-1.10 Diabetes Care. Our goal is to increase the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control >9.0%. Explain how it ties to Category 1 project

IT-12.2 Cervical Cancer Screening. Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Explain how it ties to Category 1 project

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

#### **Plan for Learning Collaborative:**

Collin County Adult Clinic, Centennial Medical Center, and Tenet Healthcare will partner in regular meetings of clinic, clinical, IT, and other leaders to determine processes and objectives that will reach metrics and milestones.

The RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best-practices. This provider will participate in these mechanisms of learning collaboration.

#### **Project Valuation:**

This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria: Meets Waiver Goals, Addresses Community Needs, Project Scope, Project Investment and Value Weight of the Project.

While CCAC will provide services at both clinics, with CCCHC at the east side seeing Medicare/Medicaid patients, both will see a large majority of patients below 100% of the federal poverty level. Currently, 80% of the 4,200 patients' visits at CCAC are below 100%, while the remainder are between 100% and 200%. Whether in the CCCHC setting or at the West Side, those under 100% must be seen for free per FQHC and CCAC guidelines. With the extensive change to CCAC's programs, the new Women's Clinic expenses, the need to provide free care at both clinic sites to those below 100% of the poverty level, medications including insulin and supplies, and the hiring of paid medical staff to see patients free of charge, patient care through CCAC, costs between \$125 and \$200 per visit (average cost \$162) depending upon whether they are seen by the CCCHC medical staff or the West Side medical staff.

This includes the patient visit, medications, testing, administrative expenses, etc. with program costs at 75% of the total. For those under 100% of the federal poverty level, there is no reimbursement by any source including Medicare and Medicaid, except for the requested \$20 co-pay, which is forgiven if the patient does not have it. The project costs for Collin County Adult Clinic, including expanded hours and staffing, enhanced diabetes and hypertension management and education, wellness check-ups and screening for women, and seamless referral for HIV/AIDS issues and testing are also including in the project valuation.

**(References in Addendum.)**



<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p><b>P-1. Milestone:</b> CCAC will improve the health of indigent adults by diagnosing and managing Type 1 and Type 2 diabetes increasing the “under control” percentage of adult patients. CCAC will expand hours and days at the East Clinic (CCCHC) and additional evenings and Saturdays at The West Side Clinic and hire medical staff...P-4 and P-5.</p> <p>Related Category 3: Improved outcomes for disparity group, improved clinical outcomes, and reduced ED utilization.</p> <p><b>P-1.1. Metric:</b> CCAC will diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data.</p>	<p><b>4. Milestone:</b> Increase number of diabetes and HTN care patients being served by 25% over Year 2. Enhance ability to accept urgent care in this area. Open additional hours into the evenings with another provider. <u>Maintain and track current patient load.</u> I-12, I-13 and I-15</p> <p><u><b>Metric 4A.</b></u> Expand services by the expected 25% increase in patients from Year 2 to diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data. Estimated Incentive</p> <p><u><b>Baseline Determination</b></u> <u><b>Numerator:</b></u> Number of adults 18 to 75 with a diagnosis of Type 1 or 2 diabetes whose most recent A1c level during the measurement year is &lt;=9 and whose patients are</p>	<p><u><b>Milestone:</b></u> Increase number of diabetes and HTN care patients being served by another 25% over Year 3. Provide urgent care. Hire another medical provider. <u>Maintain and track current patient load.</u> I-12, I-13, I15</p> <p><u><b>Metric 5A:</b></u> Expand services by the expected 25% increase in patients from Year 3 to diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data.</p> <p><b>Estimated incentive \$73,587.</b></p> <p><u><b>Metric 5B:</b></u> Expand services by 25% from Year 3 to Treat and track adult Patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG,</p>	<p><u><b>Milestone:</b></u> Increase number of diabetes and HTN care patients being served by another 10% over Year 4. Provide urgent care. <u>Maintain and track current patient load.</u> I-12, I-13, I-15</p> <p><u><b>Metric 6A:</b></u> Expand services by the expected 25% increase in patients from Year 4 to diagnose, treat and track those with hemoglobin A1c (HbA1c) whose A1c levels are &lt;=6, concentrating on reducing those with A1c levels &lt;=9, “un-controlled”, by 10%. Will use CCAC EMR system to track data.</p> <p><b>Estimated Incentive \$81,874.</b></p> <p><u><b>Metric 6B:</b></u> Treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 10%</p>	

<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>Estimated Incentive: <b>\$40,000.</b></p> <p><u>Process Milestone Two:</u> CCAC will improve the health of adult patients diagnosing and managing those with HTN. CCAC will expand hours and days at the East Clinic (CCCHC) and additional evenings and Saturdays at The West Side Clinic...P-4</p> <p><u>Metric 2.</u> CCAC will diagnose, treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Estimated incentive: \$20,000.</b></p> <p><u>Milestone:</u> Provision of basic wellness check-ups for women over forty through the new Women's Wellness Clinic, and at the expanded East</p>	<p>included in the denominator. <u>Denominator:</u> Number of adults 18 to 75 as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen at the clinic at least twice during the reporting year and do not meet any of the exclusion criteria.</p> <p><b>Estimated Incentive \$47,520.</b></p> <p><u>Metric 4B.</u> Expand services from Year 2 to treat and track adult patients for HTN reducing BP from their most recent readings to systolic readings less than 140mm HG and diastolic readings of less than 90mm HG, with an expected 60% improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Baseline Determination</b> <u>Numerator:</u> Patients 18 to 85 with a diagnosis of HTN with most recent systolic BP measured &lt;140mm HG and diastolic BP</p>	<p>with an expected 10% improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Baseline Determination</b> Same as previous Year for 5A&amp;B</p> <p><u>Milestone:</u> Increase the number of patients receiving pap smears, mammograms and regular check-ups over Year 3 by 50% within the current population, and address the number of new patients, expected to be 25%, as well.</p> <p>I-12 and I-15</p> <p><u>Metric 5:</u> CCAC will increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. Data source is CCAC's EMR system.</p>	<p>improvement rate. Will use CCAC EMR system to track data.</p> <p><b>Baseline Determination</b> Same as previous year for 6A&amp;B</p> <p><u>Milestone:</u> Increase the number of patients receiving pap smears, mammograms and regular check-ups over Year 4 by 50% within the current population, and address the number of new patients, expected to be 25%, as well.</p> <p>I-12 and I-15</p> <p><u>Metric 6:</u> CCAC will increase the percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. Data source is CCAC's EMR system.</p>	

<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>Clinic hours and day. This new clinic program is collaboration with area OB/GYN's, THR Presbyterian Hospital Plano, and other hospitals to provide basic wellness checks-ups for women, concentrating on women over 40. This service includes pap smears, breast exams with mammography, if needed, basic check-ups for diabetes and hypertension, medications/supplies, and ongoing education and compliance tracking. It is structured as a free or low cost service for indigent and uninsured women from the target population. P-1, P-4.1, P.5</p> <p><u>Metric 1:</u> CCAC will increase the Percentage of indigent women 21 to 64, concentrating on women over 40 in the target population, who received one or more Pap smears by 50% and to increase the number served by 25% each year. Data source is CCAC's EMR system.</p> <p><b>2. Process Milestone:</b> N/A</p> <p><b>Metric 2.</b></p>	<p>&lt;90mm HG among those patients included in the denominator. <u>Denominator:</u> Patients 18 to 85 who as of Dec. 31 of the measurement year of the diagnoses of HTN who were seen at least twice during the reporting year.</p> <p>Estimated Incentive <b>\$24,480.</b></p> <p><u>Milestone:</u> Increase the number of patients receiving pap smears, mammograms and regular check-ups over Year 2 by 50% within the current population, and address the number of new patients, expected to be 25%, as well. Will continue to expand hours, days, and provide additional providers, as needed.</p> <p>I-12 and I-15</p> <p><u>Metric 4.</u> CCAC will increase the Percentage of indigent women 21 to 64, concentrating on Women over 40 in the target population, who received one or more Pap smears by 50% and to</p>	<p><u><b>Baseline Determination</b></u> Same as previous year</p> <p><b>Estimated DSRIP Funding: \$57,747</b></p> <p><u>Milestone:</u> Continue to provide seamless referrals for eligible patients. Maintain and track patients referred back to CCAC.</p> <p><u>Metric 5:</u> Increase referrals by 10% and growth expectations of 25% over Year Three. I-12 and I-15</p> <p><u><b>Baseline Determination</b></u> <u>Numerator:</u> Total number of patients who receive HIV testing during the measurement year among those who are included in the denominator. <u>Denominator:</u> Number of patients by December 31 of the previous year who were seen for a medical encounter at least once during the measurement year.</p> <p><b>Estimated DSRIP Funding:</b></p>	<p><u><b>Baseline Determination</b></u> Same as previous year</p> <p><b>Estimated DSRIP Funding: \$62,866</b></p> <p><u>Milestone:</u> Continue to provide seamless referrals for eligible patients. Maintain and track patients referred back to CCAC.</p> <p><u>Metric 6:</u> Increase referrals by 10% and growth expectations of 25% over Year Four.  I-12 and I-15</p> <p><u><b>Baseline Determination</b></u> <u>Numerator:</u> Total number of patients who receive HIV testing during the previous year among those who are included in the denominator. <u>Denominator:</u> Number of patients by December 31 of the previous year who were seen for a medical encounter at least once during the measurement year.</p>	

<b>169553801.1.1</b>	<b>1.1.2</b>		<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<i>Centennial Medical Center</i>			<b>169553801</b>	
			<b>EXPAND EXISTING PRIMARY CARE CAPACITY</b>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>N/A</p> <p><b>Estimated DSRIP Funding (Max) : \$49,000</b></p> <p><b><u>Milestone:</u></b> Seamless referral for HIV/AIDS issues and testing to Health Services of North Texas and referrals back to CCAC for other medical issues. This project is in collaboration with Health Services of North Texas (Plano office) and area hospitals, if needed, to increase patients from the target population area who will receive HIV testing and HIV/AIDS education and tracking at HSNT, then referred back to CCAC for other health medical issues. This includes reimbursement for patients who are seen for free or at low-cost to manage their care, testing referrals, ongoing education and compliance tracking, and support for a licensed medical provider with HIV/AIDS experience. CCAC will expand hours and days at the East Clinic (CCCHC) and additional evenings and Saturdays at The West Side Clinic.</p>	<p>increase the number served by 25% each year. Data sources is CCAC's EMR system.</p> <p><b><u>Baseline Determination</u></b> <u>Numerator:</u> Number of females receiving one or more Pap smears during the measurement year or during the two years prior to the measurement year, among those women included in the denominator. <u>Denominator:</u> Number of females as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by CCAC before their 65<sup>th</sup> birthday.</p> <p><b>Estimated DSRIP Funding : \$58,800</b></p> <p><b><u>Milestone</u></b> Continue to provide seamless referrals for eligible patients. Maintain and track patients referred back to CCAC. Will continue to expand hours, as needed. I-12 and I-15</p>	<b>\$10,226</b>	<b>Estimated DSRIP Funding: \$5,840</b>	

169553801.1.1	1.1.2		EXPAND EXISTING PRIMARY CARE CAPACITY	
Centennial Medical Center			169553801	
			EXPAND EXISTING PRIMARY CARE CAPACITY	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
P-4 and P-5  <b><u>Metric 1:</u></b> Increase the number of patients referred to HSNT for testing by 10%, and referrals to CCAC from HSNT by 10% with a baseline of 1,000 regular patients in Year One. CCAC will include the growth of the population, expected to be 25% annually. Will refer 100 to HSNT—125 in Year Two.  <b>Estimated DSRIP Funding (Max): \$19,700</b>	<b><u>Metric 4:</u></b> Using Year Two as the baseline, increase referrals by 10% and growth expectations of 25%.  <b><u>Baseline Determination</u></b> <u>Numerator:</u> Total number of patients who receive HIV testing during the measurement year among those who are included in the denominator. <u>Denominator:</u> Number of patients by December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year.  <b>Estimated DSRIP Funding: \$18,088</b>			
Year2 Estimated Milestone Bundle Amount: \$128,700	Year3 Estimated Milestone Bundle Amount: \$148,888	Year4 Estimated Milestone Bundle Amount: \$141,560	Year5 Estimated Milestone Bundle Amount: \$150,580	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$569, 528				

## PASS 3

### CATEGORY 2

In Pass 3, three providers have proposed one project each, in Category 2:

- LifePath Systems 084001901.2.3
- Texoma Community Center: 084434201.2.3
- Lakes Regional MHMR: 121988304.2.2

## **SUMMARY PAGE: LifePath Systems: Pass 3 Category 2 Project/084001901.2.3**

**Provider:** LifePath Systems is the non-profit community center for Collin County. Collin County encompasses 886 square miles, has a population of 840,000 and is one of the fastest growing counties in the United States. LifePath Systems staff provide behavioral health treatment for individuals with mental illnesses and support services for individuals with intellectual or developmental disabilities.

**Intervention(s):** This project will establish a peer provider program, specializing in whole health, for our outpatient behavioral health clinics in Collin County.

**Need for the project:** Collin County does not currently have a peer provider program in its outpatient behavioral health clinics. All of the peer providers for this area are centered in Dallas County and as a result are not accessible to our population.

**Target population:** The target population includes those individuals in Collin County with a mental illness or substance use disorder who are receiving behavioral health services at our outpatient clinics. We plan to train at least 6 individuals as peer specialists who are certified in whole health. Once trained, we plan to use these peer specialists in our outpatient clinics as peer providers and in our Mental Health First Aid program.

**Category 1 expected patient benefits:** The project will benefit our patients by providing access to another type of specialized behavioral health service provider – the peer specialist. By focusing on whole health, the patients will benefit by the added services of a peer coordinating medical services and educating individuals on the services recommended by the US Preventative Services Task Force.

**Category 3 outcomes:** IT-10.1 Our goal is to improve the quality of life for at least 20% of the individuals receiving whole health peer services by DY5, by improving the physical health of individuals with chronic mental illness.

**Title of project:** Whole Health Peer Support Services

**Unique RHP Project Identification Number:** 084001901.2.3

**Performing Provider name/TPI:** LifePath Systems TPI: 084001901

### **Project Description**

The goal of this project is to utilize consumers of behavioral 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. By focusing on this goal, we plan to increase appropriate referrals to behavioral health treatment, and engage clients in positive, recovery-focused initiatives. These peer services are supportive and not necessarily clinical in nature.

Building on a project originally established under the State's Mental Health Transformation grant, consumers will be trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training will be 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. All of the peer specialists in this area are centered in the Dallas area. 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. Additionally, we plan to use these certified peer specialists in the successful Mental Health First Aid courses currently being offered to key community members, businesses and organizations. The purpose is to improve the identification and referral of individuals with mental health needs that are not currently receiving adequate levels of care.

We expect to train at least SIX peer providers by DY5, and utilize them to support consumers of behavioral health services as soon as the training is completed. Additionally, we plan to use these peer specialists in providing Mental Health First Aid to at least 160 Collin County individuals during the project period.

### **Starting Point/Baseline**

Currently, our baseline is 0. There are no trained peer counselors currently in Collin County.

### **Rationale**

This project will design, implement, and evaluate whole health peer support for individuals with mental health and/or substance use disorders in Collin County. This project has been selected as a priority for our region due to the high need to identify low income individuals with chronic health conditions, and to provide treatment to this population who is uninsured or underinsured. By identifying and training qualified peer providers, we will be better able to provide a wider array of behavioral health services to a growing Collin County population.

Essential core project components include:

Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.

Conduct a readiness assessment of LifePath Systems to ensure integration of peer specialists into the treatment team.

Identify potential consumers who express interest in becoming a peer specialist and who are at the appropriate level of recovery to do so.



Train identified consumers as peer specialists and then the additional training 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 other health risks such as obesity, tobacco use, or physical inactivity).

Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.

Identify patients with serious mental illness who have health risk factors that can be modified.

Implement whole health peer support.

Connect patients to primary care and preventive services.

Track patient outcomes. Review the intervention(s) impact on participants 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 unique community need identification numbers this project addresses are CN.5 (Co-morbid medical and behavioral health conditions), CN.6 (Health professions shortage), CN.8 (Diabetes), CN.9 (Cardiovascular Disease), CN.14 (Obesity and its co-morbid risk factors), and CN.11 (Behavioral Health).

### **Related Category 3 Outcome Measure**

OD- 10 Quality of Life/ Functional Status; IT-10.1 Quality of Life (Standalone measure) is the outcome measure we will use to assess this project. This outcome is a priority for our community due to the lack of access to affordable healthcare for the low income populations and the increasingly shorter lifespan of individuals with chronic mental illness due to untreated medical conditions.

Implementing whole health peer services in numerous clinics throughout Collin County will help to achieve this outcome of improved quality of life for individuals in the low income populations who otherwise do not have access to care. 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.

By focusing on improving the quality of life for low income individuals by using whole health peer specialists, this project will ensure not only that access to specialty care has been improved for low income populations, but also that those receiving services have access to a richer array of services that are currently unavailable in this region.

### **Relationship to other Projects**

This project will be enhanced by Project 084001901.1.1 (Expanding Behavioral Health Specialty Care Capacity) due to the fact that more consumers will be served in the expanded clinics, therefore more consumers will either have the chance to become a peer specialist or benefit from the additional whole health services that will be available to them from a certified peer specialist. Additionally, Project 084001901.2.1 (Integrated Primary and Behavioral Health Care) will create a referral source for the whole health peer specialists to coordinate with when consumers with significant health issues are identified.

### **Relationship to Other Performing Providers’ Projects in the RHP** Not applicable

### **Plan for Learning Collaborative**

As with other projects, LifePath staff will participate in the Learning Collaborative referenced in our other project narratives.

**Project Valuation:** In the paper, “Valuing the Peer Support and Training Expansion Program” by Brown, Alamgir, and Bohman found that using a benefit-to-cost analysis, a similar peer support model was found

to result in a benefit of \$3.71 for each dollar invested (Sari et al, 2008), whereas Kuyken et al in the same year found a \$43 dollar benefit for each dollar spent. The average benefit cost ratio between these two studies is \$23.36. The total 4 year cost of this program is \$1,995,449. Therefore, the value to be gained by this project is estimated at:

$$\$23.36 \times \$1,995,449 = \$46,613,688$$

- **References**

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Peer Support and Training Expansion Program.

<b>UNIQUE CATEGORY 2 PROJECT IDENTIFIER: 084001901.2.3</b>	<b>PROJECT OPTION: 2.18.1</b>	<b>PROJECT COMPONENTS: 2.18.1 A, B, C, D, E, F, G, H, I</b>	<b>PROJECT TITLE: WHOLE HEALTH PEER SUPPORT SERVICES</b>	
<b>Performing Provider: LifePath Systems</b>			<b>TPI: 084001901</b>	
<b>Related Category 3 Outcome Measure: OD-10 Quality of Life / Functional Status</b>	<b>Unique Category 3 IT identifier: IT-10.1</b>	<b>Reference number from RHP PP: 084001901.3.4</b>	<b>Outcome Measure (Improvement Target) Title: Quality of Life (Standalone measure)</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p>Milestone 1 [2.18.1.P-2]: Conduct an organizational readiness assessment to determine what changes must occur to successfully integrate peers into the traditional workforce.</p> <p>Metric 1 [2.18.1.P-2.1]: Number of assessments conducted</p> <p>Baseline/Goal: 100% Completion of assessments by BH management</p> <p>Data Source: Organization records of assessment scores</p> <p>Milestone 1 Estimated Incentive Payment (maximum amount): \$413,461</p> <p>Milestone 2 [2.18.1.P-1] Train administrators and key clinicians on:            *Understanding what recovery/wellness is and that it is possible            * Understanding the value of peer specialists and peer support workers            * Understanding how to integrate and support peer workers in their organizations</p>	<p>Milestone 3 [2.18.1.P-3]: Identify and train peer specialists to conduct whole health classes.</p> <p>Metric 1 [2.18.1.P-3.1]: Number of peers trained in whole health planning</p> <p>Baseline is 0 trained, Goal is 3</p> <p>Data Source: Training records</p> <p>Milestone 3 Estimated Incentive Payment: \$369,778</p> <p>Milestone 4 [2.18.1.I-17]: Receipt of Recommended Preventative Services</p> <p>Metric 1 [2.18.1.I-17.1]: The percentage of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force.            a. Numerator: The number of people receiving services as recommended by the US Preventative Services Task Force            b. Denominator: Individuals aged 18</p>	<p>Milestone 5 [2.18.1.P-3]: Identify and train peer specialists to conduct whole health classes.</p> <p>Metric 1 [2.18.1.P-3.1]: Number of peers trained in whole health planning</p> <p>Goal: Goal is 6</p> <p>Data Source: Training records</p> <p>Milestone 5 Estimated Incentive Payment: \$401,527</p> <p>Milestone 6 [2.18.1.I-17]: Receipt of Recommended Preventative Services</p> <p>Metric 1 [2.18.1.I-17.1]: The percentage of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force.            a. Numerator: The number of people receiving services as recommended by the US Preventative Services</p>	<p>Milestone 7 [2.18.1.P-7]: Evaluate and continuously improve peer support services</p> <p>Metric 1 [2.18.1.I-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</p> <p>Goal: Implement improvement suggestions</p> <p>Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement</p> <p>Milestone 7 Estimated Incentive Payment: \$367,440</p> <p>Milestone 8 [2.18.1.I-17]: Receipt of Recommended Preventative Services</p> <p>Metric 1 [2.18.1.I-17.1]: The percentage of individuals 18 years</p>	

<b>UNIQUE CATEGORY 2 PROJECT IDENTIFIER: 084001901.2.3</b>	<b>PROJECT OPTION: 2.18.1</b>	<b>PROJECT COMPONENTS: 2.18.1 A, B, C, D, E, F, G, H, I</b>	<b>PROJECT TITLE: WHOLE HEALTH PEER SUPPORT SERVICES</b>	
<b>Performing Provider: LifePath Systems</b>			<b>TPI: 084001901</b>	
<b>Related Category 3 Outcome Measure: OD-10 Quality of Life / Functional Status</b>	<b>Unique Category 3 IT identifier: IT-10.1</b>	<b>Reference number from RHP PP: 084001901.3.4</b>	<b>Outcome Measure (Improvement Target) Title: Quality of Life (Standalone measure)</b>	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>		<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Metric 1 [2.18.1.P-1.1] Metric: Number of staff trained [2.18.1.P-1.2] Metric: Positive participant evaluations of training  Baseline/Goal: 0 Trained Currently / Goal is 100% of BH staff trained  Data Source: Training records and training evaluation records  Milestone 2 Estimated Incentive Payment (maximum amount): \$413,460	years and older who receive peer support services.  Goal: 10% of individuals receiving peer support services also receive services as recommended by the US Preventative Services Task Force  Data Source: Clinical Records  Milestone 4 Estimated Incentive Payment: \$369,778		Task Force b. Denominator: Individuals aged 18 years and older who receive peer support services.  Goal: 15% of individuals receiving peer support services also receive services as recommended by the US Preventative Services Task Force  Data Source: Clinical Records  Milestone 6 Estimated Incentive Payment: \$401,526	and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force. a. Numerator: The number of people receiving services as recommended by the US Preventative Services Task Force b. Denominator: Individuals aged 18 years and older who receive peer support services.  Goal: 20% of individuals receiving peer support services also receive services as recommended by the US Preventative Services Task Force  Data Source: Clinical Records  Milestone 8 Estimated Incentive Payment: \$367,439
<b>Year 2 Estimated Milestone Bundle Amount: \$826,921</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$739,556</b>		<b>Year 4 Estimated Milestone Bundle Amount: \$803,053</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$734,879</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$3,104,409</b>				

## **SUMMARY PAGE: Texoma Community Center: Pass 3 Category 2 Project/084434201.2.3**

**Provider Description:** Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC's headquarters is in Grayson County which has a 2011 population of 121,419, up from the 2010 population of 120,877, indicating a 7.4% growth. (1a) TCC has four primary clinics treating over 1,200 adults, children, and families ranging in age from zero to death and staff provide an average of 10,226 face to face patient contacts per month. Less than 1% of TCC's patients have private insurance, between 38% and 40% have Medicaid on average and 88.05% of children and 81.34% of adult patients are at or below the federal poverty level.(1b)

**Interventions:** Project 084434201.2.3 aims to significantly expand and enhance the newly planned integration of mental and primary health care by increasing efficiency and redesigning how the primary care clinic program is accessed so that services are oriented around the patient and the patient experience can be improved. Through quality improvement of patient-centered scheduling and other focused solutions to barriers to access and patient satisfaction, TCC will improve services while expanding from the original ½ day of blended service to a full five-day, full access model for both the primary and psychiatric care services.

**Need for the Project:** Mentally ill individuals often have difficulty negotiating services without significant help and redesigning the clinic access to services will alleviate some of these barriers, especially since both their physical health needs and psychiatric health needs will be addressed simultaneously. There currently is no known facility in Grayson County that addresses all of a mentally ill patients' needs at the same time, and this is the ultimate goal of this project. With the array of rehabilitation, case management and community-based services already provided at TCC along with the psychiatric care, adding physical health services to this array will "complete the package" for true "medical home" model. This is especially true since Grayson County is an identified underserved area. (1c)

**Target Population:** Project 084434201.2.3 targets patients who have co-occurring psychiatric and physical health illnesses, especially chronic physical problems such as diabetes, heart problems, high blood pressure, etc. along with severe and persistent mental illness.

**Category 1 or 2 Expected Patient Benefits:** Milestones for this project are to increase open access services for psychiatric and primary care by redesigning patient access, first by 5% increase in DY 4 then 10% increase in DY 5. The implication for expanding the services from ½ day of blended services to full-time the provider would go from seeing approximately 12 patients in the ½ day to between 400-500 patients on a full-time basis, based current clinic schedules.

**Category 3 Outcomes:** TCC's Category 3 goal is to improve the quality of life for all of TCC's most "at risk" patients with co-occurring mental and physical health problems, thus reducing their use of more expensive health services.

**Unique Project Identifier:** 084434201.2.3

**Provider:** Texoma Community Center/084434201

**Project:** 2.3 – Redesign Primary Care

**Project Option:** - 2.3.1 Project Options: Increase efficiency and redesign primary care clinic program to be oriented around the patient so that primary care access and the patient experience can be improved.

Required Core Components:

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

**Project Description:** The goal of this project is to increase the efficiency of a planned primary care clinic that is to be blended with Texoma Community Center’s psychiatric and behavioral health clinic in order to substantially enhance the scope of the primary care services to patients in Grayson County, Texas who have severe and persistent mental illness (the target population). This project will enhance TCC’s Pass 1 Project (084434201.2.1) that is to: “Develop Care Management Function that integrates primary and behavioral health needs of individuals.” In the initial project, Texoma Community Center will implement a care management system that integrates the primary physical health care of patients with the behavioral health care to broaden the service array. Providing primary health care is a new initiative for TCC. This correlated project will expand and enhance those initial steps to integrate physical health care with psychiatric health care to significantly more patients so that better healthcare services are available for “at risk” patients. A patient-centered schedule and quality improvement activities will help scale the services to a broader patient population. Initially with Project 084434201.2.1, there would be a primary care provider (most likely a physician-supervised general practice Advanced Nurse Practitioner or Physician Assistant) and a nurse available to selected “at risk” TCC psychiatric patients for ½ day per week. This Pass 3 Project will streamline all services and allow for an expansion of blended primary care services for up to five days per week. This project will make a primary care provider available to patients in Grayson County who have schizophrenia, bi-polar disorder or Major Depressive Disorder, as well as those served by the planned substance abuse treatment program and the planned trauma-based counseling center and for those in the expanded residential and crisis respite facility.

TCC fully recognizes that prompt patient access to primary health care, consistent high-quality preventive care and coordination of care are serious health care challenges for psychiatric patients in this region (CN.1, CN.5, CN.6, CN.7, CN.12). Implementation of a project that expands primary health care opportunities for “at risk” patients with co-morbid mental illness and designing access around patient need will significantly enhance patient care and meet RHP 18 regional goals. Providing this service will improve outcomes for behavioral health patients who have complications due to chronic conditions and insufficient insurance coverage and insufficient support to meet those physical health needs.

TCC patients have significant barriers and limited access to primary care physicians (CN.1).

Case managers frequently have trouble finding physicians who take Medicaid or Indigent funding to prescribe physical health medications for low-income patients, at times putting patients at risk of not having essential medication. Integrating physical health care in this mental and behavioral health clinic and making those services “patient-centered” will help solve this access problem and contribute to the

regional goals that seek to improve quality of care, reduce the cost of health care, prevent hospitalizations and improve access to all health care services.

TCC will: (1) improve access to primary care; (2) reduce over-utilizing the emergency departments by stabilizing individuals to reduce crisis response needs; (3) reduce criminal justice involvement; and (4) improve the patient experience. The goal of this Pass 3 Project will be to enhance the access points and available appointment times, coordinating both, so that physical health issues can be addressed simultaneously with psychiatric issues. Having medical staff coordinate and collaborate about patient care will improve all outcomes. Dewa, et. al. (2009) reported cost effectiveness of a collaborative mental and physical health care model, stating: “The results suggest that with CMHC, for every 100 people on short-term disability leave for psychiatric disorders, there could be \$50 000 in savings related to disability benefits along with more people returning to work (n = 23), less people transitioning to long-term disability leave (n = 24), and 1600 more workdays.” (1) TCC aims to improve primary care capacity so that improved health outcomes and reduced costs of services occur in the region.

TCC also recognizes that quality improvement is an integral part of any programmatic operation. As part of the continuing quality improvement strategies, intervention impact on quality of care and integration will identify the “lessons learned,” explore more opportunities to broaden the patient population, and identify key challenges associated with this project.

The Core Components will be addressed by implementing a “patient-centered scheduling model” for the primary care provider within the behavioral health clinic. Then, both (b) patient visit redesign and (c) quality improvement will be analyzed so that “lessons learned” can drive service delivery. It is believed that hiring a well-qualified primary care provider (regardless of whether it is a physician, physician’s assistant or advanced nurse practitioner) and nurse who coordinates with the psychiatric provider will facilitate and improve patient satisfaction and desired outcomes. TCC will operate within the guidelines of evidence-based practices and implement those best-practices guidelines so that there will be a paradigm shift away from a specialty practice of psychiatry to a more blended “whole person” treatment, utilizing ALL of the “best-practices” guidelines.

TCC is committed to breaking new ground for TCC into the area of blending primary care and specialty mental health care. The five-year expected outcome is that current and new patients served by TCC will have quick access to both physical health treatment and psychiatric and behavioral health treatment at this center, such that significantly more “at risk” patients will improve their overall health, stabilize to reduce unnecessary emergency department visits and hospitalizations, and experience a quality of life improvement.

**Baseline Data and Project Starting Point:** Currently TCC does not provide any physical health treatment except for vital sign monitoring at the time of psychiatrist visits, with the exception of the ACT patients, who have access to a RN at all times for assessing physical problems. However, when physical health issues are evident, the actual treatment must be referred out to area physicians who are rapidly opting out of providing services to Medicaid patients and more often don’t provide services to indigent patients. Implementing the initial project that will engage a primary health care provider and nurse ½ day per week will be the baseline for this coordinated project. The “starting point” (baseline) will be ½ day of physical health care services being provided (as outlined in Project 084434201.2.1) and the goal will be to expand services from ½ day per week in DY 3 to three full days in DY 4 and then to a five days of services (40 hours/week) in DY 5 for fully-blended primary and behavioral health care. Being able to quickly and efficiently coordinate physical and psychiatric health care within the same facility for this many Grayson County patients, and establish that “medical home,” will significantly enhance rapid access and quality of health care leading to improved outcomes.

**Rationale:** Individuals with severe and persistent mental illness have difficulty accessing resources for all of their needs, including their basic health care. They encounter transportation problems, organizational problems and communication problems. They often have chronic medical conditions along with their mental illness; therefore their health and psychiatric stability are easily compromised. Individuals who are the most “at risk,” where both the psychiatric issues and chronic physical issues are concerned, tend to be high utilizers of emergency rooms, psychiatric hospitals and physical, acute care hospitals. Their overall level of functioning tends to be lower than the general population. Therefore, offering and supporting physical health treatment simultaneously with their psychiatric needs at TCC’s behavioral health clinic would significantly reduce risk factors and increase the patient’s overall stability, thus reducing their use of high dollar facilities. Texoma Community Center has already provided evidence and data with our own Assertive Community Treatment (ACT) patients showing increased support reduces hospitalizations and ER visits. TCC’s ACT patients very frequently have significant co-morbid chronic physical health problems leading to de-stabilization of both physical and psychiatric issues. With aggressive community-based treatment, TCC reduced psychiatric hospitalizations of these high utilizer patients from 1.8% being hospitalized in 2007 down to 0% in 2010 and this was, in part, due to the ACT team model including physical health awareness by: (1) having an RN on the case load who knows all ACT patients and regularly evaluates their physical health needs; (2) case manager’s being made aware of physical health issues and supporting these clients in addressing physical health issues in addition to their psychiatric needs; and (3) then ensuring that they are transported to physical health appointments as needed. (2) The “wraparound” style of services for the ACT team has improved the psychiatric and physical health of these patients and supports the evidence that this ACT model of service delivery does, indeed, improve patient functioning which, in turn, reduces high dollar utilization of ERs and hospitals. The World Health Organization notes that: “Where mental health is integrated as part of these [primary care] services, access is improved, mental disorders are more likely to be identified and treated, and comorbid physical and mental health problems managed in a seamless way.” (3) There is no reason to believe that the reverse of having primary physical care accessible in a behavioral health clinic would not also improve health outcomes. Having the opportunity through this PASS 3 project to further broaden service delivery will enhance the cost reduction for area hospitals and refine and improve global functioning and quality of life for additional Grayson County and RHP 18 “at risk” patients.

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status  
IT-10.1 Quality of life- (standalone measure)

- d. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
- e. Data source: Assessment of Quality of Life Tool Data Results
- f. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was

selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this project to “Redesign Primary Care” since primary physical care is a new initiative for TCC and will require a close watch on patient outcomes and improvement. TCC recognizes that the success of all TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the projects are having on patient care and on using the data to improve outcomes. Quality of Life (QOL) and functional status are key elements in assessing project impact results. TCC recognizes symptom improvement and patient functional levels are essential elements of health-related quality of life and improving the patient experience. This Category 3 Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effectively blended health care requires relentless focus on the patient outcomes.



The Quality of Life/Functional Status outcome domain is appropriate for this project because, again, mental/behavioral health is adversely impacted by physical health issues, and vice versa. Both reduce a patient's ability to function, which adversely affects quality of life issues. Both physical and mental health problems negatively impact a person's independent living, relationships, sense of self-worth and lead to costly emergency treatment. By focusing on assessment of QOL and functional status, we will be able to determine the efficacy of combining primary care and behavioral health care treatment at one facility. The World Health Organization (WHO) issued a report called "Integrating mental health into primary care: A global perspective" and pointed out that by blending mental health treatment and primary care treatment, patients "avoid indirect costs associated with seeking specialist care in distant locations..... [and] integrating mental health services into primary care generates good health outcomes at reasonable costs."(4) The research noted above indicates that improved access to primary physical health care while simultaneously providing mental health services will, indeed, help the low-income population served in Grayson County achieve a better quality of life, reduce high dollar hospital costs and achieve a positive patient experience and outcomes.

**Relationship to other Projects:** This project 084434201.2.3 relates to all other projects by offering the option for primary physician care to the patients being services in other programs. The services can be provided by Telemedicine, which relates to Project 084434201.1.1. It relates to the expansion of substance abuse services (084434201.1.2) and expanding counseling services to non-priority populations (084434201.1.3) in an integral way by opening up primary care to patients serviced in these programs as well. Adding primary physical care to a more comprehensive behavioral health treatment program will create a complete wellness opportunity for those served. Successful development and implementation of this project will be facilitated by the other projects through streamlining information exchange and collaboration for the benefit of patient care. This will allow for a multi-modal approach to comprehensive healthcare for unfunded, underfunded and underserved members of our community (CN.4, CN.5, CN.6, CN.11, and CN.12). This will enhance services and assist in meeting the regional health care goals to improve quality of care, improve patient satisfaction, improve the health of populations, reduce the cost of health care and improve access to health care services. Integrating primary health and behavioral health care facilitates preventive treatment and a reduction in more costly and inefficient repetition of services.

**Relationship to Other Performing Providers' Projects in the RHP:** The primary relationship this Project has to the other Projects in RHP 18 is one of collaboration, sharing of data and information, and referrals as appropriate. While there are no specific TCC projects that are combined in implementation with other providers in the region, this project specifically lends itself to future collaboration as the potential to work with physical health providers blends into a holistic, patient-centered care model. Discussion has already begun with several health care providers in RHP 18, including health clinics and hospitals participating in the DSRIP service enhancement program, and a more formal collaboration is in the future. TCC will, indeed, be a

part of collaboration and share data, knowledge and experiences with stakeholders and other providers in RHP 18 in order to enhance best practice models. The need (CN.6) for additional behavioral health providers allows for service expansion, along with physical health providers, without duplicating services or even meeting the need fully.

**Plan for Learning Collaborative:** RHP 18 plans to implement a Learning Collaborative within the region. Texoma Community Center will participate in the learning collaborative meetings with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. Part of TCC's goal is to gather information and bring new knowledge back to the

management table to help direct TCC's growth and expansion toward sound, cost-effective, evidence-based practices. Focus in the learning collaborative will be to identify project impacts, what has been learned from other entities, and expanding the projects to a broader patient population. In the case of this project, TCC will be expanding, learning and growing into an entirely new territory of combining physical health care with behavioral health care. Addressing key challenges will be done internally and as part of the learning collaborative within the region because TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences. It is important to look for solid solutions that are backed up by evidence-based research, especially in a new area for this center, so that positive outcomes can spread across the region.

**Project Valuation:** According the World Health Organization/Organization of Family Doctors, 2000 publication entitled Integrating Mental Health and Primary Care: A Global Perspective, the lack of coordination of treatment on a world-wide scale is regretful because: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." (5) The article also points out that: "Primary care for mental health forms a necessary part of comprehensive mental health care, as well as an essential part of general primary care. However, in isolation, it is never sufficient to meet the full spectrum of mental health needs of the population." (6) As documented in the American Journal of Psychiatry, June 1, 2008, medical costs are approaching 20% of the nation's Gross National Product, and 6.2% of those costs are directly related to mental health issues. (7) Persons with severe mental illness often have addictions, such as consuming 44% of all cigarettes smoked, that shorten their lifespan by 13 to 35 years. (8) The absence of integrated primary and medical care takes a toll on individuals, their families, their communities, and results in cost are greatly reduced if preventative medical treatment was used to avoid progression of illnesses to an acute care stage.

Approximately 40% of the people served by TCC are without a third-party payer source for medical care, leaving them to manage illnesses through expensive "band aide" treatment in emergency rooms. (9) Additionally, many of the people receiving psychiatric services are placed on powerful psychotropic medications, and are at risk for adverse effects. Although the psychiatric staff do a good job in screening for critical conditions, such as pulmonary and circulatory problems, it is the absence of preventative or stabilizing primary medical care that prompts emergency room visits and hospital care at its highest cost end. Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The total project value is \$4,253,327.00 including Category 3 valuation. The valuation and benefits of the proposed program are based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a) The following resources were also instrumental in supporting this valuation methodology as well as looking at other methodologies that led to additional types of savings to the community. Dewa et al. (2009) found that collaborative care saved \$503 per patient just in disability benefits. (9g) Latimer (2005) reviewed the effectiveness literature on ACT's and reported that a high-fidelity ACT Team can reduce the number of hospital days by 78%. Latimer (2005)

found the direct ACT services costs of \$9,116 per client per year in 1999/2000 and that in-patient psychiatric hospital costs averaged \$215 and he estimated that these patients were spending 60 days in a psychiatric hospital per year so that a 78% reduction meant 46.8 fewer hospital days or a savings of \$10,062.00 (@ \$215 per day cost) per patient. (9n) Using Latimer's findings, this would mean a savings of approximately \$2,555,748 to the community for the potential target population number even without any consideration for the additional potential costs savings for emergency room visits and/or criminal justice involvement or the quality-adjusted life-years savings also used to calculate project value (9a)(9n). Also, considering current hospitalization costs, this savings would be significantly more today. Since TCC has ACT services, as well as an understanding that blending physical health care with current psychiatric services, case management and community-based supports is very similar to ACT services extended to non-ACT patients, it is believed this methodology is applicable to this project. Simon, et. al. (2012) found that collaborative care yielded 47.7 additional depression-free days per year at a cost of \$52 per depression-free days. This methodology shows an additional benefit to the community of saving \$630,000.00 in health care services for the potential target patients served. (9m) Likewise, in a study by Katon, et. al. (2012), which examined collaborative care intervention for multi-symptom patients, including depression, diabetes, and coronary heart disease, the effect of the blended care intervention was 0.0335 incremental life years gained. **(9g)** Using this formula, TCC's project 084434201.2.3 would meet the physical and mental health care needs of 254 people in this target population.

084434201.2.3	PROJECT OPTION: 2.3.1	COMPONENTS: 2.3.1.A.B.C.	REDESIGN PRIMARY CARE IN ORDER TO ACHIEVE IMPROVEMENTS IN EFFICIENCY, ACCESS, CONTINUITY OF CARE, AND PATIENT EXPERIENCE
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.7	IT-10.1	Quality of Life/Functional Status
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p><b>Milestone 1:</b> P-2 Implement the patient-centered scheduling model in primary care clinics.</p> <p>P-2.1. Metric- Completion of all three phases of the redesign project: (1) Record, document, and examine random patient calls so that staff experience the process of making an appointment from client's perspective; Implement open access scheduling in primary care so patients can make same-day/next-day appointment when indicated, and (3) call patients in advance for all scheduling needs.</p> <p>Numerator: Number of patients receiving primary physical and psychiatric care</p> <p>Denominator: Total number of patients served.</p> <p>Data Source: Project, program &amp; scheduling documentation</p>	<p><b>Milestone 3:</b> P-11 -- Review project data and respond to it weekly 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.</p> <p>P-11.1 Metric Number of new ideas, practices, tools or solutions tested.</p> <p>Data Source: Description of the idea, practice, tool or solution tested by provider each week/summarized quarterly as part of utilization management</p> <p>Rationale/Evidence: The rate of testing of new solutions and ideas is one of the greatest predictors of the success of a health care system's improvement efforts.</p>	<p><b>Milestone 5:</b> I-13 – Identify and provide follow-up contact to patients who have missed appointments, are overdue for care, or are not meeting care management goals</p> <p>I-13.1 Metric: Follow-up contact occurs with 80% of patients who no-show appointment.</p> <p>Numerator: Number of patients who missed appointment in a medical home session and received a follow-up contact</p> <p>Denominator: Number of patients who missed an appointment in a medical home session.</p> <p>Data Source: Practice management system calculated for each provider &amp; progress notes documenting follow-up</p>	<p><b>Milestone 7:</b> I-13 – Identify and provide follow-up contact to patients who have missed appointments, are overdue for care, or are not meeting care management goals</p> <p>I-13.1 Metric: Follow-up contact occurs with 90% of patients who no-show appointment.</p> <p>Numerator: Number of patients who missed appointment in a medical home session and received a follow-up contact</p> <p>Denominator: Number of patients who missed an appointment in a medical home session.</p> <p>Data Source: Practice management system calculated for each provider &amp; progress notes documenting follow-up</p>

084434201.2.3	PROJECT OPTION: 2.3.1	COMPONENTS: 2.3.1.A.B.C.	REDESIGN PRIMARY CARE IN ORDER TO ACHIEVE IMPROVEMENTS IN EFFICIENCY, ACCESS, CONTINUITY OF CARE, AND PATIENT EXPERIENCE
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.7	IT-10.1	Quality of Life/Functional Status
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p>Rationale: Patient-Centered Scheduling (PCS) is proven methodology for improving the ability of patients to see their doctor when needed. PCS is designed to improve access, increase continuity of care, decrease number of no-shows and decrease days to third-next-available appointment. Patient visits are mapped from beginning to end to identify bottlenecks in the process. Focus is on reducing no-show rates and time to third next available appointments. As much “pre-work” needs to be done as possible, such as patient registration and appointment confirmation. Providers piloting the PCS model have seen significant reductions in no-show rates which is critical in offering patients a “patient-centered medical home.”</p> <p><b>Milestone 1 Estimated Incentive Payment: \$425,591.50</b></p>	<p><b>Milestone 3 Estimated Incentive Payment Amount: \$467,377.50</b></p> <p><b>Milestone 4:</b> P-12 -- Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each 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 the improvements.</p> <p>P-12.1 Metric - Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p>Data Source: Documentation of semi-annual meetings i.e., agendas, slides, meeting notes.</p>	<p>contact Rationale/Evidence: Missed appointments are known to interfere with appropriate care of acute and chronic health conditions and to misspend medical and administrative resources. They represent a major burden on health care systems and costs by reducing the effectiveness of outpatient health care delivery</p> <p><b>Milestone 5 Estimated Incentive Payment (maximum amount): \$499,975.00</b></p> <p><b>Milestone 6:</b> I-18 – Increase capacity to redesign primary care using innovative project option.</p> <p>I-18.3 Metric: Increased number of primary care visits</p>	<p>contact Rationale/Evidence: Missed appointments are known to interfere with appropriate care of acute and chronic health conditions and to misspend medical and administrative resources. They represent a major burden on health care systems and costs by reducing the effectiveness of outpatient health care delivery</p> <p><b>Milestone 7 Estimated Incentive Payment (maximum amount): \$483,069.00</b></p> <p><b>Milestone 8:</b> I-18 – Increase capacity to redesign primary care using innovative project option.</p> <p>I-18.3 Metric: Increased number of primary care visits</p>

084434201.2.3	PROJECT OPTION: 2.3.1	COMPONENTS: 2.3.1.A.B.C.	REDESIGN PRIMARY CARE IN ORDER TO ACHIEVE IMPROVEMENTS IN EFFICIENCY, ACCESS, CONTINUITY OF CARE, AND PATIENT EXPERIENCE	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.7	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p><b>Milestone 2:</b> P-5 -- Train staff on methods for redesigning clinics to improve efficiency P-5.1 Metric: Number of of staff trained Numerator: Number of clinic staff trained Denominator: Number of relevant clinical staff Data Source: HR, training records</p> <p>Milestone 2 Estimated Incentive Payment Amount: \$ 425,591.50</p>	<p>Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.</p> <p>P-12.2 Metric: Implement the “raise the floor” improvement initiatives established at the semi-annual meeting. Data Source: Documentation of “raise the floor” improvement initiatives agreed upon at each meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the meeting.</p> <p><b>Milestone 4 Estimated Incentive Payment Amount: \$467,377.50</b></p>		<p>Baseline: Total number of visits for reporting period Goal: Increased primary care visits over the baseline of 1/2 day of appointment time to 3 days of appointment time</p> <p>Data Source: Scheduling registry, EHR, encounter data</p> <p>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</p> <p><b>Milestone 6 Estimated Incentive Payment: \$499,975.00</b></p>	<p>Baseline: Total number of visits for reporting period Goal: Increased primary care visits over the baseline of 1/2 day of appointment time to 5 full days of appointment time</p> <p>Data Source: Scheduling registry, EHR, encounter data</p> <p>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</p> <p><b>Milestone 8 Estimated Incentive Payment: \$483,069.00</b></p>

084434201.2.3	PROJECT OPTION: 2.3.1	COMPONENTS: 2.3.1.A.B.C.	REDESIGN PRIMARY CARE IN ORDER TO ACHIEVE IMPROVEMENTS IN EFFICIENCY, ACCESS, CONTINUITY OF CARE, AND PATIENT EXPERIENCE	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.7	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): \$851,183.00	Year 3 Estimated Milestone Bundle Amount: \$934,755.00		Year 4 Estimated Milestone Bundle Amount: \$999,950.00	Year 5 Estimated Milestone Bundle Amount: \$966,138.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$3,752,026.00				

## **SUMMARY PAGE: Lakes Regional MHMR Pass 2 Category 2 Project/121988304.2.2**

**Project Name:** 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting; 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population; (Early Intervention Day Treatment and Outreach for Autism Spectrum (ASD) and Related Intellectual Developmental Disabilities (IDD)).

**Unique Project Identifier:** 121988304.2.2

**Provider Name:** Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays.

Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year. Over 95% of our consumers are either Medicaid eligible or indigent.

**Intervention(s):** The proposed project will house a day treatment center for children and adults with autism spectrum disorders and related behavioral, intellectual or developmental disabilities (IDD). Additionally, a community based Behavioral Support Outreach Team will provide community-based services to families and individuals referred in Rockwall County not requiring site-based treatment. The project's aim is to provide an array of treatment options to children and adults with autism and other behavioral disorders who exhibit challenging behaviors that could result in placements in more restrictive and costly settings, such as ER's, hospitals and institutions.

**Need for the project:** There is currently a lack of provider capacity that will serve the Medicaid and indigent population for these behavioral health and other specialty services. The region is looking for ways to feasibly and effectively improve provider capacity and access to services (specialists) for remote populations/ communities. Our project is focused on the expansion of behavioral health services (psychiatric and behavioral specialists), and health and wellness services for the target population (low income, rural areas of Rockwall County). Currently there is a lack of dedicated ASD (Autism Spectrum Disorder) services and supports for young children and transitional-age youth with developmental disabilities in Rockwall County.

**Target population:** The target population are dually diagnosed clients with IDD/ASD/MH needing specialty consultation ( i.e., psychiatry, certified behavioral analysts, counseling, nursing, therapy, and other specialty services consults.) Approximately 95% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from the majority of the consults.

**Category 1 or 2 expected patient benefits:** The project seeks to increase the percentage of individuals receiving specialized ABA interventions who demonstrate improved functional status on standardized instruments by 30% by end of DY5. The target population will gain access to a program that utilizes evidence-based interventions (ABA therapy) in the targeted service area (Rockwall program), encouraging successful recovery in the community, and reducing problematic behaviors that lead to avoidable inpatient admission and readmissions in settings such as psychiatric hospitals and institutions.

**Category 3 outcomes:** IT-10.1 Quality of Life --The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. To demonstrate improvement in symptoms and function, the Quality of Life (QOL) validated assessment tool will be implemented to measure improvement in Quality of Life factors. The projected improvement percentage is 10% for DY-4 and 20% for DY-5.



**Project:** Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting;

**Unique RHP Project Identification Number:** Lakes Regional MHMR Center/121988304.2.2

**Texas Provider Identifier:** 121988304**Project Option:** 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population; (Early Intervention Day Treatment and Outreach for Autism Spectrum (ASD) and Related Intellectual Developmental Disabilities (IDD))

### **Project Description:**

The proposed treatment project would be an early intervention service that will house a day treatment center for children with Autism and related Intellectual Developmental Disabilities (IDD) and Applied Behavioral Analysis (ABA) Outreach Services in Rockwall County. The project's aim is to provide treatment to children with autism who exhibit challenging behaviors that warrant placement in more restrictive and costly settings, such as ER's, hospitals and institutions. This project also would provide individualized ABA intervention with a 1:1 ratio. The ASD/IDD Outreach program would consist of interventions for behavioral challenges within the Autism Spectrum Disorder/Intellectual Developmental Disabilities (ASD/IDD). The project would provide training with a focus on parent training and generalization to the home, community, and school environments. A community-based interdisciplinary intensive behavior outreach and day treatment team shall be comprised of professionals trained in cultural competence. This project will not exclude individuals with ASD/IDD based on income, thereby ensuring access to low-income and uninsured families who are more likely to lack resources for successful management of symptoms.

Components of this project would promote wellness and recovery in the community to the target population by offering learning opportunities for staff and families, as well as opportunities to disseminate information to other performing providers in the RHP regarding ASD. The project also will provide: 1) intervention resources for the Rockwall County community, and 2) opportunities to parents of children with autism to participate in parent advisory panels, further broadening their knowledge base to ensure successful integration of the target population into the community. Data tracking methodologies would be established by project staff to monitor efficacy of project interventions.

### **Project goals:**

The goal of the project is to design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals within the ASD/IDD population who engage in challenging behaviors.<sup>6</sup> The project will utilize research-supported interventions to 1) maximize ASD/IDD individuals' skill acquisition to avert disruptive behaviors and 2) provide access to a group of appropriate peers in a positive social environment that promotes success of self-management, independence, learning, and socialization skills in the community.<sup>7</sup> Implementation of the Applied Behavior Analysis will encourage children with ASD/IDD from culturally diverse backgrounds to embrace life-long learning and successful self-management and well-being of individuals in the autism spectrum. The project seeks to utilize public and private resources, community engagement and collaboration with neighboring communities for sustainability.<sup>8</sup>

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<sup>6</sup> J Clin Child Adolescent Psychol. 2008 Jan;37(1):8-38.

<sup>7</sup> McEachin, Smith, Lovaas , Long-Term Outcome for Children With Autism Who Received Early Intensive Behavioral Treatment, American Journal on Mental Retardation, Vol. 97, No. 4, pp. 359-372, 1993, Lovaas, I. (1987), Behavioral Treatment and Normal Educational and Intellectual Functioning in young Autistic Children

<sup>8</sup> Ibid

**Challenges:** Accessibility to early intensive day treatment for children with Autism or related disorders is limited to those who can afford to pay for services out of pocket or those who have private insurance that covers Applied Behavioral Analysis. Even with private insurance, many parents pay \$12,000 - \$15,000 out of pocket per year in deductible and patient co-pay percentages. The 81st Texas legislative session established requirements for insurance coverage for ABA therapy for children from the age of diagnosis through the tenth birthday, but many insurance companies have discovered methods to avoid coverage for this underserved population. In addition, Medicaid and CHIPS do not cover ABA therapy for outreach or day treatment. Families with children diagnosed with ASD/IDD face enormous financial burdens as a barrier to accessing appropriate services and efficacious interventions. Direct medical costs, such as outpatient care, home care, and medication contribute significantly to overall expenses; non-medical costs, includes intervention services and child daycare.<sup>9</sup> A shortage of specialized day care facilities skilled in working with the unique needs of young children with ASD/IDD is scarce, thereby forcing many families into a single income status. The implementation of a day treatment program and autism outreach could greatly minimize the long-term financial burden to families by providing access to early intensive ABA intervention services. Many challenges often follow children with ASD/IDD into adulthood. Residential placements and care for adults with ASD/IDD account for the largest proportion of families' autism costs.

Additionally, a lack of infrastructure in autism-specific treatment in outlying and rural areas to persons of cultural diversity that are low-income and under-insured is often limited, fragmented, too costly or inaccessible. As a result of an inter-agency needs assessment conducted in April 2010, IDD Lakes services secured (1) Board Certified Behavioral Analyst and launched a Behavioral Outreach program that spans 12-counties. The BCBA maintains a caseload of 15-20 individuals with ASD/IDD. In most instances the BCBA is limited to providing (1) in-home/community session per month to individuals and to families that require more frequent treatment sessions to be efficacious and to ensure maximized success.

### **Plans to Address Challenges**

Lakes Regional will reduce barriers to care for the target population and provide empirical, evidence-based, and highly effective treatment for individuals with ASD/IDD and their families. This project involves designing a program model that includes a range of community-based services and linkages to residential support services, thereby preventing unnecessary ER, psychiatric hospital, and institutional admissions. The project would implement and assess interventions based on standardized quantitative measures and qualitative analysis relevant to the ASD/IDD population.

**5-year expected outcome for the performing provider and patients:** This project provides for significant expansion with an overall growth in the number of individuals served and ABA services offered over the next 5 years. Challenging behaviors in the target population that lead to unnecessary use of services in settings such as the ER, psychiatric hospitals and institutions will be minimize. The project will provide comprehensive assistance to the autism community through education, day treatment, family support, and outreach services. This research-based treatment will promote recovery in the community, wellness and adherence to medication and other treatments as they are warranted. The project will serve as a resource and support to parents and the local community by disseminating information to parents and families of individuals with autism, consultants, school districts, and other private or public agencies serving individuals with developmental disabilities.

**Relationship to Regional Goals:** This project relates to the regional goal of expanding and implementing evidence-based treatment to the behavioral health population to prevent unnecessary use of

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<sup>9</sup> ML Ganz, the cost of Autism, (2008)

costly services in hospital and other institutional settings, as well as to address the current lack of accessible ASD services (specialty services) in the Rockwall area. It specifically relates to: CN.11 Behavioral Health – all components – all ages.

**Describe the project's starting point/baseline:** Currently there is a lack of dedicated ASD services and supports for young children and transitional-age youth with developmental disabilities in Rockwall County. Lakes Regional IDD Behavioral Services currently utilize 1 BCBA to provide approximately 3 hrs per month in-home ABA therapy (per person) to a caseload of twenty (20) ASD/IDD individuals throughout 12 counties.

**Rationale:** Lakes Regional's IDD Behavioral Outreach waiting list is comprised of 60 individuals with autism and related IDD diagnosis. The expected wait time for services is approximately 6 months. An Intra-agency needs survey reveals 100(+) clients/families indicated a need for behavioral outreach services. Currently there is a lack of accessible and dedicated ASD services and supports for young children and transitional-aged youth with developmental disabilities in Rockwall County. Historically, 50-75% of individuals with autism also have some degree of mental retardation.<sup>10</sup> According to Chasson, Harris and Neely after three years of early intensive behavioral intervention the state could save on average \$84,300 per child in special education costs.<sup>11</sup> Combined with actual costs incurred by families, this could result in a savings of \$208,500 per child. The researchers also suggest that the up-front costs of implementing ABA programs will be covered within five years.

**Describe the reason(s) for selecting this project option :** The reason for selecting this project option is to provide the highest quality ABA (Applied Behavior Analysis) and behavior consulting services to individuals with ASD/IDD and their families affected by Autism Spectrum Disorders or related disorders. The project will utilize research-based methodologies delivered by highly qualified and certified professionals, and focuses on interventions that increase language, social, and daily living skills. This project encourages successful recovery in the community, reducing problematic behaviors that lead to avoidable inpatient admission and readmissions in settings such as psychiatric hospitals and institutions.

**Describe the reason (s) for selecting these project components:** The project will address the following required core components of Project Option 2.13.1: a. Assessing size, characteristics and needs of individuals with ASD's (Autism Spectrum Disorders) who exhibit challenging or deleterious behaviors; b. Conducting ongoing reviews of literature/experience to determine community-based interventions that are effective in averting negative outcomes such as inability to manage symptoms, maladaptive behaviors, decline in mental status, forensic encounters and hospitalization; c. Developing a project evaluation plan using qualitative and quantitative metrics to determine outcomes of interventions; ASD/IDD best practices will determine efficacy of interventions in this project. d. This ASD/IDD treatment model for the project consists of implementing an appropriate range of community-based services; including linking participants to residential supports in crisis respite programs in two separate RHPS' in other regions. In-home treatment will be available to encourage successful management of symptoms in the most integrated setting. e. The project will assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. The data sources would include standardized assessments of functional, mental and health status, encounter records and participant surveys. Coupled with implementing interventions to a broader population is identifying "lessons learned", as well as key challenges associated with expansion of the intervention to a broader population.

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<sup>10</sup> [http://holdsambeck.com/docs/research/Cost\\_benefit-analysis-of-intensive-behavioral-interventions-with-children-with-Autism.pdf:204](http://holdsambeck.com/docs/research/Cost_benefit-analysis-of-intensive-behavioral-interventions-with-children-with-Autism.pdf:204)

<sup>11</sup> [http://www.house.state.pa.us/SpkrJournal/documents/8/v8\\_a7.pdf:62](http://www.house.state.pa.us/SpkrJournal/documents/8/v8_a7.pdf:62)

**Reasons for selecting the milestones and metrics:** The process milestones and metrics in DY2 will involve conducting a needs assessment in the community, and designing community-based specialized interventions for the target population based on the assessment; milestones and metrics in DY3 will involve enrolling and serving children with ASD who exhibit targeted complex needs to measure the effectiveness and outcomes of interventions for the targeted behavioral health population who require a safety net for services. DY3 also will involve 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. DY's 4 and 5 will involve improvement milestones and metrics related to improved functional status in program participants. The Day Treatment would initially add 1 BCBA and 1 Trainer and grow to include BCBA(s) and Trainers based on the best-practice of providing 1:1 training. This number of certified trained professionals would grow as we increase the individuals served. Expansion of outreach services would necessitate the hiring of at least 2 BCBA's and 2 trainers. Newly hired personnel would be cross trained in the day treatment and outreach setting. Milestones would be measured through data collection, surveys, individual reports and family/community advisory panels.

**Specify the unique community need identification number the project addresses:** CN.11, Behavioral Health – all components – all ages

**Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project is a new initiative and we have not received any other federal funding for it.

**Related Category 3 Outcome Measures:**

The program will measure Quality of Life (IT-10.1) to demonstrate improvement in QOL scores, as measured by an evidence-based and validated assessment tool (to be determined). It is expected that participation in the program will allow for skills acquisition and improved overall functioning for the ASD population that normally 1) experiences barriers to access to specialized care due to low income status; and 2) is vulnerable to placement in more restrictive settings due to inability to decrease challenging behaviors and manage symptoms effectively.

**Relationship to other Projects:**

1.7 Telemedicine Project- The Lakes Regional telemedicine project will allow access to remote provider services, psychiatric counseling and primary care services. Telemedicine technology will be utilized as an integral focus of the provision of care proposed in the Autism Treatment program.

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

Behavioral Health/IDD projects in RHP 18 including those provided by LifePath Systems, Texoma Community Center, and Lakes Regional MHMR are all naturally interrelated in that the general populations of persons with behavioral health/IDD conditions in these counties are similar, and may move across geo-political boundaries in the process of obtaining healthcare services. These local behavioral health/IDD services providers will meet together in formal quarterly sessions to review and discuss/address/resolve issues including but not limited to: access to care, timely response systems, patient navigation systems, referrals, access to resources, preventing unnecessary admissions, co-morbid medical and psychiatry conditions affecting utilization, and coordination with other healthcare providers in the region. Additionally, representatives of other providers including UT Southwestern and Children's Medical Center that may also provide behavioral healthcare will be included in the coordination activities that will occur in both scheduled and routine-doing-business venues across RHP 18 and its neighboring counties.

**Plan for Learning Collaborative:** Lakes Regional is in the planning stages to establish a learning collaborative with Texas A&M University – Commerce and Rockwall ISD to share and explore best practices in treating ASD's in the project period. In addition, the RHP 18 Anchor will coordinate with all of the RHP 18 participating providers and other interested organizations/groups to provide and support

mechanisms, both in-person, and electronically, for collaborations around at least, but not only, health education initiatives, project challenges and innovation, system gaps, and best practices. This provider will participate in these mechanisms of learning collaboration.

**Project Valuation:** This project was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

In addition, this project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: The studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided).

The complete descriptions of project research studies are available at the performing provider site. Additional cost effectiveness savings can also be assumed through avoidance of higher cost crisis emergency based services and transportation costs as a result of increased specialty care access due to this project.

A priority community need valuation for ASD/IDD Day Treatment and Outreach services comes from a number of sources, including: an identified scarcity of services for autism and related disorders accessible to school districts, family concerns for the continuation of ABA based instruction and treatment for early intervention, older students. The results summarized in Chasson, suggest that “getting better” is not only possible but likely and that the vast majority of children with autism who receive appropriate interventions experience marked improvement<sup>12</sup> In particular, the findings of Chasson and others indicate that approximately 47% of the children recover “typical” function; an additional 40% make “significant” improvement.<sup>13</sup> Ganz, M.L., determined that the “lifetime per capita incremental societal cost of autism is \$3.2 million” and that “[l]ost productivity and adult care are the largest components of costs”.<sup>14</sup> These figures were expressed in 2003; using the national Consumer Price Index to inflate the data, the figure rises to \$3.7 million in 2008. Further, the authors contend that, “. . .based on the extant literature demonstrating the efficacy of behavioral interventions, it is credible to assume that the lifetime per capita incremental societal cost of autism can be mitigated substantially by appropriate interventions.”<sup>15</sup> In conclusion, while ABA therapy interventions are expensive, they are effective and “the long-term implications of failing to make these investments are severe, as autism left untreated. . .” becomes more costly for families, public agencies, and society as a whole.”<sup>16</sup>

**Total 5 - Year Project Valuation: \$3,882,940**

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<sup>12</sup>Chasson, Gregoy S, Harris, Gerald E, & Neely, Wendy J. (2007) Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism. *Journal of Child and Family Studies*. Vol 16(3):401-413

<sup>13</sup> Ibid

<sup>14</sup> Ganz, ML (2007) “The Lifetime Distribution of Incremental Societal Costs of Autism.” *Archives of Pediatric and Adolescent Medicine*. 161, Apr. 2007, 343-349

<sup>15</sup> ibid

<sup>16</sup> ibid

121988304.2.2		2.13.1 (A,B,C,D,E)	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: (ASD/IDD Day Treatment and Behavior Support Outreach Program)	
LAKES REGIONAL MHMR				121988304
Related Category 3 Outcome Measure: OD-10	121988304.3.4	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)	
<p><b>Milestone 1 P-1</b> Conduct needs assessment of complex behavioral health populations with IDD/ASD who are frequent users of community public health resources.</p> <p><b>Metric 1 P-1.1</b> Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization</p> <p><b>Baseline/Goal:</b> Completed needs assessment.</p> <p><b>Data Source:</b> Project documentation, inpatient, discharge and ED records, state psychiatric facility records, survey of stakeholders (inpatient providers, mental health providers, social services and forensics); literature review</p> <p><b>Milestone 1 Estimated Incentive Payment): \$457,734</b></p> <p><b>Milestone 2:</b> P-2 Design community-based specialized interventions for target population</p>	<p><b>Milestone 3 [P-3]:</b> Enroll and serve individuals with targeted complex needs.</p> <p><b>Metric 1 [P-3.1]:</b> Number of targeted individuals enrolled/served in the project.</p> <p><b>Baseline/Goal:</b> Targeted individuals enrolled/served.</p> <p><b>Data Source:</b> Project documentation</p> <p><b>Milestone 4 Estimated Incentive Payment: \$477,574</b></p> <p><b>Milestone 4 (P-7):</b> 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.</p> <p><b>Metric 1 [P-7.1]:</b> Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p><b>Data Source:</b> Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.</p> <p><b>Baseline Goal:</b> Completion of semiannual face to face meetings.</p> <p><b>Metric 2 [P-7.2]:</b> Implement the “raise the floor” improvement</p>	<p><b>Milestone 5 [I-5]]:</b> Functional status</p> <p><b>Metric 1 [I-5.1]:</b> Percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments.</p> <p><b>Numerator:</b> The percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment.</p> <p><b>Denominator:</b> The number of individuals receiving specialized interventions.</p> <p><b>Goal:</b> Functional status measured.</p> <p><b>Data Source:</b> Standardized functional assessment instruments</p> <p><b>Milestone 5 Estimated Incentive Payment: \$511,734</b></p> <p><b>Milestone 6 [I-5]]:</b> Functional status improved by 5%.</p>	<p><b>Milestone 7 [I-5]:</b> Functional status improved by 10% from percentage achieved in DY4</p> <p><b>Metric 1 [I-5.1]:</b> The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments.</p> <p><b>Numerator:</b> The percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment.</p> <p><b>Denominator:</b> The number of individuals receiving specialized interventions.</p> <p><b>Goal:</b> Functional status measured.</p> <p><b>Data Source:</b> Standardized functional assessment instruments</p> <p><b>Milestone 7 Estimated Incentive Payment: \$494,429</b></p> <p><b>Milestone 8 [I-5]:</b> Functional status improved by 15% from percentage achieved in Milestone 7.</p> <p><b>Metric 1 [I-5.1]:</b> The percentage of individuals receiving</p>	

121988304.2.2		2.13.1 (A,B,C,D,E)	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: (ASD/IDD Day Treatment and Behavior Support Outreach Program)	
LAKES REGIONAL MHMR			121988304	
Related Category 3 Outcome Measure: OD-10	121988304.3.4	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)	
to include specialized behavioral therapies and occupational therapy, speech and language therapy. <b>Metric 2:</b> P-2.1 Project plan which is based on evidence/experience and which addresses the project goals. <b>Baseline/Goal:</b> Project Plan completed. <b>Data Source:</b> Project documentation <b>Milestone 2 Estimated Incentive Payment: \$457,734</b>	initiatives established at the semiannual meetings. <b>Baseline/Goal:</b> “Raise the floor” improvement initiatives established. <b>Data Source:</b> 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. <b>Milestone 4 Estimated Incentive Payment: \$477,573</b>	<b>Metric 1 [I-5.1]:</b> Percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. <b>Numerator:</b> The percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. <b>Denominator:</b> The number of individuals receiving specialized interventions. <b>Goal:</b> Functional status measured. <b>Data Source:</b> Standardized functional assessment instruments <b>Milestone 6 Estimated Incentive Payment \$511,733</b>	specialized interventions who demonstrate improved functional status on standardized instruments. <b>Numerator:</b> The percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. <b>Denominator:</b> The number of individuals receiving specialized interventions. <b>Goal:</b> Functional status measured. <b>Data Source:</b> Standardized functional assessment instruments <b>Milestone 8 Estimated Incentive Payment: \$</b>	
Year 2 Estimated Milestone Bundle Amount: <b>\$915,468</b>	Year 3 Estimated Milestone Bundle Amount: <b>\$955,147</b>	Year 4 Estimated Milestone Bundle Amount: <b>\$1,023,467</b>	Year 5 Estimated Milestone Bundle Amount: <b>\$988,858</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$3,882,940</b>				

### ***E. Category 3: Quality Improvements***

**This section E of RHP 18's plan contains 17 projects in Category 3 for Pass 1 of the planning process presented in the following order:**

- Five for Children's Medical Center,
- Four for UT Southwestern Medical Center,
- One for Texoma Medical Center,
- Five for Texoma Community Center,
- One for LifePath Systems,
- One for Lakes Regional MHMR.

**These are followed by six Pass 2 Category 3 projects:**

- Two for LifePath
- One for Texoma Community Center
- One for Lakes Regional MHMR
- Two for Tenet Hospital of Frisco

**Pass 3 includes four Category 3 projects:**

- One for LifePath Systems
- One for Texoma Community Center
- Two for Lakes Regional MHMR



# **PASS 1**

## **CATEGORY 3**

These 17 projects in Pass 1, that support a category 1 or 2 project for each provider, are presented in the following order:

- Five for Children's Medical Center,
- Four for UT Southwestern Medical Center,
- One for Texoma Medical Center,
- Five for Texoma Community Center,
- One for LifePath Systems
- One for Lakes Regional MHMR

**Title of Project:** ED Appropriate Utilization

**Unique RHP project identification number:** 138910807.3.1

**Performing Provider Name:** Children's Medical Center/13890807

**Project Description**

**(Category 3 – OD-9 Preventive and Primary Care): 3.9.2 Reduce pediatric Emergency Department visits**

**Outcome Measure Description:**

Decrease inappropriate Emergency Department use by expanding access to pediatric primary care. Specific percentage of reduction will be determined during baseline measurement in DY2.

**Process Milestones:**

**DY2: Milestone P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.

**Milestone P2:** Establish baseline rates

**Milestone P3:** Develop and test data systems

**DY3: Milestone P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Milestone P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

**Outcome Improvement Targets for Each Year:**

**DY4:**

**Milestone I1:** Achieve “X% “ reduction in Emergency Department use, where “X” will be determined in Year 2 based on baseline data.

**DY5:**

**Milestone I1:** Achieve “Y% “ reduction in Emergency Department use, where “Y” will be determined in Year 2 based on baseline data.

***Rationale:***

Improving access to primary care by opening new pediatric primary care offices, providing a medical home for children with complex and chronic medical conditions and expanding hours for urgent care should reduce inappropriate use as well as overall use of Emergency Department services.

**Project Valuation:**

This project was valued using the score for project 1.1 which was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

## References

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. *J Am Board Fam Med*. 2011 May-Jun;24(3):240-8.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

*J Paediatr Child Health*. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. *Pediatr Emerg Care*. 2012 Sep 26

Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. *Pediatr Emerg Care*. 2012 Sep 26

<i>138910807.3.1</i>	<i>IT-3.9.2</i>	ED appropriate utilization (Stand-alone measure)	
<b>Children's Medical Center</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects:</b>	<b>138910807.1.1, 138910807.1.2, 138910807.2.1</b>		
<b>Starting Point/Baseline:</b>	<b>Emergency Department visits in DY1.</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> <b>Milestone 1 Estimated Incentive Payment: \$42,074</b>  <b>Milestone P2:</b> Establish baseline rates <b>Goal: Completed by 9/30/2013</b> <b>Milestone 1 Estimated Incentive Payment: \$42,074</b>  <b>Milestone P3:</b> Develop and test data systems <b>Goal: Completed by 9/30/2013</b> <b>Milestone 1 Estimated Incentive Payment: \$42,074</b>	<b>Milestone P4:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <b>Goal: Completed by 9/30/2014</b> <b>Milestone 2 Estimated Incentive Payment: \$73,154</b> <b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices to stakeholders. <b>Goal: Completed by 9/30/2014</b> <b>Milestone 2 Estimated Incentive Payment: \$73,154</b>	<b>Milestone I1:</b> Achieve “X% “ reduction in Emergency Department use, where “X” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data <b>Milestone I1 Estimated Incentive Payment: \$ 234,774</b>	<b>Milestone I1:</b> Achieve “Y% “ reduction in Emergency Department use, where “Y” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data <b>Milestone I1 Estimated Incentive Payment: \$561,415</b>
<b>Year 2 Estimated Milestone Bundle Amount: \$126,222</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$146,308</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$ 234,774</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$561,415</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 1,068,720</b>			

**Title of Project:** ED Appropriate Utilization

**Unique RHP project identification number:** 138910807.3.2

**Performing Provider Name:** Children's Medical Center/13890807

**Project Description:**

**(Category 3 – OD-9 Preventive and Primary Care): 3.9.2 Reduce pediatric Emergency Department visits**

***Outcome Measure Description:***

Decrease inappropriate Emergency Department use by expanding access to pediatric primary care by establishing a 24/7 nurse triage line and expanding primary care hours. Specific percentage of reduction will be determined during baseline measurement in DY2.

***Process Milestones:***

**DY2:**

**Milestone P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.

**Milestone P2:** Establish baseline rates

**Milestone P3:** Develop and test data systems

**DY3:**

**Milestone P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Milestone P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

***Outcome Improvement Targets for Each Year:***

**DY4:**

**Milestone I1:** Achieve “X% “ reduction in Emergency Department use, where “X” will be determined in Year 2 based on baseline data.

**DY5:**

**Milestone I1:** Achieve “Y% “ reduction in Emergency Department use, where “Y” will be determined in Year 2 based on baseline data

***Rationale:***

Improving access to primary care by opening new pediatric primary care offices, offering expanded office hours, using telecommunication to link primary care providers with specialists, providing a medical home for children with complex and chronic medical conditions, expanding hours for urgent care, providing a 24/7 nurse triage telephone service, enhancing/expanding the medical home, developing patient/family navigation, implementing evidence-based health promotion programs and implementing/expanding care transitions program should reduce inappropriate use as well as overall use of Emergency Department services.

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. *Pediatr Emerg Care*. 2012 Sep 26  
Lieberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. *Pediatr Emerg Care*. 2012 Sep 26

### **Project Valuation:**

This project was valued using the score for project 1.2 which was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

<b>138910807.3.2</b>	<b>OD 3.9.2</b>	<b>REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects:</b>	<b>138910807.1.1, 138910807.1.2, 138910807.2.1</b>		
<b>Starting Point/Baseline:</b>	<b>Emergency Department visits in DY1.</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment : <b>\$38,318</b>  <b>Milestone P2:</b> Establish baseline rates <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment : <b>\$38,318</b>  <b>Milestone P3:</b> Develop and test data systems <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment: <b>\$38,318</b>	<b>Milestone P4:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment : <b>\$66,623</b> <b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices to stakeholders. <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment : <b>\$66,623</b>	<b>Milestone I1:</b> Achieve “X% “ reduction in Emergency Department use, where “X” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data Milestone I1 Estimated Incentive Payment : <b>\$ 213,812</b>	<b>Milestone I1:</b> Achieve “Y% “ reduction in Emergency Department use, where “Y” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data Milestone I1 Estimated Incentive Payment : <b>\$511,289</b>
Year 2 Estimated Milestone Bundle Amount: <b>\$114,953</b>	Year 3 Estimated Milestone Bundle Amount: <b>\$133,245</b>	Year 4 Estimated Milestone Bundle Amount: <b>\$ 213,812</b>	Year 5 Estimated Milestone Bundle Amount: <b>\$511,289</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 973,298</b>			

**Title of Project:** Reduce Pediatric and Young Adult Asthma Emergency Visits

**Unique RHP project identification number:** 138910807.3.3

**Performing Provider Name:** Children's Medical Center/13890807

**Project Description:**

**(Category 3 – OD-9 Preventive and Primary Care): 3.9.3 Reduce Pediatric / Young Adult Asthma Emergency Department visits**

***Outcome Measure Description:***

Decrease pediatric and young adult asthma Emergency Department use by expanding access to and enrollment in a disease management program in the medical home settings of MyChildren's in RHP 18. Specific percentage of reduction will be determined during baseline measurement in DY2.

**Milestone P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.

**Milestone P2:** Establish baseline rates

**Milestone P3:** Develop and test data systems

**DY3:**

**Milestone P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Milestone P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

***Outcome Improvement Targets for Each Year:***

**DY4:**

**Milestone I1:** Achieve “X% “ reduction in Pediatric/Young Adult Asthma Emergency Department use, where “X” will be determined in Year 2 based on baseline data.

**DY5:**

**Milestone I1:** Achieve “Y% “ reduction in Pediatric/Young Adult Asthma Emergency Department use, where “Y” will be determined in Year 2 based on baseline data.

***Rationale:***

Implementing a disease management program targeting patients with asthma in the medical home setting of MyChildren's should reduce pediatric and young adult emergency use as well as overall use of Emergency Department services.

***References:***

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26



**Project Valuation:**

This project was valued using the score for Project 1.3 which was based on the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

<b>138910807.3.3</b>	<b>OD 3.9.3</b>	<b>REDUCE PEDIATRIC AND YOUNG ADULT ASTHMA EMERGENCY DEPARTMENT VISITS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>RELATED CATEGORY 1 OR 2 PROJECTS</b>	<b>138910807.1.3</b>		
<b>Starting Point/Baseline</b>	<b>Pediatric and Young Adult Asthma Emergency Department Visits in DY1</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$36,314</b>	<b>Milestone P4:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$63,139</b>	<b>Milestone I1:</b> Achieve “X%” reduction in Pediatric and Young Adult Asthma Emergency Department use, where “X” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data Milestone I1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$202,632</b>	<b>Milestone I1:</b> Achieve “Y%” reduction in Pediatric and Young Adult Asthma Emergency Department use, where “Y” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data Milestone I1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$484,555</b>
<b>Milestone P2:</b> Establish baseline rates <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$36,314</b>	<b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices to stakeholders. <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$63,139</b>		
<b>Milestone P3:</b> Develop and test data systems <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$36,314</b>			

<i>138910807.3.3</i>	<i>OD 3.9.3</i>	<i>REDUCE PEDIATRIC AND YOUNG ADULT ASTHMA EMERGENCY DEPARTMENT VISITS</i>	
<i>Children's Medical Center of Dallas</i>			<i>138910807</i>
<b>RELATED CATEGORY 1 OR 2 PROJECTS</b>	<b>138910807.1.3</b>		
<b>Starting Point/Baseline</b>	<b>Pediatric and Young Adult Asthma Emergency Department Visits in DY1</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Year 2 Estimated Milestone Bundle Amount: \$108,942</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$126,278</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$202,632</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$484,555</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$922,407</b>			

**Title of Project:** Follow-up after Hospitalization for Mental Illness

**Unique RHP project identification number:** 138910807.3.4

**Performing Provider Name:** Children's Medical Center/13890807

## **Project Description**

**(Category 3 – OD-1 Primary and Chronic Disease Management): 3.1.18 Follow-up after Hospitalization for Mental Illness**

### ***Outcome Measure Description:***

Increase follow-up within 30 days after hospitalization for mental illness in patients enrolled in the MyChildren's medical homes through the expansion of behavioral health services in MyChildren's in RHP 18. Specific percentage of increase will be determined during baseline measurement in DY2.

***Rationale:*** Expand pediatric behavioral health capacity in CMC primary care settings to align and coordinate care for behavioral and medical illnesses in an attempt to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services and other behavioral health care providers for coordination of care between medical services and behavioral health services.

Implementing a follow-up process for patients post discharge for a mental illness and enrolled in MyChildren's medical homes should reduce readmissions, exacerbation and complications of mental illnesses.

### ***Process Milestones:***

#### **DY2:**

**Milestone P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.

**Milestone P2:** Establish baseline rates

**Milestone P3:** Develop and test data systems

#### **DY3:**

**Milestone P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Milestone P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

### ***Outcome Improvement Targets for Each Year:***

#### **DY4:**

**Milestone I1:** Achieve “X%” increase in follow-up after a hospitalization for mental illness, where “X” will be determined in Year 2 based on baseline data.

#### **DY5:**

**Milestone I1:** Achieve “Y%” increase in follow-up after a hospitalization for mental illness, where “Y” will be determined in Year 2 based on baseline data.

**Project Valuation:**

This project was valued using the value of Project 1.4 which was developed using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

**References**

James P. Smith, Gillian C. Smith Long-term Economic Costs of Psychological Problems During Childhood *Social Science & Medicine*, v. 71, no. 1, July 2010, p. 110-115.

Aalsma MC, Blythe MJ, Tong Y, Harezlak J, Rosenman MB. Insurance Status of Urban Detained Adolescents. *Journal of Correct Health Care*. 2012 Aug 23. [Epub ahead of print]

Dumont IP, Olson AL, Primary care, depression, and anxiety: exploring somatic and emotional predictors of mental health status in adolescents. *J Am Board Fam Med* 2012 May-Jun;25(3):291-9.

Jacob MK, Larson JC, Craighead WE Establishing a Telepsychiatry Consultation Practice in Rural Georgia for Primary Care Physicians: A Feasibility Report. *Clin Pediatr (Phila)*. 2012 Apr 20.

<b>138910807.3.4</b>	<b>OD 3.1.18</b>	<b>FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects</b>	<b>13891087.1.4</b>		
<b>Starting Point/Baseline</b>	<b>Follow-up after Hospitalization for Mental Illness in DY2</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$37,566</b> <b>Milestone P2:</b> Establish baseline rates <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$37,566</b> <b>Milestone P3:</b> Develop and test data systems <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$37,566</b>	<b>Milestone P4:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$65,316</b> <b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices to stakeholders. <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$65,316</b>	<b>Milestone I1:</b> Achieve “X%” increase in follow-up after hospitalization for mental, where “X” will be determined in Year 2 based on baseline data. i. Numerator: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	<b>Milestone I2:</b> Achieve “Y%” increase in follow-up after hospitalization for mental, where “Y” will be determined in Year 2 based on baseline data. j. Numerator: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

<b>138910807.3.4</b>	<b>OD 3.1.18</b>	<b>FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects</b>	<b>13891087.1.4</b>		
<b>Starting Point/Baseline</b>	<b>Follow-up after Hospitalization for Mental Illness in DY2</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		b. Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the	b. Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the

<b>138910807.3.4</b>	<b>OD 3.1.18</b>	<b>FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects</b>	<b>13891087.1.4</b>		
<b>Starting Point/Baseline</b>	<b>Follow-up after Hospitalization for Mental Illness in DY2</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		<p>30- day follow- up period, count only the readmission discharge or the discharge from the facility to which the member was transferred.</p> <p>c. Data Source: EHR, Claims</p> <p>d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.</p> <p>Rate 1. The percentage of members who received follow- up within 30 days of discharge</p> <p>Rate 2. The percentage of members who received follow-up within 7 days of</p>	<p>30- day follow- up period, count only the readmission discharge or the discharge from the facility to which the member was transferred.</p> <p>c. Data Source: EHR, Claims</p> <p>d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.</p> <p>Rate 1. The percentage of members who received follow- up within 30 days of discharge</p> <p>Rate 2. The percentage of members who received follow-up within 7 days of</p>



<b>138910807.3.4</b>	<b>OD 3.1.18</b>	<b>FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects</b>	<b>13891087.1.4</b>		
<b>Starting Point/Baseline</b>	<b>Follow-up after Hospitalization for Mental Illness in DY2</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		discharge. <b>Metric I.1:</b> Documented evidence of performance achieved. <b>Goal: To be determined in DY2</b> Milestone I1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$ 209,619</b>	discharge. <b>Metric I.2:</b> Documented evidence of performance achieved. <b>Goal: To be determined in DY2</b> Milestone I1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$501,264</b>
<b>Year 2 Estimated Milestone Bundle Amount: \$112,699</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$130,632</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$ 209,619</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$501,264</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$954,214</b>			

**Title of Project:** ED Appropriate Utilization

**Unique RHP project identification number:** 138910807.3.5

**Performing Provider Name:** Children's Medical Center/13890807

**Project Description:**

**(Category 3 – OD-9 Preventive and Primary Care): 3.9.2 Reduce pediatric Emergency Department visits**

***Outcome Measure Description:***

Decrease inappropriate Emergency Department use by expanding access to medical homes. Specific percentage of reduction will be determined during baseline measurement in DY2.

***Process Milestones:***

**DY2:**

**Milestone P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.

**Milestone P2:** Establish baseline rates

**Milestone P3:** Develop and test data systems

**DY3:**

**Milestone P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Milestone P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

***Outcome Improvement Targets for Each Year:***

**DY4:**

**Milestone I1:** Achieve “X% “ reduction in Emergency Department use, where “X” will be determined in Year 2 based on baseline data.

**DY5:**

**Milestone I1:** Achieve “Y% “ reduction in Emergency Department use, where “Y” will be determined in Year 2 based on baseline data.

***Rationale:***

Improving access to primary care by enhancing/expanding the medical homes should reduce inappropriate use as well as overall use of Emergency Department services.

**Project Valuation:**

This project was valued using the score for project 2.1 which was valued using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

**References:**

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. *J Am Board Fam Med*. 2011 May-Jun;24(3):240-8.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

*J Paediatr Child Health*. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. *Pediatr Emerg Care*. 2012 Sep 26

Lieberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. *Pediatr Emerg Care*. 2012 Sep 26

<b>138910807.3.5</b>	<b>OD 3.9.2</b>	<b>REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS</b>	
<b>Children's Medical Center of Dallas</b>			<b>138910807</b>
<b>Related Category 1 or 2 Projects:</b>	<b>138910807.1.1, 138910807.1.2, 138910807.2.1</b>		
<b>Starting Point/Baseline:</b>	<b>Emergency Department visits in DY1.</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive: <b>\$42,575</b>  <b>Milestone P2:</b> Establish baseline rates <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$42,575</b>  <b>Milestone P3:</b> Develop and test data systems <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment: <b>\$42,575</b>	<b>Milestone P4:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$74,025</b> <b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices to stakeholders. <b>Goal: Completed by 9/30/2014</b> Milestone 2 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$74,025</b>	<b>Milestone I1:</b> Achieve “X% “ reduction in Emergency Department use, where “X” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data Milestone I1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$237,569</b>	<b>Milestone I1:</b> Achieve “Y% “ reduction in Emergency Department use, where “Y” will be determined in Year 2 based on baseline data. <b>Metric 4:</b> Documented evidence of performance achieved. <b>Goal: Completed by 9/30/2015</b> <b>Data source:</b> Administrative data Milestone I1 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$568,099</b>
<b>Year 2 Estimated Milestone Bundle Amount:</b> <b>\$127,725</b>	<b>Year 3 Estimated Milestone Bundle Amount:</b> <b>\$148,050</b>	<b>Year 4 Estimated Milestone Bundle Amount:</b> <b>\$237,569</b>	<b>Year 5 Estimated Milestone Bundle Amount:</b> <b>\$568,099</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR: \$1,081,442</b>			

**Title of Outcome Measure/Improvement Target:** IT-1.11 Diabetes care: BP Control (<140/80mm Hg) – NQF 0061.

**Unique RHP Outcome Identification Number:** 126686802.3.1

**Performing Provider Name/TPI:** UT Southwestern/TPI126686802

### **Outcome Measure Description**

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

1. Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is compliant if the BP is less than 140/80 mm Hg.
2. Denominator: Members 18 to 75 of age as of December 31 of the measurement year with diabetes (type 1 and 2)
3. This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with BP more than 140/80 mm Hg is greater than 15%. If the number is less than 15%, the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all BP measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly.

**Data Source** EHR, Registry, Claims, Administrative clinical data

#### **Milestones**

DY2 – engage stakeholders, establishment of baseline and registry of eligible diabetic patients in the population

DY3 – establish treatment protocols and best practices for controlling glucose and test data systems

DY4 – decrease the percent of patients with BP > 140/80 mm Hg by *TBD*

DY5 – decrease the percent of patients with BP > 140/80 mm Hg by *TBD*

### **Rationale**

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

The RHP 18 Community Needs Assessment identifies Diabetes (CN.8) as an area of focus for the region. Diabetes in Collin County, both short term and long term, contributes an average of 492 Potentially Preventable Admissions (CN.7) per year. Grayson County contributes another 193 Potentially Preventable Admissions per year. Rockwall County adds another 37 PPA per year for diabetes. In every county in RHP

18, the highest proportion of uninsured Potentially Preventable Admissions is diabetes for long-term problems. This adds up to 722 Potentially Preventable Admissions per year for Diabetic patients. Obesity is another Community Need (CN.14) that is closely related to the Diabetes problem. The prevalence of obesity in Collin County is nearly twice the national average at 66.7%.

This measure evaluates the percentage of patients who were diagnosed with type 1 or type 2 diabetes and who sustain adequate blood pressure control. Diabetes is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including poor blood pressure control and subsequent cardiovascular disease of varying severity. Maintaining a healthy blood pressure has been shown to reduce complications due to diabetes, with a 10 mm Hg reduction in systolic blood pressure lowering the risk of complications by 12%. It also reduces the chance of cardiovascular disease among patients with diabetes by up to 50% and reduces the chance of other related complications (eye, kidney, nerve) by more than 25%. This measure facilitates long-term management of blood pressure levels for patients diagnosed with diabetes. (NQF 0061)

### **Outcome Measure Valuation**

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients within RHP 18 served by the UT Southwestern Clinical Center located in RHP 18. The community benefit will be the reduction in complications from diabetes and the reduced costs of potentially preventable hospital admissions for complications from diabetes. In addition, control of diabetes was identified as one of the community priorities in the Community Needs Assessment (CN.8 Diabetes and CN.7 Potentially Preventable Admissions).

<b>Category 3 Outcome measure:</b>	<b>IT - 1.10</b>	<b>Diabetes care: HgbA1c poor control (&gt;9.0%).</b>	
<b>UT Southwestern</b>			<b>126686802</b>
<b>Related Category 1 or 2 Projects:</b>	<b>126686802.1.1</b>		
<b>Starting Point/Baseline</b>	<b>To be determined</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Engage stakeholders, determine timeline and implementation plans and document implementation plans. <u>Metric 1.1 [P-1.1]:</u> Documentation of implementation plan, including current capacity and needed resources; meeting minutes; identification of stakeholders; and established timelines. <u>Goal:</u> Create Plan with stakeholder engagement. <u>Data Source:</u> Plan Documentation.  <b>Process Milestone 1 Payment : \$10,000</b>  <b>Process Milestone 2:</b> Develop and test data systems <u>Metric 2.1 [P-3.1]:</u> Documentation of testing results for the dissemination of outcomes data to primary care physicians. <u>Goal:</u> Document the creation of outcomes data reports to primary care physicians. .	<b>Process Milestone 4 [P-4]:</b> Conduct PDSA cycles to improve data collection and intervention activities. <u>Metric 4.1 [P-4.1]:</u> Improve data collection and intervention activities. <u>Goal:</u> <u>Data Source:</u> EHR and Provider Reports.  <b>Process Milestone 4 Payment: \$50,000</b>  <b>Process Milestone 5 [P-5]:</b> Disseminate findings, including lessons learned and best practices, to stakeholders <u>Metric 5.1 [P-4.1]:</u> Insure communications with stakeholders. <u>Goal:</u> Efficient dissemination of findings <u>Data Source:</u> Documentation of meeting minutes.  <b>Process Milestone 5 Payment:</b>	<b>Outcome Improvement Target 1 :</b> <u>Improvement Target:</u> Decrease the percent of patients with BP > 140/80mm Hg by <i>TBD – Based on Baseline established in DY2 and DY3</i>  <b>Outcome Improvement Target 1 Payment: \$208,560</b>	<b>Outcome Improvement Target 2:</b> <u>Improvement Target:</u> Decrease the percent of patients with BP > 140/80mm Hg by <i>TBD – Based on Baseline established in DY2 and DY3</i>  <b>Outcome Improvement Target 2 Payment: \$226,740</b>

<b>Category 3 Outcome measure:</b>	<b>IT - 1.10</b>	<b>Diabetes care: HgbA1c poor control (&gt;9.0%).</b>	
<b>UT Southwestern</b>			<b>126686802</b>
<b>Related Category 1 or 2 Projects:</b>	<b>126686802.1.1</b>		
<b>Starting Point/Baseline</b>	<b>To be determined</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<u>Data Source:</u> Sample reports. <u>Rationale:</u>  <b>Process Milestone 2 Payment:</b> <b>\$10,000</b>  <b>Process Milestone 3 [P-2]:</b> Establish baseline BP rates <u>Metric 3.1 [P-2.2]:</u> Submission of baseline rates. <u>Goal:</u> Document the baseline rates. <u>Data Source:</u> UTSW EHR  <b>Process Milestone 3 Payment:</b> <b>\$22,000</b>	\$47,470		
<b>Year 2 Estimated Outcome Amount: \$42,000</b>	<b>Year 3 Estimated Outcome Amount: \$97,470</b>	<b>Year 4 Estimated Outcome Amount: \$208,560</b>	<b>Year 5 Estimated Outcome Amount: \$226,740</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$574,770</b>			



**Title of Outcome Measure/Improvement Target:** IT-1.10 Diabetes care: HgbA1c poor control (>9.0%) – NQF 0059

**Unique RHP Outcome Identification Number:** 126686802.3.2

**Performing Provider Name/TPI:** UT Southwestern/TPI126686802

### Outcome Measure Description

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

4. Numerator: Percentage of patients 18- 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
5. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).
6. This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly.

**Data Source** EHR, Registry, Claims, Administrative clinical data

### Milestones

- DY2 – engage stakeholders, establishment of baseline and registry of eligible diabetic patients in the population
- DY3 – establish treatment protocols and best practices for controlling glucose and test data systems
- DY4 – decrease the percent of patients with HgbA1c > 0.9% by *TBD*
- DY5 - decrease the percent of patients with HgbA1c > 0.9% by *TBD*

### Rationale

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

The RHP 18 Community Needs Assessment identifies Diabetes (CN.8) as an area of focus for the region. Diabetes in Collin County, both short term and long term, contributes an average of 492 Potentially Preventable Admissions (CN.7) per year. Grayson County contributes another 193 Potentially Preventable

Admissions per year. Rockwall County adds another 37 PPA per year for diabetes. This adds up to 722 Potentially Preventable Admissions per year for Diabetic patients. Obesity is another Community Need (CN.14) that is closely related to the Diabetes problem. The prevalence of obesity in Collin County is nearly twice the national average at 66.7%.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that improved glycemic control is correlated with a 40% decline in the development of associated micro-vascular complications (i.e., eye, kidney and nerve diseases) (ADA 2009). Clinical guidelines recommend regular HbA1c testing to facilitate patients' ability to improve and sustain acceptable levels (ADA 2009). This measure facilitates the prevention and long-term management of high blood sugar levels for patients diagnosed with diabetes. (NQF 0059)

### **Outcome Measure Valuation**

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients within RHP 18 served by the UT Southwestern Clinical Center located in RHP 18. The community benefit will be the reduction in complications from diabetes and the reduced costs of potentially preventable hospital admissions for complications from diabetes. In addition, control of diabetes was identified as one of the community priorities in the Community Needs Assessment (CN.8 Diabetes and CN.7 Potentially Preventable Admissions).

<b>Category 3 Outcome measure</b>	<b>IT - 1.10</b>	<b>Diabetes care: HgbA1c poor control (&gt;9.0%).</b>	
<b>UT Southwestern</b>			<b>126686802</b>
<b>Related Category 1 or 2 Projects:</b>	<b>126686802.1.2</b>		
<b>Starting Point/Baseline:</b>	<b>To be determined</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Engage stakeholders, determine timeline and implementation plans and document implementation plans. Metric 1.1 [P-1.1]: Documentation of implementation plan, including current capacity and needed resources; meeting minutes; identification of stakeholders; and established timelines. Goal: Create Plan with stakeholder engagement. Data Source: Plan Documentation.  <b>Process Milestone 1 Payment : \$10,000</b>  <b>Process Milestone 2:</b> Develop and test data systems Metric 2.1 [P-3.1]: Documentation of testing results for the dissemination of outcomes data to primary care physicians. Goal: Document the creation of outcomes data reports to primary care physicians. . Data Source: Sample reports.	<b>Process Milestone 4 [P-4]:</b> Conduct PDSA cycles to improve data collection and intervention activities. Metric 4.1 [P-4.1]: Improve data collection and intervention activities. Goal: Data Source: EHR and Provider Reports.  <b>Process Milestone 4 Payment: \$50,000</b>  <b>Process Milestone 5 [P-5]:</b> Disseminate findings, including lessons learned and best practices, to stakeholders Metric 5.1 [P-4.1]: Insure communications with stakeholders. Goal: Efficient dissemination of findings Data Source: Documentation of meeting minutes.  <b>Process Milestone 5 Payment: \$47,470</b>	<b>Outcome Improvement Target 1 :</b> Improvement Target: Decrease the percent of patients with HgbA1c > 0.9% by <b><i>TBD – Based on Baseline established in DY2 and DY3</i></b>  <b>Outcome Improvement Target 1 Payment: \$208,560</b>	<b>Outcome Improvement Target 2:</b> Improvement Target: Decrease the percent of patients with HgbA1c > 0.9% by <b><i>TBD – Based on Baseline established in DY2 and DY3</i></b>  <b>Outcome Improvement Target 2 Payment: \$226,740</b>

<b>Category 3 Outcome measure</b>	<b>IT - 1.10</b>	<b>Diabetes care: HgbA1c poor control (&gt;9.0%).</b>	
<b>UT Southwestern</b>			<b>126686802</b>
<b>Related Category 1 or 2 Projects:</b>	<b>126686802.1.2</b>		
<b>Starting Point/Baseline:</b>	<b>To be determined</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Rationale:  <b>Process Milestone 2 Payment: \$15,000</b>  <b>Process Milestone 3 [P-2]:</b> Establish baseline HgbA1c rates Metric 3.1 [P-2.2]: Submission of baseline rates. Goal: Document the baseline rates. Data Source: UTSW EHR  <b>Process Milestone 3 Payment: \$17,000</b>			
<b>Year 2 Estimated Outcome Amount: \$42,000</b>	<b>Year 3 Estimated Outcome Amount: \$97,470</b>	<b>Year 4 Estimated Outcome Amount: \$208,560</b>	<b>Year 5 Estimated Outcome Amount: \$42,000</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$574,770</b>			

### **IT-1.10 Diabetes care: HgbA1c poor control (>9.0%) – NQF 0059.**

Unique RHP number: 126686802.3.3

Performing provider: The University of Texas Southwestern Medical Center (“UT Southwestern” or “UTSW”)/ TPI 126686802

**Outcome Measure Description:** This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

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).

This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly.

Data Source: EHR, Registry, Claims, Administrative clinical data

The milestones for this project include

DY2 – engage stakeholders, establishment of baseline and registry of eligible diabetic patients in the population

DY3 – establish treatment protocols and best practices for controlling glucose and test data systems

DY4 – decrease the percent of patients with HgbA1c > 0.9% by *TBD*

DY5 - decrease the percent of patients with HgbA1c > 0.9% by *TBD*

**Rationale:** Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

The RHP 18 Community Needs Assessment identifies Diabetes (CN.8) as an area of focus for the region. Diabetes in Collin County, both short term and long term, contributes an average of 492 Potentially Preventable Admissions (CN.7) per year. Grayson County contributes another 193 Potentially Preventable Admissions per year. Rockwall County adds another 37 PPA per year for diabetes. This adds up to 722 Potentially Preventable Admissions per year for Diabetic patients. Obesity is another Community Need (CN.14) that is closely related to the Diabetes problem. The prevalence of obesity in Collin County is nearly twice the national average at 66.7%.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that improved glycemic control is correlated with a 40% decline in the development of associated micro-vascular complications (i.e., eye, kidney and nerve diseases) (ADA 2009). Clinical guidelines recommend regular HbA1c testing to facilitate patients' ability to improve and sustain acceptable levels (ADA 2009). This measure facilitates the prevention and long-term management of high blood sugar levels for patients diagnosed with diabetes. (NQF 0059)

**Outcome Measure Valuation:** In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients within RHP 18 served by the UT Southwestern Clinical Center located in RHP 18. The community benefit will be the reduction in complications from diabetes and the reduced costs of potentially preventable hospital admissions for complications from diabetes. In addition, control of diabetes was identified as one of the community priorities in the Community Needs Assessment (CN.8 Diabetes and CN.7 Potentially Preventable Admissions).

<b>Unique Cat 3 ID: 126686802.3.3</b>	<b>Reference Number: IT - 1.10</b>	Diabetes care: HgbA1c poor control (>9.0%).	
<i>Performing provider - UT Southwestern Faculty Practice Plan</i>			<b>TPI 126686802</b>
<b>Related Category 1 or 2 Projects::</b>	<b>126686802.1.1</b> <b>126686802.1.2</b>		
<b>Starting Point/Baseline:</b>	<i>Zero (0) – New Clinic</i>		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1 [P-1]:</b> Engage stakeholders, determine timeline and implementation plans and document implementation plans.</p> <p><u>Metric 1.1 [P-1.1]:</u> Documentation of implementation plan, including current capacity and needed resources; meeting minutes; identification of stakeholders; and established timelines.</p> <p><u>Goal:</u> Create Plan with stakeholder engagement.</p> <p><u>Data Source:</u> Plan Documentation.</p> <p><b>Process Milestone 1 Payment : \$9,333.33</b></p> <p><b>Process Milestone 2:</b> Develop and test data systems</p> <p><u>Metric 2.1 [P-3.1]:</u> Documentation of testing results for the dissemination of outcomes data to primary care physicians.</p>	<p><b>Process Milestone 4 [P-4]:</b> Conduct PDSA cycles to improve data collection and intervention activities.</p> <p><u>Metric 4.1 [P-4.1]:</u> Improve data collection and intervention activities.</p> <p><u>Goal:</u></p> <p><u>Data Source:</u> EHR and Provider Reports.</p> <p><b>Process Milestone 4 Payment: \$32,490</b></p> <p><b>Process Milestone 5 [P-5]:</b> Disseminate findings, including lessons learned and best practices, to stakeholders</p> <p><u>Metric 5.1 [P-4.1]:</u> Insure communications with stakeholders.</p> <p><u>Goal:</u> Efficient dissemination of findings</p>	<p><b>Outcome Improvement Target 1 :</b></p> <p><u>Improvement Target:</u> Decrease the percent of patients with HgbA1c &gt; 0.9% by <b>TBD – Based on Baseline established in DY2 and DY3</b></p> <p><b>Outcome Improvement Target 1 Payment: \$139,040</b></p>	<p><b>Outcome Improvement Target 2:</b></p> <p><u>Improvement Target:</u> Decrease the percent of patients with HgbA1c &gt; 0.9% by <b>TBD – Based on Baseline established in DY2 and DY3</b></p> <p><b>Outcome Improvement Target 2 Payment: \$151,160</b></p>

<b>Unique Cat 3 ID: 126686802.3.3</b>	<b>Reference Number: IT - 1.10</b>	Diabetes care: HgbA1c poor control (>9.0%).	
<i>Performing provider - UT Southwestern Faculty Practice Plan</i>			<b>TPI 126686802</b>
<b>Related Category 1 or 2 Projects::</b>	<b>126686802.1.1</b> <b>126686802.1.2</b>		
<b>Starting Point/Baseline:</b>	<i>Zero (0) – New Clinic</i>		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<u>Goal:</u> Document the creation of outcomes data reports to primary care physicians. . <u>Data Source:</u> Sample reports. <u>Rationale:</u> <b>Process Milestone 2 Payment: \$9,333.33</b>  <b>Process Milestone 3 [P-2]:</b> Establish baseline HgbA1c rates <u>Metric 3.1 [P-2.2]:</u> Submission of baseline rates. <u>Goal:</u> Document the baseline rates. <u>Data Source:</u> UTSW EHR <b>Process Milestone 3 Payment: \$9,333.34</b>	<u>Data Source:</u> Documentation of meeting minutes.  <b>Process Milestone 5 Payment: \$32,490</b>		
<b>\$28,000</b>	<b>\$64,980</b>	<b>\$139,040</b>	<b>\$151,160</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$383,180</b>			



### **IT-1.11 Diabetes care: BP Control (<140/80mm Hg) – NQF 0061.**

Unique RHP number: 126686802.3.4

Performing provider: The University of Texas Southwestern Medical Center (“UT Southwestern” or “UTSW”)/ TPI 126686802

**Outcome Measure Description:** This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is compliant if the BP is less than 140/80 mm Hg.

Denominator: Members 18 to 75 of age as of December 31 of the measurement year with diabetes (type 1 and 2)

This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with BP more than 140/80 mm Hg is greater than 15%. If the number is less than 15%, the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all BP measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly.

Data Source: EHR, Registry, Claims, Administrative clinical data

The milestones for this project include

DY2 – engage stakeholders, establishment of baseline and registry of eligible diabetic patients in the population

DY3 – establish treatment protocols and best practices for controlling glucose and test data systems

DY4 – decrease the percent of patients with BP > 140/80 mm Hg by *TBD*

DY5 – decrease the percent of patients with BP > 140/80 mm Hg by *TBD*

**Rationale:** Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

The RHP 18 Community Needs Assessment identifies Diabetes (CN.8) as an area of focus for the region. Diabetes in Collin County, both short term and long term, contributes an average of 492 Potentially Preventable Admissions (CN.7) per year. Grayson County contributes another 193 Potentially Preventable Admissions per year. Rockwall County adds another 37 PPA per year for diabetes. In every county in RHP 18, the highest proportion of uninsured Potentially Preventable Admissions is diabetes for

long-term problems. This adds up to 722 Potentially Preventable Admissions per year for Diabetic patients. Obesity is another Community Need (CN.14) that is closely related to the Diabetes problem. The prevalence of obesity in Collin County is nearly twice the national average at 66.7%.

This measure evaluates the percentage of patients who were diagnosed with type 1 or type 2 diabetes and who sustain adequate blood pressure control. Diabetes is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including poor blood pressure control and subsequent cardiovascular disease of varying severity. Maintaining a healthy blood pressure has been shown to reduce complications due to diabetes, with a 10 mm Hg reduction in systolic blood pressure lowering the risk of complications by 12%. It also reduces the chance of cardiovascular disease among patients with diabetes by up to 50% and reduces the chance of other related complications (eye, kidney, nerve) by more than 25%. This measure facilitates long-term management of blood pressure levels for patients diagnosed with diabetes. (NQF 0061)

**Outcome Measure Valuation:** In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data, and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients within RHP 18 served by the UT Southwestern Clinical Center located in RHP 18. The community benefit will be the reduction in complications from diabetes and the reduced costs of potentially preventable hospital admissions for complications from diabetes. In addition, control of diabetes was identified as one of the community priorities in the Community Needs Assessment (CN.8 Diabetes and CN.7 Potentially Preventable Admissions).

<b>Unique Category 3 ID:</b> <b>126686802.3.4</b>	<b>IT-1.11</b>	<b>Diabetes care: BP Control (&lt;140/80mm Hg)</b>	
<i>Performing provider - UT Southwestern</i>			<i>[RHP Performing Provider - TPI]</i>
<b>Related Category 1 or 2 Projects::</b>	126686802.1.1 126686802.1.2		
<b>Starting Point/Baseline:</b>	<i>Zero (0) – new clinic</i>		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Engage stakeholders, determine timeline and implementation plans and document implementation plans. <u>Metric 1.1 [P-1.1]:</u> Documentation of implementation plan, including current capacity and needed resources; meeting minutes; identification of stakeholders; and established timelines. <u>Goal:</u> Create Plan with stakeholder engagement. <u>Data Source:</u> Plan Documentation. <b>Process Milestone 1 Payment : \$9,333.33</b>  <b>Process Milestone 2:</b> Develop and test data systems <u>Metric 2.1 [P-3.1]:</u> Documentation of testing results for the dissemination of outcomes data to primary care	<b>Process Milestone 4 [P-4]:</b> Conduct PDSA cycles to improve data collection and intervention activities. <u>Metric 4.1 [P-4.1]:</u> Improve data collection and intervention activities. <u>Goal:</u> <u>Data Source:</u> EHR and Provider Reports. <b>Process Milestone 4 Payment: \$32,490</b>  <b>Process Milestone 5 [P-5]:</b> Disseminate findings, including lessons learned and best practices, to stakeholders <u>Metric 5.1 [P-4.1]:</u> Insure communications with stakeholders. <u>Goal:</u> Efficient dissemination of findings <u>Data Source:</u> Documentation of meeting minutes.	<b>Outcome Improvement Target 1 :</b> <u>Improvement Target:</u> Decrease the percent of patients with BP > 140/80mm Hg by <i>TBD – Based on Baseline established in DY2 and DY3</i> <b>Outcome Improvement Target 1 Payment: \$139,040</b>	<b>Outcome Improvement Target 2:</b> <u>Improvement Target:</u> Decrease the percent of patients with BP > 140/80mm Hg by <i>TBD – Based on Baseline established in DY2 and DY3</i> <b>Outcome Improvement Target 2 Payment: \$151,160</b>

<b>Unique Category 3 ID: 126686802.3.4</b>	<b>IT-1.11</b>	<b>Diabetes care: BP Control (&lt;140/80mm Hg)</b>	
<i>Performing provider - UT Southwestern</i>			<i>[RHP Performing Provider - TPI]</i>
<b>Related Category 1 or 2 Projects::</b>	126686802.1.1 126686802.1.2		
<b>Starting Point/Baseline:</b>	<i>Zero (0) – new clinic</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
physicians. <u>Goal:</u> Document the creation of outcomes data reports to primary care physicians. . <u>Data Source:</u> Sample reports. <u>Rationale:</u>  <b>Process Milestone 2 Payment: \$9,333.33</b>  <b>Process Milestone 3 [P-2]:</b> Establish baseline BP rates <u>Metric 3.1</u> [P-2.2]: Submission of baseline rates. <u>Goal:</u> Document the baseline rates. <u>Data Source:</u> UTSW EHR  <b>Process Milestone 3 Payment: \$9,333.34</b>	<b>Process Milestone 5 Payment: \$32,490</b>		
<b>\$28,000</b>	<b>\$64,980</b>	<b>\$139,040</b>	<b>\$151,160</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$383,180</b>			

**Title of Outcome Measure/Improvement Target:** OD- 10 Quality of Life  
**Title of project:** Establish More Primary Care Clinics  
**Unique RHP Project Identification Number:** 194997601.3.1  
**Performing Provider Name/TPI:** Texoma Medical Center/194997601

**Title of Outcome Measure (Improvement Target):**

OD-1 – Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment 217, 218

IT-1.6 Cholesterol management for patients with cardiovascular conditions

**Outcome Description:** Please describe the outcome measure, specifically process milestones and selected improvement target(s) for each year (e.g., improve by 5% by end of waiver).’

In DY 2-3, Process Measure (P-3) the provider will implement a system by month 11 that will ensure that the average length of time in days between the day a patient makes a request for an appointment at the clinic and the third available appointment for a new patient physical routine exam or a return visit exam.

In DY 2-3, the provider will develop plans for implementing a cholesterol management program for patients with cardiovascular conditions for those with an LDL-C Level deemed unhealthy.

In DY 4-5, the provider will continue to implement a cholesterol management program for patients with cardiovascular conditions for those with an LDL-C Level deemed unhealthy.

By the end of the waiver Year 5, the provider will ensure an average daily goal of reaching the third next available appointment numerator and will have implemented a cholesterol management program..

**Rationale** As this is a new clinic, established in part to alleviate congested emergency rooms by caring for non-emergent primary care issues, this Category 3 Outcome fits with the model of care.

IT-1.1 and IT-1.6 complement each other because cholesterol screenings are based on the scheduling of regular appointment dates among patients. As the clinic develops techniques for the scheduling of patients, clinic workers will have a system for preventative care.

**Outcome Measure Valuation**

**Approach/Methodology:** Please describe your approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets).

DY 2-3 – In DY 2, a system will be created to easily monitor the registration of new patients and the logging of existing patients. In addition, a method for evaluating cholesterol will be developed.

DY 4 – Patients with LDL-C levels deemed unhealthy by the physician or nurse practitioner will be placed on a regimen and will return periodically, based on best practices. Blood will be redrawn in the next annual visit. Meanwhile, regular scheduling of new and existing patients will continue.

DY 5 – Patients with LDL-C levels deemed unhealthy by the physician or nurse practitioner will be placed on a regimen and will return periodically, based on best practices. Blood will be redrawn in the next annual visit. Meanwhile, regular scheduling of new and existing patients will continue.

**Rationale/Justification:** Because this is a new office in an area in great need of a primary care clinic, establishing a mechanism for scheduling and visiting with patients in a targeted amount of time is

appropriate. The three-day appointment target allows clinic management to plan, develop, establish and evaluate a system for managing patient visits. As shown in the Community Needs Assessment, obesity is a concern in Grayson County, the cholesterol testing system is one mechanism the clinic will utilize to monitor patient progress in addressing obesity and accompanying heart disease. (Please refer to chart below.)

**Outcome Measure -- Patient/population health will improve.**

The obesity rate in Grayson County residents is high – only two percentage points below the state average. The appointment availability, combined with cholesterol screening Category 3 outcomes, is appropriate. The identification of these outcomes is partially based on information provided in the RHP-18 Community Needs Assessment. Details regarding the health of Grayson County residents are provided in the chart.

	Grayson	Texas
Adult Smoking	24%	19%
Adult Obesity	27%	29%
Physical Inactivity	27%	25%
Excessive Drinking	11%	16%
Primary Care Physicians to Patients Ratio	1,305:1	1,050:1

**Project Scope** – To provide primary healthcare services to poor and uninsured populations in Grayson County and measure performance outcomes through scheduling initiatives and cholesterol monitoring

**Population Served** – Grayson County residents

**Community Benefit and Cost Avoidance** – To provide primary healthcare services to poor and uninsured populations in Grayson County

**Addressing Priority Community Need** – To provide primary healthcare services to poor and uninsured populations in Grayson County

**Related Category 1 projects.** In addition to the Grayson County Clinic 194997601.1.1 project, Category 1 & 2 projects by Texoma Community Center can be linked in order to provide primary care for behavioral health patients.

194997601.3.1	OD-1/IT-1.1/IT-1.6	Percent improvement over baseline of patient QOL/Functional Status scores	
Texoma Medical Center			194997601
Related Category 1 or 2 Projects:	194997601.1.1		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will 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)
<b>Process Milestone 1 (IT-1.1):</b> Develop a written plan that outlines a mechanism for enhancing patient care by reducing days to third next available appointment. <b>Data Source:</b> Scheduling system information  <b>Est. Incentive Payment:</b> <b>\$350,000</b>  <b>Process Milestone 1 (IT-1.6):</b> Develop a written plan that outlines a mechanism for providing consistent cholesterol screening for patients with identified LDL-C levels. <b>Data Source:</b> Registry  <b>Est. Incentive Payment:</b> <b>\$350,000</b>	<b>Process Milestone 2 (IT-1.1):</b> Utilize the written plan to develop methodology and scheduling system (scheduling implementation by Month 6). <b>Data Source:</b> Scheduling system information  <b>Est. Incentive Payment:</b> <b>\$315,000</b>  <b>Process Milestone 2 (IT-1.6):</b> Begin to see patients for primary care and place them on a regular schedule of appointments. If LDL-C levels are high based on the written plan, a course of treatment will be established based on the plan. <b>Data Source:</b> Registry  <b>Est. Incentive Payment:</b> <b>\$315,000</b>	<b>Outcome Improvement Target 1 (IT-1.1):</b> Test study a group of patients (in two groups – new and existing). Review visit frequency during Months 1-6 and evaluate the institution of the “third next available appointment” plan; including a survey. <b>Data Source:</b> Scheduling system information  <b>Est. Incentive Payment:</b> <b>\$430,000</b>  <b>Outcome Improvement Target 1 (IT-1.6):</b> Study a group of high cholesterol patients identified through blood work DY 3. Track improved cholesterol levels DY 4. <b>Data Source:</b> Registry  <b>Est. Incentive Payment:</b> <b>\$430,000</b>	<b>Outcome Improvement Target 1 (IT-1.1):</b> Implement necessary updates to the “third next available appointment” plan. <b>Data Source:</b> Scheduling system information  <b>Est. Incentive Payment:</b> <b>\$1,500,000</b>  <b>Outcome Improvement Target 1 (IT-1.6):</b> Continue to monitor progress of test study group based on those patients who continue to return for regular appointments. <b>Data Source:</b> Registry  <b>Est. Incentive Payment:</b> <b>\$1,500,000</b>
Year 2 Estimated Outcome Amount: \$700,000	Year 3 Estimated Outcome Amount: \$630,000	Year 4 Estimated Outcome Amount: \$860,000	Year 5 Estimated Outcome Amount: \$3,000,000
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$5,190,000</b>			

**Unique RHP Outcome Identification Number:** 084001901.3.1

**Performing Provider Name/TPI:** LifePath Systems TPI: 084001901

### **Outcome Measure Description**

OD- 10 Quality Of Life/ Functional Status; IT-10.1 Quality of Life (Standalone measure)

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 for quality of life, either the AQoL or SFv12.

**Rationale/Evidence** Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Process milestones for the first 6 month of year 2 includes choosing the most appropriate Quality of Life assessment (either AQoL or SFv12), obtaining necessary rights to use the instrument, and establishing procedures for its use. During the second 6 months of year 2, our process milestone is to train all appropriate staff in the utilization of the chosen Quality of Life assessment and to initiate its use. The process milestone for the first 6 months of year 3 is to establish baseline data for the admission scores on the chosen Quality of Life assessment. In the second 6 months of year 3, we plan to demonstrate at least a 10% improvement in Quality of Life scores for the identified population. For Year 4, the outcome improvement target is a 15% improvement in Quality of Life scores. For Year 5, the outcome improvement target is a 20% improvement in Quality of Life scores.

**Rationale** The reasons for selecting our identified process milestones and outcome improvement target is that we are not currently using a standardized Quality of Life assessment and we are not currently offering integrated care or whole health peer services. The rationale for this outcome measure includes the fact that many low income individuals are unable to access primary or behavioral health care and could benefit from additional services to assist them with the process of setting and achieving health goals. With the integration of these services, we expect to see an improvement in this population's overall quality of life. However, we must first choose the most appropriate assessment for our population, obtain rights to use the assessment, establish internal procedures for its use, train necessary staff in its use, and initiate use of the assessment. Improvement scores (15% in year 4 and 20% in year 5) are conservative estimates as we have no data to compare these percentages to at this time.

**Outcome Measure Valuation** The valuation for outcome measures was derived using a cost-effectiveness analysis. Simon et al (2012) found 47.7 additional depression-free days from a collaborative approach, with an established cost savings of \$52 per day. Measuring and reporting this data will result in a community benefit by demonstrating that effective, collaborative treatment can have a dramatic and positive impact on individuals with co-occurring illnesses.



<b>Category 3 Outcome Measure:</b>	<b>IT-10.1</b>	<b>Quality of Life</b>	
<b>LifePath Systems</b>			<b>084001901</b>
<b>Related Category 1 or 2 Projects:</b>	<b>084001901.2.1 and 084001901.2.4</b>		
<b>Starting Point/Baseline:</b>	<b>Baseline is 0% improvement in Quality of Life score as we have not used an assessment in order to establish a baseline</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [3.1.P-7]:</b> Obtain rights to utilize a Quality of Life assessment (AQoL or SFv12) and establish procedures for use Data Source: Project documentation  Process Milestone 1 Estimated Incentive Payment (maximum amount): \$  <b>Process Milestone 2 [3.1.P-7]:</b> Train staff in utilization of Quality of Life assessment and initiate use  Data Source: Project documentation, Training records  <b>Process Milestone 2 Estimated Incentive Payment (maximum amount): \$ 0</b>	<b>Process Milestone 3 [3.1.P-2]:</b> Establish baseline rates for admission scores with the chosen Quality of Life assessment Data Source: Project Documentation  Process Milestone 3 Estimated Incentive Payment (maximum amount): \$89,278  <b>Outcome Improvement Target 1 [3.1.IT-10.1]:</b> Demonstrate improvement in Quality of Life scores Improvement Target: 10% of population assessed demonstrate improvement in Quality of Life scores Data Source: Quality of Life assessment scores  <b>Outcome Improvement Target 1 Estimated Incentive Payment: \$89,278</b>	<b>Outcome Improvement Target 2 [3.1.IT-10.1]:</b> Demonstrate improvement in Quality of Life scores Improvement Target: 15% of population assessed demonstrate improvement in Quality of Life scores Data Source: Quality of Life assessment scores  <b>Outcome Improvement Target 2 Estimated Incentive Payment: \$178,555</b>	<b>Outcome Improvement Target 3 [3.1.IT-10.1]:</b> Demonstrate improvement in Quality of Life scores Improvement Target: 20% of population assessed demonstrate improvement in Quality of Life scores Data Source: Quality of Life assessment scores  <b>Outcome Improvement Target 3 Estimated Incentive Payment: \$357,110</b>
<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$178,555</b>	<b>Year 4 Estimated Outcome Amount: \$178,555</b>	<b>Year 5 Estimated Outcome Amount: \$357,110</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$714,220</b>			

**Unique RHP Outcome Identification Number: 084434201.3.1**

**Outcome Measure Title:** OD-10 Quality of Life/Functional Status

**Provider:** Texoma Community Center/084434201

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status

**IT-10.1 Quality of life- (standalone measure)**

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

Data source: Assessment of Quality of Life Tool Data Results

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

**Outcome Measure Description:** Quality of Life/Functional Status was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and Quality of Life in a variety of areas, as well as reduce the impact of mental and behavioral health and substance abuse issues on emergency rooms, acute care hospitals and psychiatric hospitals in TCC's service area.

The Category 1 and Category 2 process milestones selected are designed to ensure effective implementation of each project regardless of the project scope. The process milestones selected are designed to ensure effective implementation of each project. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact improvement percentages will be determined in DY-2. TCC emphasizes evidenced-based treatment and curricula, and has an established

history over the past five to seven years of already reducing internal medication costs, and reducing psychiatric hospitalizations all while expanding rehab services, stabilizing more and more patients, and improving outcomes. TCC is poised to continue this improvement trend into the next five years and beyond.

**Rationale:** Hyde reports in a SAMHSA presentation titled “Behavioral Health: Public Health Challenge Public Health Opportunity” that: “One-half of U.S. adults will develop at least one mental illness in their lifetime. Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity.”(42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that “69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder” and that “Health care costs [are] higher with co-morbid BH [behavioral health] conditions” which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: “Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses.” She explains that: “Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care...” (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services, expanding provider network for substance abuse treatment, providing counseling options for those with no health insurance and expanding capacity through telementalhealth options as well as ensuring quality improvements across all projects will have an overall positive impact on patient functioning and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for Texoma Community Center to use to assess the impact of both individual projects and to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

**Outcome Measure Valuation:** “The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging.” (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the “standalone” outcome indicator of Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of the projects. Using measured quality of life improvements to give definition to the size, scope, community benefit, efficiency and cost reduction/avoidance, beneficial outcomes can be quantified.

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

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

Based on the correlating Category 1 Project expectations, TCC can expect to intervene with approximately 240 individuals by expanding telemedicine services to additional patients in the existing adult and children's programs, expanding telemedicine services to the intended substance abuse treatment program, anticipated Internship program and counseling services program as well as adding the primary care physician to current psychiatric services. The benefits of the proposed program are valued based on assigning this monetary value of \$50,000 per life-year gained due to expanding intervention services through telemedicine, which will have a significantly positive impact (potentially \$12 million reduction) on the community healthcare resources. This valuation threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)**.

084434201.3.1	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
<b>Related Category 1 or 2 Projects:</b>	084434201.1.1		
<b>Starting Point/Baseline:</b>	There is no baseline established but will be after first AQoL scores are received in each project area.		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<p>Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$ 2,112.50</p> <p>Process Milestone 2 [P-2]: Establish baseline number of individuals in underserved area using telemedicine/telehealth/ telemonitoring/ telementoring Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results</p> <p><b>Process Milestone 2 Estimated Incentive Payment: \$ 2,112.50</b></p>	<p>Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results &amp; assessment results Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys</p> <p>Process Milestone 3 Estimated Incentive Payment: \$ 4,897.50</p> <p>Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD IT-1 Metric: Target established Data Source: AQoL survey assessment results</p> <p><b>Outcome Improvement Target 1 Estimated Incentive Payment: \$ 4,897.50</b></p>	<p>Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys</p> <p><b>Outcome Improvement Target 2 Estimated Incentive Payment: \$ 10,478.00</b></p>	<p>Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys</p> <p><b>Outcome Improvement Target 3 Estimated Incentive Payment: \$ 22,779.00</b></p>

084434201.3.1	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:		084434201.1.1	
Starting Point/Baseline:	There is no baseline established but will be after first AQoL scores are received in each project area.		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Outcome Amount: \$ 4,225.00	Year 3 Estimated Outcome Amount: \$ 9,795.00	Year 4 Estimated Outcome Amount: \$ 10,478.00	Year 5 Estimated Outcome Amount: \$ 22,779.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 47,277.00			

**Unique RHP Outcome Identification Number:** 084434201.3.2

**Outcome Measure Title:** OD-10 Quality of Life/Functional Status

**Provider:** Texoma Community Center/084434201

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status

**IT-10.1 Quality of life- (standalone measure)**

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

Data source: Assessment of Quality of Life Tool Data Results

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

**Outcome Measure Description:** Quality of Life/Functional Status was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and Quality of Life in a variety of areas, as well as reduce the impact of mental and behavioral health and substance abuse issues on emergency rooms, acute care hospitals and psychiatric hospitals in TCC's service area.

Process Milestones: The Category 1 process milestones selected for Project 084434201.1.2 are as follows: DY2 (1) procurement of necessary equipment & licenses; and (2) develop protocols and clinical guidelines needed; DY 3 (3) hire and train certified and experienced licensed professionals for the program; (4) establish appropriate service sites, (5) participate in regional learning collaborative; DY 4 (7) participate in regional learning collaborative; DY 5 (9) Participate in regional learning collaborative.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.2 are as follows: DY 4 (6) increase utilization of substance abuse community behavioral health program by 20+ patients over zero baseline and have 2 internships in place; DY 5 (8) increase utilization of substance abuse community behavioral health program by 15 patients over zero baseline and have 3 internships in place.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service

requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

**Rationale:** Hyde reports in a SAMHSA presentation titled “Behavioral Health: Public Health Challenge Public Health Opportunity” that: “One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity.” (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that “69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder” and that “Health care costs [are] higher with co-morbid BH [behavioral health] conditions” which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: “Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses.” She explains that: “Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care...” (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services as well as ensuring quality improvements across all projects will have an overall positive impact on their functioning in the community and result in a reduction of health costs across the regional area. The Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier to assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.6,CN.7)

**Outcome Measure Valuation:** “The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging.” (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects.

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



to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. Two studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. **(9e)** Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. The average of these two values is 0.11135. **(9f)** Based on project expectations, TCC can expect to intervene with estimated 44 individuals. The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. Using the QALY methodology, the correlated Category 1 Project is valued at \$295,756.00 and the expected Category 3 valuation is \$39,514.00.

Substance abuse services and the Internship program will focus TCC energies on increased individual and community value by expanding services to the “un-served” individual. In concert with enhanced technological capabilities and a Quality Improvement Department, the expanded services will evidence an increased value that will ultimately equate to improved quality of life for more people than have been traditionally served by TCC. As with all of TCC’s projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid.

084434201.3.2	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
<b>Related Category 1 or 2 Projects:</b>	084434201.1.2		
<b>Starting Point/Baseline:</b>	There is no baseline established but will be after first AQoL scores are received in each project area.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p>Process Milestone 1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve AQoL scores for patients. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$ 1,765.50</p> <p>Process Milestone 2 [P-2]: Establish baseline TBD P-2 Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results Rationale: It is necessary to</p>	<p>Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results &amp; assessment results Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys</p> <p>Process Milestone 3 Estimated Incentive Payment: \$ 4,093.50</p> <p>Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD IT-1 Metric: Target established Data Source: AQoL survey assessment results</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$ 4,093.50</p>	<p>Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$ 8,757.00</p>	<p>Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$ 19,039.00</p>

084434201.3.2	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
<b>Related Category 1 or 2 Projects:</b>	084434201.1.2		
<b>Starting Point/Baseline:</b>	There is no baseline established but will be after first AQoL scores are received in each project area.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
measure current performance to plan improvement.  Process Milestone 2 Estimated Incentive Payment: \$ 1,765.50			
<b>Year 2 Estimated Outcome Amount: \$3,531.00</b>	<b>Year 3 Estimated Outcome Amount: \$8,187.00</b>	<b>Year 4 Estimated Outcome Amount: \$8,757.00</b>	<b>Year 5 Estimated Outcome Amount: \$19,039.00</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 39,514.00</b>			

**Unique RHP Outcome Identification Number:** 084434201.3.3

**Outcome Measure Title:** OD-10 Quality of Life/Functional Status

**Provider:** Texoma Community Center/084434201

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status

**IT-10.1 Quality of life- (standalone measure)**

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

Data source: Assessment of Quality of Life Tool Data Results

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

**Outcome Measure Description:** Quality of Life/Functional Status was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and Quality of Life in a variety of areas, as well as reduce the impact of mental and behavioral health and substance abuse issues on emergency rooms, acute care hospitals and psychiatric hospitals in TCC's service area.

Process Milestones: The Category 1 process milestones selected for Project 084434201.1.3 are as follows: DY2 (1) procurement of necessary equipment & licenses to operate services; and (2) develop administrative protocols and clinical guidelines needed; DY 3 (3) hire and train 2 experienced licensed professionals for the program; (4) establish counseling services in 1 new community-based service site who are serving 1.5% over TCC baseline; (5) participate in regional learning collaborative; DY 4 (7) participate in regional learning collaborative; DY 5 (9) Participate in regional learning collaborative.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.3 are as follows: DY 4 (6) increase utilization of counseling community behavioral health program by 5 patients over DY 3 goal; DY 5 (8) increase utilization of counseling community behavioral health program by 6 patients over DY 4 goal.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements, goals to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

**Rationale:** Hyde reports in a SAMHSA presentation titled “Behavioral Health: Public Health Challenge Public Health Opportunity” that: “One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity.” (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that “69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder” and that “Health care costs [are] higher with co-morbid BH [behavioral health] conditions” which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: “Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses.” She explains that: “Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care...” (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services, expanding provider network for substance abuse treatment, providing counseling options for those with no health insurance and expanding capacity through telementalhealth options as well as ensuring quality improvements across all projects will have an overall positive impact on their functioning in the community and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for this Local Mental Health Authority to use in assessing in impact of not only the individual projects, but to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.4, CN.5,CN.6, CN.7, CN.11, CN.112)

**Outcome Measure Valuation:** “The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging.” (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome

indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects. This measure spans four of the five projects; using measured quality of life improvements to give definition to the size, scope, community benefit, and even efficiency and cost reduction/avoidance as each produces beneficial outcomes.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. To support this methodology, a study by Hollinghurst, et. al. (2010) examines online cognitive behavioral treatment (CBT) of depression and found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245. **(9g)** The calculated value of the correlated Category 1 Expand Behavioral Health Care Project was \$470,370.00 and there is an expected minimum of 23 individuals to be served. Thus, the calculated related Category 3 value is \$62,844.00.

The expanded behavioral health care through counseling project will focus TCC energies on increased individual and community value by expanding services to the “un-served” individual. In concert with enhanced technological capabilities and a Quality Improvement Department, the expanded services will evidence an increased value that will ultimately equate to improved quality of life for more people than have been traditionally served by TCC. As with all of TCC’s projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

084434201.3.3	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
<b>Related Category 1 or 2 Projects:</b>	084434201.1.3		
<b>Starting Point/Baseline:</b>	Baseline to be established in DY 2.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 2,808.00 Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results Process Milestone 2 Estimated Incentive Payment: \$ 2,808.00	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: \$6,510.00 Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD IT-1 Metric: Target established Data Source: AQoL survey assessment results Outcome Improvement Target 1 Estimated Incentive Payment: \$ 6,510.00	Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment: \$ 13,928.00	Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment: \$ 30,280.00
<b>Year 2 Estimated Outcome Amount: \$ 5,616.00</b>	<b>Year 3 Estimated Outcome Amount: \$ 13,020.00</b>	<b>Year 4 Estimated Outcome Amount: \$ 13,928.00</b>	<b>Year 5 Estimated Outcome Amount: \$30,280.00</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</b>			<b>\$ 62,844.00</b>

**Outcome Measure Title:** OD-9 ED Appropriate Utilization (Standalone measure)

**Unique RHP Outcome Identification Number:** 084434201.3.4

**Provider:** Texoma Community Center/084434201

**Outcome Measure Description:** Reduce Emergency Department visits for target conditions:

- Behavioral Health/Substance Abuse

The process milestones selected to facilitate reporting outcomes for this

Category 3 Projects will be as follow:

P-1-- The Project Planning- engage stakeholders, identify current capacity and needed resources.

P-2—Establish baseline rates.

P-3—Develop and test data systems.

P-5—Disseminate findings, including lessons learned and best practices, to stakeholders.

**Outcome Measure Description:** As capacity and resources are determined in Year 2, specific target reductions rates will then be determined and set. Based on past experience by TCC crisis staff, a reduction of emergency room visits will be experienced as additional patients are stabilized both in the existing programs and in the newly planned substance abuse treatment facility and counseling center. Part of the project will be to track and document individuals with mental health, behavioral health, and substance abuse issues as presenting to emergency rooms for treatment, and reduce these ED visits over time. It is expected that TCC's other anticipated projects. 084434201.1.1, 2, and 3, and 2.1, can, when facilitated, directly impact Category 3 Outcome Domain 9, and over time reduce costly emergency department visits for the targeted individuals receiving behavioral health and substance abuse treatment.

The Category 1 and Category 2 process milestones selected are designed to ensure effective implementation of each project regardless of the project scope. The process milestones are designed to ensure effective implementation of each project and the "Expand Quality Improvement Capacity" Project is specifically designed to enhance all other project's implementation success. The Process Milestone for DY 2 is: (1) Hire and train two quality improvement staff who will be trained in well-proven quality and efficiency improvement principles, tools and processes. DY 3, DY 4 and DY 5 have the same Outcome Improvement measure with incrementing percentages (2) (3) and (4): Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports by 20% over baseline, then 15% over DY 3, and 10% over DY 4. Goals are in place to improve quality of care and collaboration of care with other providers in the region. TCC is poised to continue improvement trends into the next four years and beyond.

**Rationale:** This Outcome Domain was selected by TCC for our Quality Improvement Project since these are areas TCC treat and intend to expand treatment. The Quality Improvement Project will focus attention on the targeted Category 3 elements and, based on TCC's intervention experience, will lead to positive outcomes. At this point, baseline improvement targets were not determined and will be established as the project rolls out in DY2 and the baseline is established, along with evaluating capacity and resources.(CN.4, CN.5, CN.6, CN.11)

**Project Valuation:** "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, according to a [2010 survey](#) by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. Ten percent said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients and overcrowding. The problem has worsened during the economic downturn. Since 2009, 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on



Mental Illness, a patient advocacy group. And since 2010, states have closed or are planning to close nearly [4,000 state psychiatric beds](#), about 8 percent of capacity, according to the National Association of State Mental Health Program Directors Research Institute. “ (39) Although the emergency room wait times are not as severe for hospitals in the TCC service area, emergency room care is costly and does not produce long-term results. Quality care means that providers are “... treating mental disorders as early as possible, holistically and close to the person’s home and community lead to the best health outcomes.”(40) Quality improvement for TCC will be focused on reducing emergency room visits, and readmissions, for persons with behavioral and or substance abuse problems. Substantial value will be created for individuals, and for the community at large, as TCC implements its projects and focuses its attention on delivering the right care at the right time. Interception of individuals inclined to seek care through hospital emergency rooms will result in reduced cost for an over-burdened medical system by creating more effective treatment options that result in stabilization of individuals with behavioral health and/or substance abuse issues because continuing community supports are “Very cost effective in the community when primary care is linked to a network of services.” (41) To this end, the projects will collectively and progressively increase value by using an array of community-based services as the right care is delivered in the proper location.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a) One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). (9g) In this study, the effect of the intervention was 0.0335 incremental life years gained. Likewise, Dewa et al. (2009) found that collaborative care saved \$503 per patient in disability benefits. (9h) Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. (9a) Simon et al. (2012) found that collaborative health care yielded 47.7 additional depression-free days per year at a cost of \$52 per depression-free day. (9m) Utilizing the QALY methodology, with the research as backup, the related Category 1 Project’s value will be \$143,249.00 and the Outcome Measure value is \$ 19,139.00.

As with all of TCC’s projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

084434201.3.4	3.IT-9.2	Right Care, Right Setting	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:		084434201.1.4	
Starting Point/Baseline:	There is no baseline established but will be in DY2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 855.00 Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results <b>Process Milestone 2 Est. Incentive Payment: \$ 855.00</b>	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Data Source: Quality Improvement Records Process Milestone 3 Estimated Incentive Payment: \$ 1,982.50 Outcome Improvement Target 1 [IT-9.2]: ED utilization reduced for target condition Improvement Target: TBD Data Source: UM and encounter data records  <b>Outcome Improvement Target 1 Estimated Incentive Payment: 1,982.50</b>	Outcome Improvement Target 2 [IT-9.2]: ED utilization reduced for target condition Improvement Target: TBD Data Source: UM and encounter data records  <b>Outcome Improvement Target 2 Estimated Incentive Payment: \$ 4,242.00</b>	Outcome Improvement Target 3 [IT-9.2]: ED utilization reduced for target condition Improvement Target: TBD Data Source: UM and encounter data records  <b>Outcome Improvement Target 3 Estimated Incentive Payment: \$ 9,222.00</b>
<b>Year 2 Estimated Outcome Amount: \$ 1,710.00</b>	<b>Year 3 Estimated Outcome Amount: \$ 3,965.00</b>	<b>Year 4 Estimated Outcome Amount: \$ 4,242.00</b>	<b>Year 5 Estimated Outcome Amount: \$ 9,222.00</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 19,139.00</b>			

**Unique RHP Outcome Identification Number:** 084434201.3.5

**Outcome Measure Title:** OD-10 Quality of Life/Functional Status

**Provider:** Texoma Community Center/084434201

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status

**IT-10.1 Quality of life- (standalone measure)**

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

Data source: Assessment of Quality of Life Tool Data Results

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

**Outcome Measure Description:** Quality of Life/Functional Status was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and Quality of Life in a variety of areas, as well as reduce the impact of mental and behavioral health and substance abuse issues on emergency rooms, acute care hospitals and psychiatric hospitals in TCC's service area.

**Process Milestones:** The Category 1 and Category 2 process milestones selected for Project 084434201.2.1 are as follows: DY2 (1) Identify 3 community agencies that have relevant data to identify service patterns of individuals with co-occurring disorders; (2) Identify and train BH case managers for blended services; DY 3 (3) Develop and put protocols and clinical guidelines in place, (4) Hire physician, nurse and clerical staff.

**Outcome Improvement Targets:** The selected Improvement Milestones for Project 084434201.2.1 are as follows: DY 4 (5) Increase use of routine preventive and primary care by 5% for identified "at risk" patients; (6) Increase use of routine preventive and primary care by 10% for identified "at risk" patients.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add

service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

**Rationale:** Hyde reports in a SAMHSA presentation titled “Behavioral Health: Public Health Challenge Public Health Opportunity” that: “One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity.” (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that “69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder” and that “Health care costs [are] higher with co-morbid BH [behavioral health] conditions” which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: “Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses.” She explains that: “Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care...” (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing primary care physician treatment along with psychiatric care, as well as ensuring quality improvements across all projects, will have an overall positive impact on patient functioning in the community and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for this Local Mental Health Authority to use in assessing in impact of not only the individual projects, but to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.4, CN.5, CN.6, CN.11)

**Outcome Measure Valuation:** “The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging.” (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects. This measure spans four of the five projects; using measured quality of life improvements to give definition to the size, scope, community benefit, and even efficiency and cost reduction/avoidance as each produces beneficial outcomes. The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a) One study examined collaborative care intervention for multi-symptom

patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained. **(9g)** TCC's Quality Improvement Project increases value by creating an evolving system of continuous quality improvement, which will use rapid and low cost retrieval of electronically stored information, to assess life quality improvements for individuals and continue to "raise the floor" in their improved levels of functioning.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Utilizing this methodology for the correlated Category 1 Project, the value will be \$143,249.00 and benefit a minimum of 88 low-income individuals in this service area, with the related Category 3 valuation set at \$58,957.00.

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

The quality improvement project will create value for individuals, funding sources that may be applicable, and the community at large as it continuously reviews treatment planning and service system designs for implementing best practices that reduce costs by applying the types of supports in the right amounts at the right time.

084434201.3.5	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
<b>Related Category 1 or 2 Projects:</b>	084434201.2.1		
<b>Starting Point/Baseline:</b>	Baseline Data to be determined in DY 2		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$ 2,634.50 Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results Process Milestone 2 Estimated Incentive Payment: \$ 2,634.50	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: \$ 6,107.50 Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD IT-1 Metric: Target established Data Source: AQoL survey Outcome Improvement Target 1 Estimated Incentive Payment: \$ 6,107.50	Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment: \$ 13,067.00	Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment: \$ 28,406.00
<b>Year 2 Estimated Outcome Amount: \$ 5,269.00</b>	<b>Year 3 Estimated Outcome Amount: \$ 12,215.00</b>	<b>Year 4 Estimated Outcome Amount: \$13,067.00</b>	<b>Year 5 Estimated Outcome Amount: \$ 28,406.00</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 58,957.00</b>			

**Title of Outcome Measure (Improvement Target):** 3IT-10 Quality of Life  
**Performing Provider Name/TIN** Lakes Regional MHMR Center/121988304  
**Unique RHP Outcome Identification Number:** 121988304.3.1

### **Outcome Description:**

\*In DY3, Process Measure (P-3) we will develop and test the data system for administration of validated assessment tool;

\*In DY 4, Improvement Target-10.1 is to demonstrate 10% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals with ASD/IDD;

\*In DY 5, Improvement Target-10.1 is to demonstrate 20% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals with ASD/IDD;

By the end of the waiver Year 5, our goal is to achieve 20% improvement in QOL scores.

### **Rationale:**

Our telemedicine/ telehealth program will develop and incorporate data systems to provide information and feedback with technical and clinical processes. This data will be used to help us manage the expansion of clinical programs serving individuals with ASD/IDD/MH and ensure that we are continuously improving the quality of the services we provide to ensure improvement in Quality of Life factors. Although this Telemedicine/Telehealth Introduction/Expansion Project will enable services from multiple provider specialties, it will share significant focus with the Lakes Regional Behavior Supports and Day Programs, Crisis Respite Wraparound services, and other behavioral health service providers in and around the targeted project area. Within the IDD population, research has shown that there is a much greater instance of health problems<sup>17</sup>; with the help of telemedicine/telehealth technology, program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population<sup>18</sup>. The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. The sharing of consumer satisfaction data (overall health survey results) between agencies and providers in the region will result in a greater awareness of the efficacy of evidence-based services in improving quality of life factors, following better self-management skills and follow-up to care. There is significant data analysis planned with encounter based assessments to show and measure improvement in quality of life factors.

### **Outcome Measure Valuation:**

**Approach/Methodology:** Please describe your approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets).

The project will implement outcome measure 3IT-10.1 to measure improvement in Quality of Life (QOL) scores. The agency will utilize existing QM staff to administer the QOL measure and process/manage the survey results for the project, along with IT staff currently employed by the agency.

This outcome measure will be valued by assessing community needs identified for Region 18 addressed through the RHP Plan, such as the need to address preventable acute care admissions and a need for additional health care providers who can address the specialty needs of the ASD/IDD population in a

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<sup>17</sup> Journal of Intellectual Disability Research 48 (2): 93-102, 2004

<sup>18</sup> Journal of Applied Research in Intellectual Disabilities. 19: 214-218

setting that is accessible. When patients with ASD/IDD do not have adequate supports and services in the community, they are more likely to utilize the ER and psychiatric hospital settings to manage crises related to the inability to manage challenging behaviors. This affects the target populations' overall perception of quality of life factors and leads to a cycle of ineffective coping and inability to manage behaviors in the community.

By the use of telemedicine technology to support clinical services in the community, we will assist in eliminating barriers to access to care for the target population.

Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater quality of life satisfaction.

DY3 – Process Milestone (P-3) will involve Information Technology and Quality Management staff (already hired by the agency) to develop and test data systems for administration of the validated assessment tool to measure QOL in DY's 4 and 5...

DY4 – Improvement Target 10.1 is to establish 10% improvement in QOL scores. QM staff (part-time) will administer surveys to measure improvement in QOL scores. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and in other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage challenging behaviors and symptoms in the community.

DY5 – Improvement Target 10.1 to establish 20% improvement in QOL scores: See approach/methodology for IT-10.1 for DY4.

### **Rationale/Justification:**

**Outcome Measure - 3IT-10.1 Quality of Life.** A process milestone in Year 3 will develop and test data systems for administration of validated assessment tool; improvement targets in DY's 4 and 5 will demonstrate percent improvement in Quality of Life scores, ending Year 5 with a 20% improvement in QOL scores.

**Size -** The project will utilize current staff to administer QOL surveys, provide monitoring and follow-up and documentation of responses, and collection and maintenance of data on potentially and approximately 200 respondents receiving care in the project. IT staff for the project are currently hired with the agency.

**Project Scope -** The proposed project is projected to demonstrate 20% improvement in Quality of Life factors as measured by a validated assessment tool by Year 5 in approximately 200 individuals (children and adults) with ASD/IDD/MH in Rockwall County.

**Population Served -** The population targeted to be served are individuals (children and adults) with ASD/IDD/MH (one or a combination of these diagnoses).

**Community Benefit, and Cost Avoidance -** Improved satisfaction with Quality

of Life factors will lead to improved self-management of psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area 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.”<sup>19</sup>

**Addressing Priority Community Need** - Currently there is no accessible safety net telemedicine programs in the targeted area to serve the needs of the target population when in crisis, or trying to access specialty care services. This results in the frequent transportation issues and use of more restrictive and expensive settings for care, such as psychiatric hospitals and institutional settings. Rural areas of Rockwall County have difficulty accessing these services population and telemedicine will reduce those barriers to care.

**Related Category 1 and/or 2 projects:**

Lakes Regional is proposing several Pass 2 projects that will link to this Telemedicine/Telehealth Project. One of the potential Pass-2 Projects is: Intervention 2.13 – Early Intervention and Outreach for Autism Spectrum (ASD) and Related Intellectual Developmental Disabilities (IDD) – (Behavior Supports).

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<sup>19</sup> RHP Protocol, Category 3 Quality Improvements, 398.

121988304.3.1	IT- 10.1	Percent improvement over baseline of patient QOL/Functional Status scores	
Lakes Regional MHMR Center			TPI-121988304
Related Category 1 or 2 Projects:	121304988.1.1		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will 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)
N/A (Starts in DY-3)	<b>Process Milestone 1 [P-3]:</b> Develop and test data systems related to measuring patient QOL assessment.  Data Source: Project documentation and data systems  Process Milestone 1 Estimated Incentive Payment: \$26,419	<b>Outcome Improvement Target 1 [IT-6.1]:</b>  Improvement Target: 10% improvement over baseline of patient QOL scores  Data Source: Patient Survey  Outcome Improvement Target 2 Estimated Incentive Payment: \$28,262	<b>Outcome Improvement Target 2 [IT-6.1]:</b>  Improvement Target: 20% improvement over baseline of QOL scores  Data Source: Patient Survey  Outcome Improvement Target 3 Estimated Incentive Payment: \$61,441
Year 2 Estimated Outcome Amount: N/A	Year 3 Estimated Outcome Amount: \$26,419	Year 4 Estimated Outcome Amount: \$28,262	Year 5 Estimated Outcome Amount: \$61,441
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD \$116,122</b>			

## **PASS 2**

### **CATEGORY 3**

Category 3 projects:

- Two for LifePath
- One for Texoma Community Center
- One for Lakes Regional MHMR
- Two for Tenet Hospital of Frisco

**Title of Outcome Measure/Improvement Target** OD-1-Primary Care and Chronic Disease Management; IT-1.9 Depression management: Depression Remission at Twelve Months

**Unique RHP Outcome Identification Number** 084001901.3.2

**Performing Provider Name/TPI** LifePath Systems/084001901

### **Outcome Measure Description**

OD-1-Primary Care and Chronic Disease Management; IT-1.9 Depression management: Depression Remission at Twelve Months (Standalone Measure)

Numerator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.

Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine. (Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.)

Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records

Process milestones for Year 2 include initial project planning by engaging stakeholders, identifying current capacity and needed resources, determining timelines, and documenting implementation phase in the first 6 months. This will be followed by developing and initiating use of PHQ-9 in our electronic health record by the second 6 months of Year 2. Process milestone for the first 6 months of Year 3 includes enrolling and serving individuals with targeted complex needs. By the second 6 months of Year 3, we plan to have the outcome improvement target of establishing baseline PHQ-9 data for admission and the 12 month reassessment. For Year 4, the outcome improvement target is a 10% remission rate for the depression at the twelve month reassessment. For Year 5, the outcome improvement target is a 20% remission rate for the depression at the twelve month reassessment.

### **Rationale**

The reason for selecting our identified process milestones and outcome improvement targets is that we are not currently using a standardized assessment such as the PHQ-9. We will need time to upgrade our electronic health record to add this assessment, train clinical staff in its use, and begin to accumulate data for admission scores and eventually the 12 month reassessment scores. Improvement scores (10% in year 4 and 20% in year 5) are conservative estimates as we have no data to compare these percentages to at this time.

### **Outcome Measure Valuation**

The valuation for outcome measures was derived using a cost-effectiveness analysis. Simon et al (2001) found 47.7 additional depression-free days from a collaborative approach, with an established cost savings of \$52 per day. Measuring and reporting this data will result in a community benefit by demonstrating that effective, collaborative treatment can have a dramatic and positive impact on individuals with depression. Based on 50% of the additional 3,726 individuals served having a diagnosis of depression, the valuation for this project is: 1,863 individuals x \$52 x 47.7 days = \$4,620,985 in value

### **References**

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Project to Implement a Chronic Disease Prevention/Management Model.

## **Valuing the Project to Implement a Chronic Disease Prevention/Management Model**

Austin Travis County Integral Care (ATCIC) – Travis County; Region 7 – Central Health; Texas Healthcare Transformation and Quality Improvement Program: (Project Number 11-W-00278/6), Brown, Alamgir, and Bohman

Austin Travis County Integral Care (ATCIC) proposes to develop a model for addressing chronic disease prevention and treatment with individuals who have serious mental illness. This project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Category II Program Innovation and Redesign goal. This project will train ATCIC staff in all aspects of chronic disease management. Staff will identify individuals who smoke, who have diabetes, are obese and/or are inactive and will use motivational interviewing techniques to engage individuals with the appropriate specialists in the module components for individual planning, coaching and education as well as long-term monitoring. The goal is to optimize consumer health and healthcare utilization.

The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

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

### **Cost-Utility Analysis**

One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.335 incremental life years gained.

A study by Feenstra et al. (2005) studied the cost-effectiveness of smoking cessation interventions (not specific to individuals with behavioral disorders). Researchers found that even providing minimal short-term counseling through a general practice physician resulted in 1.7 QALYs gained. Combining minimal counseling with nicotine replacement therapy (patches or gum) increased the QALYs gained to 3.6 and intensive counseling coupled with nicotine replacement therapy increased the QALYs gained to 4.5.

Averaging the findings in these two studies (taking the most conservative figure from the Feenstra et al. study), results in an average 1.0175 QALYs gained. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

$$\begin{aligned} &100 \text{ (persons served)} \\ &\quad \times 1.0175 \text{ (QALY gained)} \\ &\quad \times \$50,000 \text{ (life year value)} \\ &= \$5,087,500 \end{aligned}$$

### **Cost-Effectiveness and Cost Savings**

Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. Simon et al. (2012) found that collaborative care yielded 47.7 additional depression-free days per year at a cost of \$52 per depression-free day. Liu et al. (2003) found a similar cost of \$24 dollars per depression-free day.

Dewa et al. (2009) found that collaborative care saved \$503 per patient in disability benefits.

### **Summary and Total Valuation**

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). The total valuation is \$5,087,500. There is additional supporting evidence that the intervention will lead to increased depression-free days.

### **References**

- Dewa, C. S., Hoch, J. S., Carmen, G., Guscott, R., & Anderson, C. (2009). Cost, effectiveness, and cost-effectiveness of a collaborative mental health care program for people receiving short-term disability benefits for psychiatric disorders. [Research Support, Non-U.S. Gov't]. *Can J Psychiatry*, 54(6), 379-388.
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- Simon, G. E., Manning, W. G., Katzelnick, D. J., Pearson, S. D., Henk, H. J., & Helstad, C. S. (2001). Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. *Arch Gen Psychiatry*, 58(2), 181-187.

<b>Unique Category 3 Outcome Measure Identifier(s):</b> 084001901.3.2	<b>Outcome Measure (Improvement Target) Reference Number from RHP Planning Protocol: IT-1.9</b>	<b>Outcome Measure (Improvement Target) Title: Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone Measure)</b>	
<b>Performing Provider: LifePath Systems</b>			<b>TPI: 084001901</b>
<b>Related Category 1 or 2 Projects:</b>	<b>Unique Category 1 project identifier(s): 084001901.1.1</b>		
<b>Starting Point/Baseline:</b>	Baseline is 0% improvement in PHQ-9 score as we have not used this assessment in order to establish a baseline		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [3.9.P-1]:</b> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation phase.  Data Source: Project documentation  Process Milestone 1 Estimated Incentive Payment (maximum amount): \$0  <b>Process Milestone 2 [3.9.P-2]:</b> Develop and initiate use of PHQ-9  Data Source: Electronic Health Record  Process Milestone 2 Estimated Incentive Payment (maximum amount): \$0	<b>Process Milestone 3 [3.9.P-3]:</b> Collect PHQ-9 initial & 12 month scores on all MDD clients served  Data Source: Electronic Health Record (PHQ-9 Assessment)  Process Milestone 3 Estimated Incentive Payment (maximum amount): \$237,898  <b>Outcome Improvement Target 1 [3.9.IT-1.9]:</b> Establish baseline PHQ-9 data for admission and 12 month reassessment.  Improvement Target: establishing baseline scores  Data Source: Electronic Health Record (PHQ-9 Assessment)  Outcome Improvement Target 1 Estimated Incentive Payment: \$237,898	<b>Outcome Improvement Target 2 [3.9.IT-1.9]:</b> Depression Remission at Twelve Month  Improvement Target: 10% of individuals diagnosed with MDD score a 5 or less on the PHQ-9 at 12 months into treatment  Data Source: Electronic Health Record (PHQ-9 Assessment)  Outcome Improvement Target 2 Estimated Incentive Payment: \$490,070	<b>Outcome Improvement Target 3 [3.9.IT-1.9]:</b> Depression Remission at Twelve Month  Improvement Target: 20% of individuals diagnosed with MDD score a 5 or less on the PHQ-9 at 12 months into treatment  Data Source: Electronic Health Record (PHQ-9 Assessment)  Outcome Improvement Target 3 Estimated Incentive Payment: \$1,009,544
Year 2 Estimated Outcome Amount: \$0	Year 3 Estimated Outcome Amount: \$475,796	Year 4 Estimated Outcome Amount: \$490,070	Year 5 Estimated Outcome Amount: \$1,009,544

<b>Unique Category 3 Outcome Measure Identifier(s):</b> 084001901.3.2	<b>Outcome Measure (Improvement Target) Reference Number from RHP Planning Protocol:</b> IT-1.9	<b>Outcome Measure (Improvement Target) Title: Depression management:</b> Depression Remission at Twelve Months (NQF# 0710) (Standalone Measure)	
<b>Performing Provider:</b> LifePath Systems			<b>TPI:</b> 084001901
<b>Related Category 1 or 2 Projects:</b>	<b>Unique Category 1 project identifier(s):</b> 084001901.1.1		
<b>Starting Point/Baseline:</b>	Baseline is 0% improvement in PHQ-9 score as we have not used this assessment in order to establish a baseline		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</b> \$1,975,410			



**Title of Outcome Measure/Improvement Target:** OD-9 Right Care, Right Setting

**Unique RHP Outcome Identification Number:** 084001901.3.3

**Performing Provider Name/TPI:** LifePath Systems/084001901

**Outcome Measure Description:** [Describe outcome measure, specifically process milestones and selected outcome improvement target(s) for each year (e.g., improve by 5% by end of waiver).]

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)

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

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

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

Rationale/Evidence: Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

Process milestones for Year 2 include initial project planning by engaging stakeholders, identifying current capacity and needed resources, determining timelines, and documenting implementation phase in the first 6 months. This will be followed by designing community-based specialized interventions for target populations. Interventions may include (but are not limited to) Assertive Community Treatment Teams and Family Counseling. Process milestone for the first 6 months of Year 3 includes enrolling and serving individuals with targeted complex needs. By the second 6 months of Year 3, we plan to see a 5% decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons or CPS involvement. For Year 4, the outcome improvement target is a 10% decrease in readmissions. For Year 5, the outcome improvement target is a 20% decrease in readmissions.

**Rationale:** [A narrative describing the reasons for selecting the process milestones and outcome improvement targets. If improvement targets are not determined, please indicate that outcome improvement targets will be determined in DY 2 for implementation in DY 3.]

The reasons for selecting our identified process milestones and outcome improvement targets is that we are not currently providing these services and will need time to develop the program and initiate services prior to assessing improvement targets. Improvement scores (10% in year 4 and 20% in year 5) are conservative estimates as we have no data to compare these percentages to at this time.

**Outcome Measure Valuation:** The value associated with diverting individuals from jail admissions has been calculated in the paper, “Valuing the Jail Diversion Program” by Brown, Alamgir, & Bohman at \$3.18 for every dollar spent. As the total Category 3 value for this project is \$1,309,299, the true value to the community is over \$4 million.

## References

Brown, H. S.; Alamgir, A. H.; Bohman, T. B. (2012). Valuing the Jail Diversion Program.

## Valuing the Youth Counseling Program

Bluebonnet Trails Community Services (BTCS) – Lee County; Region 7 – Central Health, Texas Healthcare Transformation and Quality Improvement Program: (Project Number 11-W-00278/6), Brown, Alamgir, and Bohman

The Bluebonnet Trails Community Services (BTCS) – Region 7 proposal to provide additional youth counselors meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Category II Program Innovation and Redesign goal. This BTCS proposal will supplement the counseling programs in Fayette and Lee County Independent School Districts with the goal of providing early intervention and solution-focused counseling to students in need.

The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

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

### Cost-Utility Analysis

Lynch et al. (2005) studied the cost effectiveness of delivering cognitive behavioral therapy (CBT) to adolescents with depressed parents in an effort to prevent or reduce depression symptoms in the teens. Results indicated that intervention participants (received CBT) had an average of 53 fewer depressed days in a year than control participants (treatment as usual through other community programs). The intervention group showed a significant increase in QALYs of .059 compared to the control group. Researchers calculated the average incremental cost-effectiveness ratio (ICER) as \$10 per depression-free day or \$9,275 per QALY.

In a study by Gospodarevskaya and Segal (2012), researchers looked at CBT provided to sexually abused children who were diagnosed with post-traumatic stress disorder. They compared three treatment groups to a no-treatment control group and results showed increased QALYs in all three treatment groups: an increase of .06 QALYs for the group that received non-directive counseling, an increase of

.09 QALYs for the group that received CBT only, and an increase of .1 QALY for the group that received CBT plus an SSRI medication.

Averaging the QALYs obtained from these two studies (one from Lynch et al. and three from Gospodarevskaya and Segal), the QALYs in the current proposed project would be .07725. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

$$\begin{aligned} &100 \text{ (persons served)} \\ &\times 0.07725 \text{ (QALY gained)} \\ &\times \$50,000 \text{ (life year value)} \\ &= \$386,250 \end{aligned}$$

### Summary and Total Valuation

This valuation analysis shows that the intervention will have a positive value for participants. The expected value of benefits is \$386,250.

### References

Gospodarevskaya, E. and Segal, L. (2012). Cost-utility analysis of different treatments for post-traumatic stress disorder in sexually abused children. *Child and Adolescent Psychiatry and Mental Health*, 6 (15). doi:10.1186/1753-2000-6-15

Lynch, F.L., Hornbrook, M., Clarke, G.N., Perrin, N., Polen, M.R., O'Connor, E., and Dickerson, J. (2005). Cost-effectiveness of an intervention to prevent depression in at-risk teens. *Archives of General Psychiatry*, 62, 1241-1248.

### Valuing the Jail Diversion Program

Bluebonnet Trails Community Services (BTCS) – Bastrop County, Region 7 – Central Health, Texas Healthcare Transformation and Quality Improvement Program: (Project Number 11-W-00278/6); Brown, Alamgir and Bohman

Bluebonnet Trails Community Services (BTCS) – Region 7 in Bastrop County will provide early identification and diversion to the most appropriate treatment alternative for inmates with serious mental illness. Early identification and treatment will prevent psychiatric hospitalization for most inmates. This project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Category II Program Innovation and Redesign goal. Stabilizing inmates on medication will enable case managers to utilize psychosocial rehabilitative programs and residential options that can lead to permanent housing with ongoing support.

The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved.

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

**adjusted life-years** (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

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

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

### **Cost-Utility Analysis**

A search of the scientific literature did not identify any relevant cost-effectiveness or cost-utility studies for jail diversion.

### **Cost-Effectiveness and Cost Savings**

We did identify cost-savings studies of jail diversion for person with mental and behavioral issues. Steadman (2005) found that expensive arrests and jail time could be diverted for prisoners with serious mental illness. He found that there were 1.03 arrests for the diverted group compared to a higher average number of average arrests (1.20) for the non-diverted group. The average number of arrests per month was 0.11 for the diverted group and 0.15 for the non-diverted group.

Another study by Daly et al (2004) found that prison-based substance abuse treatment reduced re-arrest rates across four tiers of services provided to inmates. These differences were used in a benefit-cost analysis that showed the following ratios: 5.74 for Tier 2, 3.18 for Tier 3, and 1.79 for Tier 4. The average across tiers was 3.18, which is used to value this program. Assuming that 100 persons were served at a cost of \$50,000, the total value of the program would be:

$$\begin{aligned} & \$3.18 \text{ (benefit per dollar spent)} \\ & \times \$50,000.00 \text{ (program cost)} \\ & = \$159,000.00 \end{aligned}$$

### **Summary and Total Valuation**

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention resulting in a total valuation of \$159,000.

### **References**

Daley, M., Love, C.T., Shepard, D.S., Petersen, C.B., White, K.L., Hall, F.B.(2004). Cost-effectiveness of Connecticut's in-prison substance abuse treatment. *Journal of Offender Rehabilitation*, v39(3), 69-92  
Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behav Sci Law*, 23(2), 163-170.

### **Valuing the Expansion of Crisis Intervention Project**

Austin Travis County Integral Care (ATCIC) – Travis County; Region 7 – Central Health, Texas Healthcare Transformation and Quality Improvement Program: (Project Number 11-W-00278/6)

Brown, Alamgir and Bohman

Austin Travis County Integral Care (ATCIC) proposes to expand a crisis system to address the needs of individuals with co-occurring substance use and mental health disorders by providing specialized crisis

residential treatment and jail diversion services. This project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Category II Program Innovation and Redesign goal. The project proposes to provide intensive intervention, stabilization and wrap-around services with the goal of improving patient experience, decreasing costs, and improving patient outcomes. By expanding crisis residential treatment, individuals in crisis will receive appropriate, cost effective care at the right time and the right place by specialty behavioral health providers.

The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

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

## Cost-Utility Analysis

### Increase access to psychiatric crisis care through telemedicine (telepsychiatry)

A search of the scientific literature identified the following studies that were used to determine the valuation figures. The first study we identified looking at telemedicine and mental health was conducted by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010) examining online Cognitive Behavioral treatment of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

$$\begin{aligned} &100 \text{ (persons served)} \\ &\quad \times 0.0245 \text{ (QALY gained)} \\ &\quad \times \$50,000 \text{ (life year value)} \\ &= \$122,500 \end{aligned}$$

### Jail Diversion Program

There were not cost-effectiveness studies of jail diversion for person with mental problems. However, Steadman (2005) found that expensive arrests and jail time could be diverted. He found that there were 1.03 arrests and the non-diverted group an average of 1.20 arrests; average number of arrests per month was 0.11 for the diverted group and 0.15 for the non-diverted group. Cusack (2010) found a reduction in crisis contacts for frequent jail users with serious mental illness.

### Create and implement intensive wraparound services

The closest study we identified examined collaborative care intervention for multi-symptom patients including depression (Katon, 2012). In this study, the effect of the intervention was 0.018 incremental life years gained. After quality-adjusting, 0.335 quality-adjusted life-years were added. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

$$\begin{aligned} &100 \text{ (persons served)} \\ &\quad \times 0.335 \quad \text{(QALY gained)} \\ &\quad \times \$50,000 \quad \text{(life year value)} \\ &= \$1,675,000 \end{aligned}$$

### **Summary and Total Valuation**

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). The following table shows the total amount across the individual delivery systems. All valuations used 100 individuals that would receive all components of the program.

<b>Service Delivery System</b>	<b>Valuation</b>
Create and implement intensive wraparound services to provide behavioral health, primary healthcare and substance abuse services to support individuals and ensure community retention; Integrate primary healthcare services & behavioral healthcare to increase system capacity and health outcomes	\$1,675,000
Increase access to specialty care (telepsychiatry)	\$122,500
Total Valuation	\$1,797,500

Cusack, K. J., Steadman, H. J., & Herring, A. H. (2010). Perceived coercion among jail diversion participants in a multisite study. *Psychiatric Services*, 61(9), 911-916.

Katon, W., Russo, J., Sherbourne, C., Stein, M.B., Craske, M., Fan, M.Y., Roy-Byrne, P. (2006). Incremental cost-effectiveness of a collaborative care intervention for panic disorder. *Psychol Med*. 36(3), 353-63. Epub 2006 Jan 10.

Katon, W.J., Roy-Byrne, P., Russo, J., Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Arch Gen Psychiatry*. 59(12), 1098-104.

Katon, W.J., Schoenbaum, M., Fan, M.Y., Callahan, C.M., Williams, J. Jr, Hunkeler, E., Harpole, L., Zhou, X.H., Langston, C., & Unützer, J. (2005). Cost-effectiveness of improving primary care treatment of late-life depression. *Arch Gen Psychiatry*. 62(12), 1313-20.

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

Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behav Sci Law*, 23(2), 163-170.

### Valuing the Community Behavior Support (CBS) Program

Austin Travis County Integral Care (ATCIC) – Travis County; Region 7 – Central Health; Texas Healthcare Transformation and Quality Improvement Program: (Project Number 11-W-00278/6)  
Brown, Alamgir and Bohman

Austin Travis County Integral Care – Region 7 proposes to develop a Community Behavior Support (CBS) team that specializes in the assessment and stabilization of persons with co-occurring BH disorders and IDD. This program meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Program Category I Infrastructure Development goal. The goal of the project is to reduce unnecessary emergency department usage and psychiatric hospitalizations for people with IDD. The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

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

The number of life-years added is based on a review of the scientific literature.

#### Cost-Utility Analysis

A search of the scientific literature identified the following study that was used to determine the valuation figures. A study by Clark et al. (1998) considered the use of Assertive Community Treatment (ACT) for people with severe mental illness and substance use disorders versus standard care. This is not a perfect comparison, however, because the ATCIC proposed program plans to serve individuals with IDD. QALYs were 0.03 higher for ACT than for standard care.

Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

$$\begin{array}{l} 100 \text{ (persons served)} \\ \times 0.03 \text{ (QALY gained)} \end{array}$$

$$\begin{aligned} & \times \$50,000 \text{ (life year value)} \\ & = \$150,000 \end{aligned}$$

### Cost Effectiveness and Cost Savings

Essock et al. (1998) found that societal costs for participants in their study who joined when out of the hospital were \$26,536 when compared to the comparison group's \$22,483. However, for participants who joined the study while in the hospital, ACT participants had lower costs of \$52,814 compared with standard treatment participants (\$77,706). The net gain assuming equal patients of each type would be \$20,839.

Latimer (2005) reviewed the effectiveness literature on ACTs and reported that a high-fidelity ACT team can reduce number of hospital days by about 78%. Latimer (2005) found the direct ACT services costs of about \$9,116 per client per year in 1999/2000, while the direct cost for an inpatient day in the adult psychiatry ward was \$215. Based on these assumptions, for a patient spending on 60 days annually in a psychiatric hospital per year, a 78% reduction would yield a saving of  $46.8 \text{ (days)} \times \$215 = \$10,062$ . The net difference between ACT and treatment as usual was \$946. These calculations do not factor in any other potential cost saving from reduction in emergency department usage or social costs such as criminal justice encounters.

Lehamn (1999) examined the cost-effectiveness of ACT versus standard care and found that the overall average cost per ACT client was \$15,732 less than the cost per client for treatment as usual (\$50,748 cost per ACT client versus \$66,480 cost per client for treatment as usual).

The average gain across all studies was \$13,856.67. If we were to value the program based on cost saving the total valuation would be:

$$\begin{aligned} & 100 \text{ (persons served)} \\ & \times \$13,856.67 \quad \text{(cost savings)} \\ & = \$1,385,667.00 \end{aligned}$$

### Summary and Total Valuation

Based on valuing the incremental QALYs gained, the total valuation of the program is \$150,000. Additional cost savings are likely as well.

### References

- Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., ... Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. [Clinical Trial Comparative Study Randomized Controlled Trial Research Support, Non-U.S. Gov't Research Support, U.S. Gov't, P.H.S.]. *Health Services Research*, 33(5 Pt 1), 1285-1308.
- Essock, S. M., et al. (1998). Cost-effectiveness of assertive community treatment teams. *American Journal of Orthopsychiatry* 68(2), 179-190.
- Latimer, E. (2005). Economic considerations associated with assertive community treatment and supported employment for people with severe mental illness. *Journal of Psychiatry & Neuroscience* 30(5), 355-359.
- Lehman, A. F., et al. (1999). Cost-effectiveness of assertive community treatment for homeless persons with severe mental illness. *British Journal of Psychiatry* 174, 346-352.



<b>Unique Category 3 Outcome Measure Identifier(s):</b> 084001901.3.3	<b>Outcome Measure (Improvement Target) Reference Number from RHP Planning Protocol: IT-9.1</b>	<b>Outcome Measure (Improvement Target) Title: OD-9 Right Care, Right Setting</b>	
<b>Performing Provider: LifePath Systems</b>			<b>TPI: 084001901</b>
<b>Related Category 1 or 2 Projects:</b>	<b>Unique Category 2 project identifier(s): 084001901.2.2</b>		
<b>Starting Point/Baseline:</b>	<i>Baseline is 0% improvement as we have not provided services in this area in order to establish a baseline</i>		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [3.9.1.P-1]:</b> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation phase.  Data Source: Project documentation  Process Milestone 1 Estimated Incentive Payment (maximum amount): \$0  <b>Process Milestone 2 [3.9.1.P-1]:</b> Project Planning - Design community-based specialized interventions for target populations. Interventions may include (but are not limited to) Assertive Community Treatment Teams and Family Counseling  Data Source: Project documentation  Process Milestone 2 Estimated Incentive Payment (maximum amount): \$0	<b>Process Milestone 3 [3.9.1.P-3]:</b> Enroll and serve individuals with targeted complex needs  Data Source: Electronic Health Record  Process Milestone 3 Estimated Incentive Payment (maximum amount): \$220,671  <b>Outcome Improvement Target 1 [3.9.1.IT-9.1]:</b> Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons or CPS involvement  Improvement Target: 5% Decrease in readmissions  Data Source: Court Records, Project Documentation  Outcome Improvement Target 1 Estimated Incentive Payment: \$220,671	<b>Outcome Improvement Target 2 [3.9.1.IT-9.1]:</b> Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons or CPS involvement  Improvement Target: 10% Decrease in readmissions  Data Source: Court Records, Project Documentation  Outcome Improvement Target 2 Estimated Incentive Payment: \$443,002	<b>Outcome Improvement Target 3 [3.9.1.IT-9.1]:</b> Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons or CPS involvement  Improvement Target: 20% Decrease in readmissions  Data Source: Court Records, Project Documentation  Outcome Improvement Target 3 Estimated Incentive Payment: \$886,003
<b>Year 2 Estimated Outcome Amount:</b> <b>\$0</b>	<b>Year 3 Estimated Outcome Amount:</b> <b>\$441,342</b>	<b>Year 4 Estimated Outcome Amount:</b> <b>\$443,002</b>	<b>Year 5 Estimated Outcome Amount:</b> <b>\$886,003</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$1,770,347</b>			

**Outcome Measure Title:** OD-9 ED Appropriate Utilization (Standalone measure)

**Unique RHP Outcome Identification Number:** 084434201.3.6

**Performing Provider Name:** Texoma Community Center/084434201

**Outcome Measure Description:** Reduce Emergency Department visits for target conditions:

- Behavioral Health/Substance Abuse

The process milestones selected to facilitate reporting outcomes for this

Category Three Project will be as follows:

- P-1-- The Project Planning- engage stake holders, identify current capacity and needed resources.
- P-2—Establish baseline rates.
- P-5—Disseminate findings, including lessons learned and best practices, to stakeholders and other entities.

**Outcome Measure Description:** As capacity and resources are determined in Year 2, specific target improvement rates will then be determined and set. Based on past experience of TCC crisis staff, a reduction of emergency room visits will occur as additional patients are stabilized through the utilization of existing and planned programs. Part of the project will be to track and document individuals' outcomes of individuals with mental health, behavioral health, and substance abuse issues who present to emergency rooms for treatment. The goal is to reduce these ED visits over time. It is expected that all of TCC's PASS 1 projects (084434201.1.1, 084434201.1.2, 084434201.1.3 and 084434201.2.1) and PASS 2 project (084434201.2.2) can, when implemented, positively impact Category 3 Outcome Domain 9. Again, this will reduce costly emergency department visits and hospitalizations for the targeted individuals, as it did with TCC's ACT patients and other high-risk psychosocial rehabilitation patients. The selected Outcome Improvement Targets have not been determined for each year yet, since the baseline still needs to be established. However, each year will have an Improvement Target goal so that when the target percentages are determined, the outcome data can be tracked. These interventions are expected to have positive outcomes across RHP 18.

The selected Category 2 process milestones in the related project (084434201.2.2) are designed to ensure effective implementation of the project and facilitate improvement. The Process Milestone for DY 2 is: Design the community-based specialized interventions for the target populations, including significantly expanding the existing residential/respite facility and implementing an extensive community based-support system. It is recognized that proper planning and designing is the foundation for project success.

DY 3 is implementation year and the process milestones are to: (1) Secure and ensure compliance of residential facility and enroll and serve individuals with targeted complex needs; and (2) Evaluate and continuously improve interventions using the "plan, do, study, act quality improvement cycles." These goals are self-evident in that success requires implementation of the resources needed and actualization of the interventions being used. DY 4 and DY 5 are about continuous expansion of services to increased numbers of patients and quality improvement of the project goals. Both years have the same Outcome Improvement measure to monitor functional status with incrementing improvement percentages of 5% over baseline in DY4 and then 10% over baseline in DY5. Goals are in place to improve quality of care and collaboration with other providers in the region. TCC is poised to continue improvement trends into the next four years and beyond.

**Rationale:** This Outcome Domain was selected by TCC for Project 084434201.2.2 since "Right Care, Right Setting" and reducing emergency department usage are TCC goals. TCC will expand treatment and,

based on the reported past experience, have a solid positive impact on reducing emergency room, hospital and jail use by the target population. One way to do this is to improve overall patient functioning. This intervention expansion will focus attention on the targeted Category 3 elements to reduce and, based on TCC's intervention experience, will lead to positive outcomes. Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (11) Lost output and low productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across will give a picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report: "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to efforts to stabilize individuals with co-occurring disorders. She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care..." (12) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history.

The baseline target for this intervention effort will begin in DY 2 and be zero. While qualifying individuals are served by TCC already, the DY 3 enrollment assessments (ANSA) will be used for the expansion quality improvement baseline and improvement will be calculated as a percentage over these initial scores as if they are at zero.(CN.4, CN.5, CN.6, CN.11)

**Project Valuation:** "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, according to a [2010 survey](#) by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. Ten percent said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients and overcrowding. The problem has worsened during the economic downturn. Since 2009, 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on Mental Illness, a patient advocacy group. And since 2010, states have closed or are planning to close nearly [4,000 state psychiatric beds](#), about 8 percent of capacity, according to the National Association of State Mental Health Program Directors Research Institute." (13) Emergency room care is costly and does not produce long-term results. Substantial value is inherent for both individuals and for the community at large as TCC implements its projects and focuses its attention on delivering the right care at the right time. Intervention with the target population, who are inclined to seek care through hospital emergency rooms, will reduce health care costs for an over-burdened medical system. Creating more effective treatment options will result in stabilization of individuals with behavioral health and/or substance abuse issues. The World Health Organization (2003) states that community supports are: "Very cost effective in the community when primary care is linked to a network of services." (14) To this end, the projects will collectively and progressively increase value by using an array of community-based services as the right care is delivered in the proper location.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). **(9g)** In this study, the effect of the intervention was 0.0335 incremental life years gained. Likewise, Dewa et al. (2009) found that collaborative care saved \$503 per patient in disability benefits. **(9h)** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. **(9a)** Simon et al. (2012) found that collaborative health care yielded 47.7 additional depression-free days per year at a cost of \$52 per depression-free day. **(9m)** Utilizing the QALY methodology, with the research as backup, the related Category 1 Project's value is \$4,498,916.00 and the Outcome Measure value is \$ 601,084.00.

As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

<b>084434201.3.6</b>	<b>3.IT-9.2</b>	<b>ED appropriate utilization (Standalone Measure)</b>	
<b>Texoma Community Center</b>			<b>084434201</b>
<b>Related Category 1 or 2 Projects:</b>	<b>084434201.2.2</b>		
<b>Starting Point/Baseline:</b>	There is no baseline established but will be in DY2		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$53,718 .00	Process Milestone 2 [P-2]: Establish the TBD baseline Metric: Baseline set. Data Source: Plan and resource documentation, AQoL scores  Process Milestone 2 Estimated Incentive Payment: \$124,536.00	Outcome Improvement Milestone 3 – OD 9—Right Care, Right Setting  Metric [IT-9.2]: Reduce emergency department visits for targeted behavioral health/ substance abuse patients  Improvement Target: % improvement TBD Data Source: Hospital records/ UM, AQoL scores and crisis encounter data records  Outcome Improvement Target 3 Estimated Incentive Payment: \$ 133,225 .00	Outcome Improvement Milestone 4 – OD 9—Right Care, Right Setting  Metric [IT-9.2]: Reduce emergency department visits for targeted behavioral health/ substance abuse patients  Improvement Target: % improvement TBD Data Source: Hospital records/ UM, AQoL scores and crisis encounter data records  Outcome Improvement Target 4 Estimated Incentive Payment: \$ 289,605.00
<b>Year 2 Estimated Outcome Amount: \$53,718.00</b>	<b>Year 3 Estimated Outcome Amount: \$124,536.00</b>	<b>Year 4 Estimated Outcome Amount: \$133,225.00</b>	<b>Year 5 Estimated Outcome Amount: \$289,605.00</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 601,084 .00</b>			

**Title of Outcome Measure (Improvement Target):** OD- 6 Patient Satisfaction

**Performing Provider Name/TIN** Lakes Regional MHMR Center/121988304

**Unique RHP Outcome Identification Number:** 121988304.3.2

### **Outcome Description**

\*In DY3, Process Milestone 1 [P-4] Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities.

\*In DY4 Outcome Improvement Target IT6.1- to achieve a mean of 10% improvement over baseline of per individual patient satisfaction scores.

\*In DY5, Outcome Improvement Target IT6.1- to achieve a mean of 10% improvement over baseline of per individual patient satisfaction scores.

By the end of the waiver, the goal of LRMHMR is to maintain an average 10% improvement over individual baseline of per individual satisfaction scores with program participants' overall health status/functional status.

### **Rationale**

The project is to introduce in Rockwall County the Individualized Self Health Action Plan for Empowerment (In SHAPE) program thereby improving their physical health knowledge and functioning in a normalized setting. The state has mandated a change to the functional assessment of individuals with SMI enrolled in services on a quarterly basis through use of the Adult Needs and Skills Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment instruments. A project improvement tracking measure will be the SP-36 quality of life measurement to inform the individual and the project of the broader impact the service change is having. Finally, the outcome improvement target measure of the level of satisfaction with services using the validated instrument Mental Health Statistics Improvement Program Consumer Survey (MHSIP). Use of the MHSIP provides a standardized instrument and protocol for data collection and processing consistent with the effort of Center for Mental Health Services (CMHS) for improvement of state mental health programs. DY2 and DY3 efforts at establishing baselines will inform and likely lead to refinement of gross improvement target estimations.

### **Outcome Measure Valuation**

**Approach/Methodology:** The project will implement outcome measure IT-6.1 to measure improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status. This outcome measure will be valued by assessing community needs identified for Region 18 addressed through the RHP Plan, such as the need for more care coordination and reduction of overuse of emergency department services. When patients experience stagnation after stabilization on medications but have no effective service for life improvement in the prodromal aspects of their illness, they experience lack of satisfaction and inability to self-monitor and manage symptoms effectively as a result. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is related effects of overall improvement in self-management of health, functioning and personal efficacy in the community, and greater quality of life satisfaction in people with serious mental illness (SMI).

**DY3–** Process Milestone (P-4): conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities will inform the project for continuous quality improvement.

**DY4 –** Improvement Target 6.1: to establish a mean of 10% improvement over baseline of individual patient satisfaction scores in selected domain. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and other barriers to access to

care in the community for the target population, as well as improved ability to successfully and consistently self-manage symptoms in the community.

**DY5 – Improvement Target 6.1:** to establish a mean of 10% improvement over baseline of individual patient satisfaction scores in selected domain: See approach/methodology for IT-6.1 for DY4.

### **Rationale/Justification**

**Outcome Measure:** IT-6.1 Percent improvement over baseline of patient satisfaction scores. A preparation activity will establish baseline for individual participant improvement in patient satisfaction with overall health/functional status; Improvement targets in DY4 and DY5 will establish percent improvement over baseline in patient satisfaction scores, ending DY5 with a mean 10% improvement over baseline in patient satisfaction scores for all participants.

**Size –** The project will be In SHAPE serving sixteen (16) to twenty (20) mental health clinic clients weekly over a six (6) month period. DY2 activity is surveying and establishing what portion of the clinic population would meet inclusion criteria.

**Project Scope –** The proposed project is projected to measure satisfaction with improvement in overall health status/functional status in the targeted population of identified eligible individuals in the LRMHMRRC offices in Rockwall, TX.

**Population Served –** The population targeted to be served are individuals stable on medications with Severe and Persistent Mental Illness (SPMI).

**Community Benefit and Cost Avoidance –** Improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area 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” (RHP Protocol, page 398).

**Addressing Priority Community Need–** In keeping with the Region 18 results of the Community Needs Assessment, this population particularly has (CN.5) Co-morbid medical and behavioral health conditions – all ages and (CN.14) Obesity and its co-morbid risk factors due in large part to the side effects of psychotropic medications.

**Related Category 1 and/or 2 projects.** Please list the projects linked to this outcome below.

**Lakes Regional 121988304:** 121988304.2.1 In-SHAPE

121988304.3.2	IT- 6.1	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			121988304
Related Category 1 or 2 Projects:	121988304.2.1 In-SHAPE		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will 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)
	<p><b>Process Milestone 1 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</p> <p><b>Data Source:</b> Project operational plan and PDSA reports.</p> <p><b>Process Milestone 1 Estimated Incentive Payment: \$23,455</b></p>	<p><b>Outcome Improvement Target 1 [IT-6.1]:</b> 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 MHSIP survey may be used to establish if patients:</p> <p>(1) are getting timely care, appointments, and information; (Standalone measure)</p> <p>(2) how well their doctors / providers communicate; (Standalone measure)</p> <p>(3) patient's involvement in shared decision making, and (Standalone measure)</p> <p>(4) Patient's overall health status/functional status.</p> <p><b>Data Source:</b> MHSIP surveying of participants</p>	<p><b>Outcome Improvement Target 1 [IT-6.1]:</b> 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 MHSIP survey may be used to establish if patients:</p> <p>(1) are getting timely care, appointments, and information; (Standalone measure)</p> <p>(2) how well their doctors / providers communicate; (Standalone measure)</p> <p>(3) patient's involvement in shared decision making, and (Standalone measure)</p> <p>(4) Patient's overall health status/functional status.</p> <p><b>Data Source:</b> MHSIP surveying of participants</p> <p><b>Improvement Target:</b> 10% improvement over baseline of</p>



121988304.3.2	IT- 6.1	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			121988304
Related Category 1 or 2 Projects:	121988304.2.1 In-SHAPE		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will 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)
		<b>Improvement Target:</b> 10% improvement over baseline of patient satisfaction scores  <b>Metric:</b> <b>Numerator:</b> Percent improvement in targeted patient satisfaction domain.  <b>Denominator:</b> Number of patients who were administered the survey.  <b>Data Source:</b> Patient MHSIP Survey  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: \$25,839	patient satisfaction scores  <b>Metric:</b> <b>Numerator:</b> Percent improvement in targeted patient satisfaction domain. <b>Denominator:</b> Number of patients who were administered the survey.  <b>Data Source:</b> Patient MHSIP Survey  <b>Outcome Improvement Target 3</b> Estimated Incentive Payment: \$58,023
Year 2 Estimated Outcome Amount: N/A	Year 3 Estimated Outcome Amount: \$ 23,455	Year 4 Estimated Outcome Amount: \$25,839	Year 5 Estimated Outcome Amount: \$58,023
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$107,317			

**Title of Project:** IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059

**Unique RHP project identification number:** 169553801.3.1

**Performing Provider Name:** Centennial Medical Center/169553801

**Project Description Category 3 – IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059**

**Outcome Measure Description:** Through engagement, education, and identification, this project will increase diabetes education, establish a baseline, provide testing to an increased number of indigent care patients, and ultimately produce an outcome of improvements in the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) control >9.0%.

**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.

**Process Milestones:**

**DY2: Milestone P1:** Project Planning – engage stakeholders through combining education and nurse/clinical resources, identify current capacity and needed resources, determine timelines and document implementations plans.

**DY3: Milestone P2:** Establish baseline rates – clinic personnel will administer blood draws for each patient and notate the results in the patient file for utilization in future visits to view concerns and differentials. In particular, patients with diabetes and those with risk factors of diabetes will be tested upon annual visits for hemoglobin A1c – the results, of which, will be logged in the patient record. In addition, the physician will implement any necessary prescription, nutritional or wellness interventions. Clinic personnel will keep a record of the number of patients within this diabetic category for reporting purposes.

**Outcome Improvement Targets for Each Year:**

**DY4:** TBD Identification and implementation of wellness plan for all diabetic and potential diabetic patients

**DY5:** TBD Identification and implementation of wellness plan for all diabetic and potential diabetic patients

**Project Valuation:**

This project was valued using the value of Project 1.1, which was developed using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

**References**

Data Source: HER, Registry, Claims, Administrative Clinical Data

<b>169553801.3.1</b>	<b>IT 1.10</b>	<b>DIABETES CARE: HBA1C POOR CONTROL (&gt;9%)</b>	
<b>Centennial Medical Center</b>			<b>169553801</b>
<b>Related Category 1 or 2 Projects</b>	<b>169553801.1.1</b>		
<b>Starting Point/Baseline</b>	<b>DIABETES CARE: HBA1C POOR CONTROL (&gt;9%)</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$21,600</b>	<b>Milestone P2: Establish baseline rates</b> <b>Goal: Completed by 9/30/2014</b>  Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$17,280</b>	<b>Milestone P4:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  <b>Goal: Completed by 9/30/2015</b>  <b>Outcome Improvement Target:</b> Achieve TBD “x%” improvement compared to baseline, with x determined in Year 2 based on baseline data. k. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0%. l. 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, Claims, Administrative clinical data d. Rationale/Evidence: Diabetes is one of the most costly and highly prevalent	<b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices to stakeholders.  <b>Goal: Completed by 9/30/2016</b>  <b>Outcome Improvement Target:</b> Achieve TBD “Y%” improvement compared to baseline, with x determined in Year 2 based on baseline data. 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, Claims, Administrative clinical data d. Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States.

		<p>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.</p> <p>Incentive Payment (<i>maximum amount</i>): <b>\$38,880</b></p>	<p>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.</p> <p>Incentive Payment (<i>maximum amount</i>): <b>\$59,097</b></p>
<b>Year 2 Estimated Outcome Amount:</b> <b>\$21,600</b>	<b>Year 3 Estimated Outcome Amount:</b> <b>\$17,280</b>	<b>Year 4 Estimated Outcome Amount:</b> <b>\$38,880</b>	<b>Year 5 Estimated Outcome Amount:</b> <b>\$59,097</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$136,857</b>			

**Title of Project: IT-12.2 Cervical Cancer Screening (HEDIS 2012)**

**Unique RHP project identification number:** 1695538013.2

**Performing Provider Name:** Centennial Medical Center/169553801

**Project Description**

IT-12.2 Cervical Cancer Screening (HEDIS 2012)

***Outcome Measure Description:***

Through improved access to primary care and expanded women's services and education, this project will increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years, first establishing a baseline.

***Rationale:*** Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

***Process Milestones:***

**DY2:**

Milestone P1: Project Planning – engage stakeholders through combining education and nurse/clinical resources, identify current capacity and needed resources, determine timelines and document implementations plans.

**DY3:**

Milestone P2: Establish baseline rates – provide cervical cancer screenings to all women aged 21 through 64 who have named the clinic as their home physician's office. This designation will be made through a patient signature for the annual well-woman check.

***Outcome Improvement Targets for Each Year:***

**DY4:**

Milestone P3: Develop and test data systems.

**DY5:**

Milestone P5: Disseminate findings, including lessons learned and best practices, to stakeholders.

**Project Valuation:**

This project was valued using the value of Project 1.1, which was developed using the RHP 18 Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope

- Project Investment
- Value Weight of the Project

Further valuation was determined using the Community Needs Assessment for the region and through researching numerous preventive care materials.

## **References**

Data Source: HER, Registry, Claims, Administrative Clinical Data; Ann S. O'Malley, "After-Hours Access To Primary Care Practices Linked With Lower Emergency Department Use And Less Unmet Medical Need," Health Affairs, no. (2012): doi: 10.1377/hlthaff.2012.0494

<b>169553801.3.2</b>	<b>IT 12.2</b>	<b>CERVICAL CANCER SCREENING (HEDIS 2012)</b>	
<b>Centennial Medical Center</b>			<b>169553801</b>
<b>Related Category 1 or 2 Projects</b>	<b>169553801.1.1</b>		
<b>Starting Point/Baseline</b>	<b>CERVICAL CANCER SCREENING (HEDIS 2012)</b>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Milestone P1:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. <b>Goal: Completed by 9/30/2013</b> Milestone 1 Project Planning – engage stakeholders through combining education and nurse/clinical resources, identify current capacity and needed resources, determine timelines and document implementations plans. Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$21,600</b>	<b>Milestone P2:</b> Establish baseline rates <b>Goal: Completed by 9/30/2013</b> Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$17,280	<b>Milestone P3:</b> Develop and test data systems. <b>Goal: Completed by 9/30/2014</b>  <b>Outcome Improvement Target:</b> Achieve TBD “x%“ improvement compared to baseline, with x determined in Year 2 based on baseline data. c. Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. d. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded. c. Data Source: EHR, Claims, Administrative clinical data d. Rationale/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection	<b>Milestone P5:</b> Disseminate findings, including lessons learned and best practices, to stakeholders.  <b>Outcome Improvement Target:</b> Achieve TBD “Y%“ improvement compared to baseline, with x determined in Year 2 based on baseline data. a. Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. b. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded. c. Data Source: EHR, Claims, Administrative clinical data d. Rationale/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test

<i>169553801.3.2</i>	<i>IT 12.2</i>	<i>CERVICAL CANCER SCREENING (HEDIS 2012)</i>	
<i>Centennial Medical Center</i>			<i>169553801</i>
<b>Related Category 1 or 2 Projects</b>	<i>169553801.1.1</i>		
<b>Starting Point/Baseline</b>	<i>CERVICAL CANCER SCREENING (HEDIS 2012)</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.	to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.



<i>169553801.3.2</i>	<i>IT 12.2</i>	<i>CERVICAL CANCER SCREENING (HEDIS 2012)</i>	
<i>Centennial Medical Center</i>			<i>169553801</i>
<b>Related Category 1 or 2 Projects</b>	<i>169553801.1.1</i>		
<b>Starting Point/Baseline</b>	<i>CERVICAL CANCER SCREENING (HEDIS 2012)</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
		<b>Goal: To be determined in DY2</b>  Estimated Incentive Payment <b>\$38,880</b>	<b>Metric I.1:</b> Documented evidence of performance achieved. <b>Goal: To be determined in DY2</b> Milestone II  Estimated Incentive Payment <i>(maximum amount):</i> <b>\$59,097</b>
<b>Year 2 Estimated Outcome Amount: \$21,600</b>	<b>Year 3 Estimated Outcome Amount: \$17,280</b>	<b>Year 4 Estimated Outcome Amount: \$38,880</b>	<b>Year 5 Estimated Outcome Amount: \$59,097</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$136,857</b>			

## PASS 3

### CATEGORY 3

In Pass 3, three providers have Category 3 projects that are aligned with their Pass 3 Category 1 and Category 2 projects. There are four Category 3 projects in this section:

- One for LifePath Systems: 084001901.3.4 related to 2.3
- One for Texoma Community Center: 084434201.3.7 related to 2.3
- Two for Lakes Regional MHMR: 121988304.3.3 related to 1.2 and 3.4 related to 2.2

**Title of Outcome Measure/Improvement Target:** OD- 10 Quality Of Life/ Functional Status

**Unique RHP Outcome Identification Number:** 084001901.3.4

**Performing Provider Name/TPI:** LifePath Systems TPI: 084001901

### **Outcome Measure Description**

OD- 10 Quality Of Life/ Functional Status; IT-10.1 Quality of Life (Standalone measure)

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 for quality of life, either the AQoL or SFv12.

Rationale/Evidence: Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

Process milestones for the first 6 month of year 2 includes choosing the most appropriate Quality of Life assessment (either AQoL or SFv12), obtaining necessary rights to use the instrument, and establishing procedures for its use. During the second 6 months of year 2, our process milestone is to train all appropriate staff in the utilization of the chosen Quality of Life assessment and to initiate its use. The process milestone for the first 6 months of year 3 is to establish baseline data for the admission scores on the chosen Quality of Life assessment. In the second 6 months of year 3, we plan to demonstrate at least a 10% improvement in Quality of Life scores for the identified population. For Year 4, the outcome improvement target is a 15% improvement in Quality of Life scores. For Year 5, the outcome improvement target is a 20% improvement in Quality of Life scores.

### **Rationale**

The reasons for selecting our identified process milestones and outcome improvement target is that we are not currently using a standardized Quality of Life assessment and we are not currently offering integrated care or whole health peer services. The rationale for this outcome measure includes the fact that many low income individuals are unable to access primary or behavioral health care and could benefit from additional services to assist them with the process of setting and achieving health goals. With the integration of these services, we expect to see an improvement in this population's overall quality of life. However, we must first choose the most appropriate assessment for our population, obtain rights to use the assessment, establish internal procedures for its use, train necessary staff in its use, and initiate use of the assessment. Improvement scores (15% in year 4 and 20% in year 5) are conservative estimates as we have no data to compare these percentages to at this time.

**Outcome Measure Valuation:** The valuation for outcome measures was derived using a cost-effectiveness analysis. Simon et al (2001) found 47.7 additional depression-free days from a collaborative approach, with an established cost savings of \$52 per day. Measuring and reporting this data will result in a community benefit by demonstrating that effective, collaborative treatment can have a dramatic and positive impact on individuals with co-occurring illnesses.

## **Valuing the Peer Support and Training Expansion Program**

Austin Travis County Integral Care (ATCIC) – Travis County; Region 7 – Central Health, Texas Healthcare Transformation and Quality Improvement Program: (Project Number 11-W-00278/6): Brown, Alamgir, and Bohman

Austin Travis County Integral Care proposes to expand their peer training resources and enhance the capacity of peer supports in Region 7. This program meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component's Program Category II Innovation and Redesign goal. The proposed project will implement a multi-component, evidenced based peer support training curriculum that addresses the traditional roles of peer supports in mental health and expands skill sets to help peers and those with whom they work to adapt tobacco-free lifestyles. ATCIC will work collaboratively with Via Hope to add to their current curricula.

The following valuation is aligned with the Demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

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

### **Cost-Utility Analysis**

A search of the scientific literature did not identify any QALY-based studies related to peer support.

### **Cost-effectiveness and Cost Savings**

The closest studies identified were benefit-cost studies. Sari et al. (2008) found the benefit-cost ratio for a peer support program related to preventing adolescent suicide was \$3.71 for each dollar invested. Kuyken et al. (2008), in another peer-support program for prevention of adolescent suicide, found a benefit cost ratio of \$43 for each dollar invested for Native-American youth. The average benefit cost ratio between these two studies is \$23.36. Based on these results, assuming that a peer support model would cost \$50,000 to operate annually, the expected value would be \$1,167,750.

### **Summary and Total Valuation**

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s).

#### References

Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., . . . Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *J Consult Clin Psychol*, 76(6), 966-978.

Sari, N., de Castro, S., Newman, F.L., & Mills, G. (2008). Should we invest in suicide prevention programs? *The Journal of Socio-Economics* 37 (2008), 262–275.

<b>Unique Category 3 Outcome Measure Identifier(s):</b> 084001901.3.4	<b>Outcome Measure (Improvement Target) Reference Number from RHP Planning Protocol: IT-10.1</b>	<b>Outcome Measure (Improvement Target) Title: Quality of Life</b>	
<b>Performing Provider: LifePath Systems</b>			<b>TPI: 084001901</b>
<b>Related Category 1 or 2 Projects:</b>	<b>Unique Category 1 &amp; 2 project identifier(s): 084001901.2.1 and 084001901.2.3</b>		
<b>Starting Point/Baseline:</b>	<i>Baseline is 0% improvement in Quality of Life score as we have not used an assessment in order to establish a baseline</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [ IT-10.1.P-1]:</b> Obtain rights to utilize a Quality of Life assessment (AQoL or SFv12) and establish procedures for use  Data Source: Project documentation  Process Milestone 1 Estimated Incentive Payment (maximum amount): \$0  <b>Process Milestone 2 [ IT-10.1.P-1]:</b> Train staff in utilization of Quality of Life assessment and initiate use  Data Source: Project documentation, Training records  Process Milestone 2 Estimated Incentive Payment (maximum amount): \$0	<b>Process Milestone 3 [ IT-10.1.P-2]:</b> Establish baseline rates for admission scores with the chosen Quality of Life assessment  Data Source: Project Documentation  Process Milestone 3 Estimated Incentive Payment (maximum amount): \$41,087  <b>Outcome Improvement Target 1 [IT-10.1]:</b> Demonstrate improvement in Quality of Life scores  Improvement Target: 10% of population assessed demonstrate improvement in Quality of Life scores  Data Source: Quality of Life assessment scores  Outcome Improvement Target 1 Estimated Incentive Payment: \$41,086	<b>Outcome Improvement Target 2 [IT-10.1]:</b> Demonstrate improvement in Quality of Life scores  Improvement Target: 15% of population assessed demonstrate improvement in Quality of Life scores  Data Source: Quality of Life assessment scores  Outcome Improvement Target 2 Estimated Incentive Payment: \$89,228	<b>Outcome Improvement Target 3 [IT-10.1]:</b> Demonstrate improvement in Quality of Life scores  Improvement Target: 20% of population assessed demonstrate improvement in Quality of Life scores  Data Source: Quality of Life assessment scores  Outcome Improvement Target 3 Estimated Incentive Payment: \$183,720
<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$82,173</b>	<b>Year 4 Estimated Outcome Amount: \$89,228</b>	<b>Year 5 Estimated Outcome Amount: \$183,720</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$355,121</b>			

**Unique RHP Outcome Identification Number:** 084434201.3.7  
**Outcome Measure Title:** OD-10 Quality of Life/Functional Status  
**Provider:** Texoma Community Center/084434201

**Related Category 3 Outcome Measure(s):** OD-10 Quality of Life/Functional Status  
IT-10.1 Quality of life- (standalone measure)

- a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
- b. Data source: Assessment of Quality of Life Tool Data Results
- c. Rationale/Evidence: The Quality of Life/Functional Status Outcome Measure was

selected by TCC in order assess service delivery improvement across all expansion efforts. This is especially true for this project to “Redesign Primary Care” since primary physical care is a new initiative for TCC and will require a close watch on patient outcomes and improvement. TCC recognizes that the success of all TCC projects is dependent upon the accurate, timely and meaningful collection of data, on accurately interpreting the quantifiable effects that the projects are having on patient care and on using the data to improve outcomes. Quality of Life (QOL) and functional status are key elements in assessing project impact results. TCC recognizes symptom improvement and patient functional levels are essential elements of health-related quality of life and improving the patient experience. This Category 3 Outcome Measure will assess those two components, as well as independent living, mental health status, coping abilities, relationship issues, self-worth concepts and sensory experiences in addition to overall happiness. It is recognized that effectively blended health care requires relentless focus on the patient outcomes.

The Quality of Life/Functional Status outcome domain is appropriate for this project because, again, mental/behavioral health is adversely impacted by physical health issues, and vice versa. Both reduce a patient’s ability to function, which adversely affects quality of life issues. Both physical and mental health problems negatively impact a person’s independent living, relationships, sense of self-worth and lead to costly emergency treatment. By focusing on assessment of QOL and functional status, we will be able to determine the efficacy of combining primary care and behavioral health care treatment at one facility. The World Health Organization (WHO) issued a report called “Integrating mental health into primary care: A global perspective” and pointed out that by blending mental health treatment and primary care treatment, patients “avoid indirect costs associated with seeking specialist care in distant locations..... [and] integrating mental health services into primary care generates good health outcomes at reasonable costs.”(4) The research noted above indicates that improved access to primary physical health care while simultaneously providing mental health services will, indeed, help the low-income population served in Grayson County achieve a better quality of life, reduce high dollar hospital costs and achieve a positive patient experience and outcomes.

**Outcome Measure Description:** Outcome Domain Measure “Quality of Life/Functional Status” (OD 10) was selected by Texoma Community Center (TCC) specifically because the related Category 2 Project is designed to enhance “efficiency, access, continuity of care and patient experience.” A Core Component of the related project is for quality improvement and improving patient experience, so assessing these components in the Category Three Project is appropriate. While the interventions selected by TCC are all designed to improve a patient’s access to care, enhance service array and ramp up the quality of care provided to current patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician, redesigning the clinic utilization to further improve access and experience is the goal. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality

Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All TCC projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

**Process Milestones:** The Category 2 process milestones selected for Project 084434201.2.3 are as follows: (1) Implement a patient-centered scheduling model for primary care clinic; (2) Train staff on methods for redesigning clinic to improve efficiency; (3) Review project data weekly and respond with new ideas, practices, tools and solutions; (4) Participate in the face-to-face learning collaborative twice per year with other RHHP providers.

**Outcome Improvement Targets:** The selected Improvement Milestones for Project 084434201.2.3 are as follows: (1) Identify and provide follow-up contact to patients who miss appointments or are overdue for care; (2) Increase the capacity to redesign primary care using innovative project options and these Improvement Targets will be used in DY 4 and DY 5 to improve, expand and enhance primary health care with the behavioral health clinic.

All TCC milestones are designed to ensure effective implementation regardless of the project scope. There are process milestones for hiring appropriate personnel for the tasks, procuring the necessary equipment and service requirements for implementation, and to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

**Rationale:** Hyde reports in a SAMHSA presentation titled “Behavioral Health: Public Health Challenge Public Health Opportunity” that: “One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity.” (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that “69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder” and that “Health care costs [are] higher with co-morbid BH [behavioral health] conditions” which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: “Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses.” She explains that: “Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care...” (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing primary care physician treatment along with psychiatric care, as well as ensuring quality improvements across all projects, will have an overall positive impact on patient functioning in the community and result in a reduction of health costs across the regional area.



The Quality of Life and Functional Status Outcome Measure is the best quantifier for this Local Mental Health Authority to use in assessing impact of the Redesign Primary Care Project and to assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.4, CN.5, CN.6, CN.11)

**Outcome Measure Valuation:** “The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging.” (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects. The benefits of the proposed program are valued based on assigning a monetary value of \$50,000 per life-year gained due to intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a) One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained. (9g) TCC’s Quality Improvement Project increases value by creating an evolving system of continuous quality improvement, which will use rapid and low cost retrieval of electronically stored information, to assess life quality improvements for individuals and continue to “raise the floor” in their improved levels of functioning.

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Utilizing this methodology for the correlated Category 2 Project, the value will be \$3,752,026.00 and the related Category 3 valuation set at \$501,301.00 and benefitting a minimum of 254 target low-income individuals.

Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

Quality improvement for this project will be valuable to the community at large as it continuously reviews service system designs for implementing best practices that reduce costs by applying the right types of supports in the right amounts at the right time.

084434201.3.7	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 2 Projects:	084434201.2.3		
Starting Point/Baseline:	Baseline Data to be determined in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<p>Process Milestone 1: Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$22,399.50</p> <p>Process Milestone 2 [P-2]: Establish baseline TBD Metric: Baseline established Data Source: Plan and resource documentation, AQoL Initial Results Process Milestone 2 Estimated Incentive Payment: \$22,399.50</p>	<p>Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results &amp; assessment results Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Data Source: Documentation of implementation, data collections and AQoL Surveys Process Milestone 3 Estimated Incentive Payment: \$ 51,931.00</p> <p>Outcome Improvement Target 1 [IT-10.1]: Quality of Life Improvement Target: TBD IT-1 Metric: Target established Data Source: AQoL survey results Outcome Improvement Target 1 Estimated Incentive Payment: \$ 51,931.00</p>	<p>Outcome Improvement Target 2 [IT-10.1]: Quality of Life IT-2 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 2 Estimated Incentive Payment: \$111,105.00</p>	<p>Outcome Improvement Target 3 [IT-10.1]: Quality of Life IT-3 Metric: Improved Outcomes Improvement Target: TBD Data Source: AQoL surveys Outcome Improvement Target 3 Estimated Incentive Payment: \$ 241,535.00</p>
<b>Year 2 Estimated Outcome Amount: \$44,799.00</b>	<b>Year 3 Estimated Outcome Amount: \$103,862.00</b>	<b>Year 4 Estimated Outcome Amount: \$111,105.00</b>	<b>Year 5 Estimated Outcome Amount: \$241,535.00</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$ 501,301.00</b>			

**Title of Outcome Measure (Improvement Target):** IT-10.1 Quality of Life (Standalone Measure)  
**Unique RHP Outcome Identification Number:** Lakes Regional MHMR/121988304.3.3

**Outcome Description:**

**\*In DY3,** Process Measure (P-3) Develop and test data systems; Improvement Target-10.1 is to demonstrate 10% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals.

**\*In DY 4,** Improvement Target-10.1 is to demonstrate 10% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals.

**\*In DY 5,** Improvement Target-10.1 is to demonstrate 10% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals;

By the end of the waiver Year 5, our goal is to achieve 10% improvement in QOL scores.

**Rationale:**

Process Milestone P-3 DY3 for Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) Depression / Trauma Counseling Center in Region 18 will involve developing and testing data systems for administration of the QOL validation assessment tool, to ensure accuracy and efficiency in the management and collection of data related to the project. Improvement Targets 10-1 in DY's 4 and 5 will involve administration of the QOL assessment tool to project participants (target population) and determining percentage of improvement in QOL scores. According to the RHP Protocol (page 406), two (2) essential components of health-related quality of life are specific to improvement in symptoms and functioning. The RHP Protocol goes on to say that ". . .the best way to measure symptoms and functional status is by direct patient survey," since. . ."effective quality improvement requires relentless focus on the patient outcomes" (RHP Protocol, p. 406). Measuring improvement in Quality of Life will allow project staff to work collaboratively with the target population to highlight the importance of implementing evidence-based approaches to care that are tailored to the individual's needs. In addition, measuring improvement in QOL status will involve the target population in 1) being accountable for participation in consistent self-monitoring, and 2) exhibiting increased ability to manage challenging behaviors and symptoms, leading to greater quality of life satisfaction. Sharing survey results with other agencies and providers in the region in a semiannual face to face learning collaborative regarding improvement in QOL status for the target population will pave the way for other service providers to make improvements in their own approaches to the provision of health care leading to improved patient outcomes overall. Other providers in the region also will be made aware of the specialty needs of the target population and of efficacious, research-based approaches to provision of care that avert unnecessary placement of these individuals in more restrictive settings. As baseline data is established in DY2 refinement of gross estimates of improvement target yearly percentages is expected through the PDSA process.

**Outcome Measure Valuation - Approach/Methodology:**

The project will implement outcome measure 3-IT-10.1 to measure improvement of Quality of Life (QOL) scores. In keeping with the waiver Program Funding & Mechanics (PFM) Protocol for the DSRIP pool the approach to valuation followed the formula prescribed on page 27 of the document for Non-Hospital Performing Providers for Category 3 allowing DY2 5%, DY3 10%, DY4 10%, and DY5 20%. The Project Coordinator will ensure the protocol as set forth the SF-36 manuals will be followed for administering the QOL measure. This outcome measure will be valued by assessing community needs identified for Region 18 addressed through the RHP Plan, such as the need to address preventable acute care admissions and a need for additional health care providers who can address the specialty needs of the target population in a setting that is accessible. When patients do not have adequate supports and services in the community, they are more likely to utilize the ER and psychiatric hospital settings to manage crises

which escalate due to inability to access the right level of services at the right time. This affects the target populations' overall perception of quality of life factors and leads to a cycle of ineffective coping and inability to manage behaviors in the community. Therefore, supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater QOL satisfaction.

DY3 – Process Milestone (P-3) will involve existing Information Technology and Quality Management staff to select and install data systems for electronic medical record, scheduling and system data collection connected to Lakes Regional MHMR Center (LRMHMRC) parent data system. The pre- and post-application of the survey and analysis of the data per individual will continue through DY5 to inform PDSA cycles.

DY4 – Improvement Target 10.1 is to establish an aggregate 10% improvement over individual entry baseline in QOL scores. Opening of services in DY3 will see the inclusion of the QOL instrument SF-36 at intake and the close of services for each individual participant of the Depression Trauma Counseling Center. Pre and post considered of the same instrument in the individual's data will provide the outcome for each individual as well as across the services rendered. This QOL measure will be repeated for all clients through FY5. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and in other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage challenging behaviors and symptoms in the community.

DY5 – Improvement Target 10.1 to maintain the aggregate 10% improvement in QOL scores. Since average length of stay is anticipated to be 10 weeks the aggregate pool should be substantial: See approach/methodology for IT-10.1 for DY4.

#### **Rationale/Justification:**

##### **Outcome Measure -**

3IT-10.1 Quality of Life. The quality of life measure SP – 36 is a construction of 36 items categorized into eight (8) scales that create two summary measures: Physical Health and Mental Health. It has established validity and the MH scales have been shown to be useful in screening for psychiatric disorders.

**Size** – The project staff will administer QOL surveys, provide monitoring and follow-up and documentation of responses, and collection and maintenance of data on potentially and approximately 100 respondents per year receiving care in the project.

**Project Scope** – The proposed project is projected to demonstrate 10% improvement in Quality of Life factors as measured by a validated assessment tool by DY5 in approximately 100 individuals per year utilizing the services in LRMHMRC RHP18 counties.

**Population Served** – The population targeted to be served are individuals who have depression or trauma related symptoms and do not qualify for State supported services to the SMI population. This includes individuals referred by hospitals, police and other sources due to lack of ability to afford private care.

**Community Benefit and Cost Avoidance** – Improved satisfaction with Quality of Life factors will lead to improved self-management of psychiatric health outcomes, as well as less frequent need for hospital visits

and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area 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” (RHP Protocol, page 398).

**Addressing Priority Community Need** – Currently there is no accessible safety net program in the targeted area to serve the needs of the target population when in crisis, resulting in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals and institutional settings.

The project relates to the Region 18 goal to improve access to behavioral health services (CN.11) and to reduce the preventable acute care admissions (CN.7).

**Related Category 1 and/or 2 projects:** services may be delivered in underserved areas: (Lakes Regional Depression / Trauma Counseling Centers)

121988304.3.3	3.IT-10.1	Quality of Life	
Lakes Regional MHMR Centers			121988304
<b>Related Category 1 or 2 Projects:</b>	<b>Category 1:</b> 121988304.1.2 Expand number of community based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression / Trauma Counseling Centers)		
<b>Starting Point/Baseline:</b>	New Project – Build baseline in DY 2		
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
N/A (starts in DY-3)	<b>Process Milestone 1 [P-3]:</b> Develop and test data systems Determine and install clinical charting software. Determine screening and intake protocols. <b>Data Source:</b> Program records, EMR operational  <b>Process Milestone 1 Estimated Incentive Payment: \$70.752</b>	<b>Outcome Improvement Target 1 [IT-10.1]:</b> Quality of Life <b>Improvement Target:</b> Improvement of 10% in Quality of Life scores as measured by the SP-36 <b>Data Source:</b> EMR, Project reports  <b>Outcome Improvement Target 1 Estimated Incentive Payment: \$75,812</b>	<b>Outcome Improvement Target 1 [IT-10.1]:</b> Quality of Life <b>Improvement Target:</b> Improvement of 10% in Quality of Life scores as measured by the SP-36 <b>Data Source:</b> EMR, Project reports  <b>Outcome Improvement Target 1 Estimated Incentive Payment: \$164,810</b>
<b>Year 2 Estimated Outcome Amount: \$ N/A</b>	<b>Year 3 Estimated Outcome Amount: \$70.752</b>	<b>Year 4 Estimated Outcome Amount: \$75,812</b>	<b>Year 5 Estimated Outcome Amount: \$164,810</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$311,374</b>			

**Performing Provider Name:** Lakes Regional MHMR Center  
**Texas Provider Identifier:** 121988304

**Title of Outcome Measure:** IT-10.1 Quality of Life (Standalone Measure)  
**Unique RHP Outcome Identification Number:** 121988304.3.4

**Outcome Description:** IT-10.1 Quality of Life (Standalone Measure)

\*In DY3, Process Measure (P-3) we will develop and test the data system for administration of validated assessment tool;

\*In DY 4, Improvement Target-10.1 is to demonstrate 10% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals with ASD/IDD;

\*In DY 5, Improvement Target-10.1 is to demonstrate 20% improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for individuals with ASD/IDD;  
By the end of the waiver Year 5, our goal is to achieve 20% improvement in QOL scores.

**Rationale:**

Process Milestone P-3 DY3 will involve developing and testing data systems for administration of the QOL validation assessment tool, to ensure accuracy and efficiency in the management and collection of data related to the project. Improvement Targets 10-1 in DY's 4 and 5 will involve administration of the QOL assessment tool to project participants (target population) and determining percentage of improvement in QOL scores. According to the RHP Protocol (page 406), two essential components of health-related quality of life are specific to improvement in symptoms and functioning. The RHP Protocol goes on to say that ". . .the best way to measure symptoms and functional status is by direct patient survey," since. . ."[e]ffective quality improvement requires relentless focus on the patient outcomes."<sup>20</sup> Measuring improvement in Quality of Life will allow project staff to work collaboratively with the target population to highlight the importance of implementing evidence-based approaches to care that are tailored to the individual's needs. In addition, measuring improvement in QOL status will involve the target population in 1) being accountable for participation in consistent self-monitoring, and 2) exhibiting increased ability to manage challenging behaviors and symptoms, leading to greater quality of life satisfaction.

Sharing survey results with other agencies and providers in the region in a semiannual face to face learning collaborative regarding improvement in QOL status for the target population will pave the way for other service providers to make improvements in their own approaches to the provision of health care, leading to improved patient outcomes overall. Other providers in the region also will be made aware of the specialty needs of the ASD/IDD population and of efficacious, research-based approaches to provision of care that avert unnecessary placement of these individuals in more restrictive settings.

**Outcome Measure Valuation:**

**Approach/Methodology:**

The project will implement outcome measure 3IT-10.1 to measure improvement of Quality of Life (QOL) scores. A part-time QM staff will administer the QOL measure and process/manage the survey results for the project, along with IT staff currently employed by the agency.

This outcome measure will be valued by assessing community needs identified for Region 18 addressed through the RHP Plan, such as the need to address preventable acute care admissions and a need for additional health care providers who can address the specialty needs of the ASD/IDD population in a setting that is accessible. When patients with ASD/IDD do not have adequate supports and services in the

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<sup>20</sup> RHP Protocol, Category 3 Quality Improvements, 406.

community, they are more likely to utilize the ER and psychiatric hospital settings to manage crises related to the inability to manage challenging behaviors. This affects the target populations' overall perception of quality of life factors and leads to a cycle of ineffective coping and inability to manage behaviors in the community.

Therefore, supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater quality of life satisfaction.

DY3 – Process Milestone (P-3) will involve Information Technology staff (already hired by the agency) and Quality Management staff (to be hired at part-time) to develop and test data systems for administration of the validated assessment tool to measure QOL in DY's 4 and 5...

DY4 – Improvement Target 10.1 is to establish 10% improvement in QOL scores. QM staff (part-time) will administer surveys to measure improvement in QOL scores. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and in other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage challenging behaviors and symptoms in the community.

DY5 – Improvement Target 6.1 to establish 20% improvement in QOL scores: See approach/methodology for IT-6.1 for DY4.

**Rationale/Justification: Outcome Measure:** 3IT-10.1 Quality of Life. A process milestone in Year 3 will develop and test data systems for administration of validated assessment tool; improvement targets in DY's 4 and 5 will demonstrate percent improvement in Quality of Life scores, ending Year 5 with a 20% improvement in QOL scores.

**Size** – The project will involve hiring 1 part-time Quality Assurance staff to administer QOL surveys, provide monitoring and follow-up and documentation of responses, and collection and maintenance of data on potentially and approximately 260 respondents receiving care in the project. IT staff for the project are currently hired with the agency.

**Project Scope** – The proposed project is projected to demonstrate 20% improvement in Quality of Life factors as measured by a validated assessment tool by Year 5 in approximately 260 individuals (children and adults) with ASD/IDD in Rockwall County.

**Population Served** – The population targeted to be served are individuals (children and adults) with ASD/IDD (one or both of those diagnoses).

**Community Benefit and Cost Avoidance** – Improved satisfaction with Quality of Life factors will lead to improved self-management of psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area 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.”<sup>21</sup>

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<sup>21</sup> RHP Protocol, Category 3 Quality Improvements, 398.



**Addressing Priority Community Need** – Currently there is no accessible safety net program in the targeted area to serve the needs of the target population when in crisis, resulting in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals and institutional settings.

**Related Category 1 and/or 2 projects:**

121988304.2.2: - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified.(Lakes Regional ASD Program)

121988304.3.4	IT- 10.1	Quality of Life/Functional Status; Demonstrate improvement in quality of life (QOL) scores as measured by evidence based and validated assessment tool, for the target population	
Lakes Regional MHMR Center			121988304
<b>Related Category 1 or 2 Projects::</b>	121988304.2.2: - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified.(Lakes Regional ASD Program)		
<b>Starting Point/Baseline:</b>	Baseline for improvement in Quality of Life (QOL) scores		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
N/A	<b>Process Milestone 1 [P-3]</b> <u>Develop and test data system for administration of validated assessment tool.</u>  <b>Data Source:</b> Data System and planning documentation  <b>Process Milestone 1 Estimated Incentive Payment: \$106,127</b>	<b>Outcome Improvement Target 1</b> [IT-10.1]: Quality of Life  <b>Improvement Target:</b> Demonstrate 10% improvement in QOL scores from baseline..  <b>Data Source:</b> Validated Assessment Tool  <b>Outcome Improvement Target 2</b> Estimated Incentive Payment: <b>\$113,719</b>	<b>Outcome Improvement Target 2</b> [IT-10.1]: Quality of Life  <b>Improvement Target:</b> Demonstrate 20% improvement in QOL scores from DY4.  <b>Data Source:</b> Validated Assessment Tool  <b>Outcome Improvement Target 3</b> Estimated Incentive Payment: <b>\$247,214</b>
<b>Year 2 Estimated Outcome Amount:</b>	<b>Year 3 Estimated Outcome Amount: \$106,127</b>	<b>Year 4 Estimated Outcome Amount: \$113,719</b>	<b>Year 5 Estimated Outcome Amount: \$247,214</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: \$467,060</b>			

## **Category 4: Population-Focused Improvements (Hospitals only)**

In Pass 2 of the process, three hospitals in RHP 18 have submitted Category 4 projects:

Children's Medical Center of Plano

Texoma Medical Center, Grayson County

Centennial Medical Center of Frisco (Pass 2 workbook included these projects: Narrative and metrics tables for Centennial Medical Center were added in Pass 3 document)

## **DOMAIN 1: POTENTIALLY PREVENTABLE ADMISSIONS**

These outcome measures which are pediatric specific relate to the Category 1, Category 2 and Category 3 projects:

**Project 138910807.1.1** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by opening a new MyChildren's location, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to reducing potentially preventable admissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.2** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by extending the operating hours of MyChildren's locations, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to reducing potentially preventable admissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.3** Implement Disease Management Program: By formally identifying and actively managing pediatric patients with chronic disease, potentially preventable admissions in this population should be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.4** Expand Access to Behavioral Health Services: By providing behavioral health services within the medical home setting of MyChildren's, more children will receive coordinated behavioral and medical care. Potentially preventable admissions due to disjointed medical and behavioral care will be avoided. Earlier intervention for behavioral health needs should also reduce potentially avoidable admissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.2.1** Expand Medical Homes: Providing pediatric primary care in a medical home setting will support better coordination of care, integrated primary and preventative care and a more comprehensive and cohesive care delivery system, all of which should lead to reduction in potentially preventable admissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**Projects 138910807.3.1, 138910807.3.2 and 138910807.3.5: OD 3.9.1:** Reduce Inappropriate Emergency Department Visits. By focusing on care delivery in the most appropriate outpatient setting, both inappropriate emergency department visits and potentially preventable admissions should be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**138910807.3.2: OD 3.9.2** Reduce Pediatric and Young Adult Asthma Emergency Department Visits. By focusing on disease management for patients with asthma, there should be a reduction in both emergency department visits as well as potentially preventable admissions with this population of patients. It is

unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.3: OD 3.1.18** Follow-up After a Hospitalization for Mental Illness. By providing primary care and behavioral health care follow-up after a hospitalization for mental illness, future potentially preventable admissions for either subsequent behavioral or medical needs can be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable admissions; however, the information will be monitored over the lifetime of the project.

## **DOMAIN 2: POTENTIALLY PREVENTABLE READMISSIONS – 30 DAYS (7 MEASURES)**

These outcome measures which are pediatric specific relate to the Category 1, Category 2 and Category 3 projects:

**Project 138910807.1.1** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by opening a new MyChildren's location, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to reducing potentially preventable readmissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.2** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by extending the operating hours of MyChildren's locations, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to reducing potentially preventable readmissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.3** Implement Disease Management Program: By formally identifying and actively managing pediatric patients with chronic disease, potentially preventable readmissions in this population should be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.4** Expand Access to Behavioral Health Services: By providing behavioral health services within the medical home setting of MyChildren's, more children will receive coordinated behavioral and medical care. Potentially preventable readmissions due to disjointed medical and behavioral care will be avoided. Earlier intervention for behavioral health needs should also reduce potentially avoidable readmissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.2.1** Expand Medical Homes: Providing pediatric primary care in a medical home setting will support better coordination of care, integrated primary and preventative care and a more comprehensive and cohesive care delivery system, all of which should lead to reduction in potentially preventable readmissions. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Projects 138910807.3.1, 138910807.3.2 and 138910807.3.5: OD 3.9.1:** Reduce Inappropriate Emergency Department Visits. By focusing on care delivery in the most appropriate outpatient setting, both inappropriate emergency department visits and potentially preventable readmissions should be

reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.2: OD 3.9.2 Reduce Pediatric and Young Adult Asthma Emergency Department Visits.** By focusing on disease management for patients with asthma, there should be a reduction in both emergency department visits as well as potentially preventable readmissions with this population of patients. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.3: OD 3.1.18 Follow-up After a Hospitalization for Mental Illness.** By providing primary care and behavioral health care follow-up after a hospitalization for mental illness, future potentially preventable readmissions for either subsequent behavioral or medical needs can be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable readmissions; however, the information will be monitored over the lifetime of the project.

### **DOMAIN 3: POTENTIALLY PREVENTABLE COMPLICATIONS (64 MEASURES)**

These outcome measures which are pediatric specific relate to the Category 1, Category 2 and Category 3 projects:

**Project 138910807.1.1 Expand Pediatric Primary Care:** By providing more pediatric primary care capacity by opening a new MyChildren's location, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to reducing potentially preventable complications. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.2 Expand Pediatric Primary Care:** By providing more pediatric primary care capacity by extending the operating hours of MyChildren's locations, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to reducing potentially preventable complications. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.3 Implement Disease Management Program:** By formally identifying and actively managing pediatric patients with chronic disease, potentially preventable complications in this population should be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.4 Expand Access to Behavioral Health Services:** By providing behavioral health services within the medical home setting of MyChildren's, more children will receive coordinated behavioral and medical care. Potentially preventable complications due to disjointed medical and behavioral care will be avoided. Earlier intervention for behavioral health needs should also reduce potentially avoidable complications. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**Project 138910807.2.1 Expand Medical Homes:** Providing pediatric primary care in a medical home setting will support better coordination of care, integrated primary and preventative care and a more comprehensive and cohesive care delivery system, all of which should lead to reduction in potentially preventable complications. It is unknown at this time the specific impact this project will have in

reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**Projects 138910807.3.1, 138910807.3.2 and 138910807.3.5: OD 3.9.1:** Reduce Inappropriate Emergency Department Visits. By focusing on care delivery in the most appropriate outpatient setting, both inappropriate emergency department visits and potentially preventable complications should be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**138910807.3.2: OD 3.9.2** Reduce Pediatric and Young Adult Asthma Emergency Department Visits. By focusing on disease management for patients with asthma, there should be a reduction in both emergency department visits as well as potentially preventable complications with this population of patients. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.3: OD 3.1.18** Follow-up After a Hospitalization for Mental Illness. By providing primary care and behavioral health care follow-up after a hospitalization for mental illness, future potentially preventable complications for either subsequent behavioral or medical needs can be reduced. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project.

#### **DOMAIN 4: PATIENT-CENTERED HEALTHCARE (2 MEASURES)**

These outcome measures which are pediatric specific relate to the Category 1, Category 2 and Category 3 projects:

**Project 138910807.1.1** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by opening a new MyChildren's location, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to improving patient-centered healthcare measures. It is unknown at this time the specific impact this project will have in improving patient-centered healthcare measures however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.2** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by extending the operating hours of MyChildren's locations, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to improving patient-centered healthcare measures. It is unknown at this time the specific impact this project will have in reducing potentially preventable complications; however, the information will be monitored over the lifetime of the project

**Project 138910807.1.3** Implement Disease Management Program: By formally identifying and actively managing pediatric patients with chronic disease, patient-centered healthcare measures in this population should improve. It is unknown at this time the specific impact this project will have in improving patient-centered healthcare measures; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.4** Expand Access to Behavioral Health Services: By providing behavioral health services within the medical home setting of MyChildren's, more children will receive coordinated behavioral and medical care. Reductions patient-centered healthcare measures due to disjointed medical and behavioral care will be avoided. Earlier intervention for behavioral health needs should also improve patient-centered healthcare measures. It is unknown at this time the specific impact this project will have

in improving patient-centered healthcare measures; however, the information will be monitored over the lifetime of the project.

**Project 138910807.2.1** Expand Medical Homes: Providing pediatric primary care in a medical home setting will support better coordination of care, integrated primary and preventative care and a more comprehensive and cohesive care delivery system all of which should lead to improving patient-centered healthcare measures. It is unknown at this time the specific impact this project will have in improving patient-centered healthcare measures; however, the information will be monitored over the lifetime of the project.

**Projects 138910807.3.1, 138910807.3.2 and 138910807.3.5: OD 3.9.1:** Reduce Inappropriate Emergency Department Visits. By focusing on care delivery in the most appropriate outpatient setting, patient-centered healthcare measures should improve. It is unknown at this time the specific impact this project will have in improving patient-centered healthcare measures; however, the information will be monitored over the lifetime of the project

**138910807.3.2: OD 3.9.2** Reduce Pediatric and Young Adult Asthma Emergency Department Visits. By focusing on disease management for patients with asthma, there should be a reduction in both emergency department visits as well as improvement in patient-centered healthcare measures with this population of patients. It is unknown at this time the specific impact this project will have in improving patient-centered healthcare measures; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.3: OD 3.1.18** Follow-up After a Hospitalization for Mental Illness. By providing primary care and behavioral health care follow-up after a hospitalization for mental illness, patient-centered healthcare measures should improve. It is unknown at this time the specific impact this project will have in improving patient-centered healthcare measures; however, the information will be monitored over the lifetime of the project.

## **DOMAIN 5: EMERGENCY DEPARTMENT (1 MEASURE)**

These outcome measures which are pediatric specific relate to the Category 1, Category 2 and Category 3 projects:

**Project 138910807.1.1** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by opening a new MyChildren's location, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to improving emergency department efficiency. It is unknown at this time the specific impact this project will have in improving emergency department efficiency however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.2** Expand Pediatric Primary Care: By providing more pediatric primary care capacity by extending the operating hours of MyChildren's locations, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to improving emergency department efficiency. It is unknown at this time the specific impact this project will have in emergency department efficiency; however, the information will be monitored over the lifetime of the project

**Project 138910807.1.3** Implement Disease Management Program: By formally identifying and actively managing pediatric patients with chronic disease, emergency department efficiency in this population should improve. It is unknown at this time the specific impact this project will have in to improving



emergency department efficiency; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.4 Expand Access to Behavioral Health Services:** By providing behavioral health services within the medical home setting of MyChildren's, more children will receive coordinated behavioral and medical care. Overall efficiency in emergency departments should increase as patients with behavioral health concerns in an emergency department are a stress to operations of the department. It is unknown at this time the specific impact this project will have in to improving emergency department efficiency; however, the information will be monitored over the lifetime of the project.

**Project 138910807.2.1 Expand Medical Homes:** Providing pediatric primary care in a medical home setting will support better coordination of care, integrated primary and preventative care and a more comprehensive and cohesive care delivery system, all of which should lead to improving emergency department efficiency. It is unknown at this time the specific impact this project will have in improving emergency department efficiency; however, the information will be monitored over the lifetime of the project.

**Projects 138910807.3.1, 138910807.3.2 and 138910807.3.5: OD 3.9.1:** Reduce Inappropriate Emergency Department Visits. By focusing on care delivery in the most appropriate outpatient setting, emergency department efficiency should improve. It is unknown at this time the specific impact this project will have in improving emergency department efficiency; however, the information will be monitored over the lifetime of the project

**138910807.3.2: OD 3.9.2** Reduce Pediatric and Young Adult Asthma Emergency Department Visits. By focusing on disease management for patients with asthma, there should be a reduction in both emergency department visits as well as improvement in emergency department efficiency with this population of patients. It is unknown at this time the specific impact this project will have in improving emergency department efficiency; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.3: OD 3.1.18** Follow-up After a Hospitalization for Mental Illness. By providing primary care and behavioral health care follow-up after a hospitalization for mental illness, repeat emergency department visits can be avoided. Overall efficiency in emergency departments should increase as patients with behavioral health concerns in an emergency department are a stress to operations of the department. It is unknown at this time the specific impact this project will have in to improving emergency department efficiency; however, the information will be monitored over the lifetime of the project.

## **OPTIONAL DOMAIN 6: CHILDREN AND ADULT CORE MEASURES (8 MEASURES)**

These outcome measures which are pediatric specific relate to the Category 1, Category 2 and Category 3 projects:

**Project 138910807.1.1 Expand Pediatric Primary Care:** By providing more pediatric primary care capacity by opening a new MyChildren's location, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to improving Children and Adult Core Measures. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.2 Expand Pediatric Primary Care:** By providing more pediatric primary care capacity by extending the operating hours of MyChildren's locations, more children will have access to care earlier in a disease process and access to preventive and primary care which can all contribute to

improving Children and Adult Core Measures. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project

**Project 138910807.1.3 Implement Disease Management Program:** By formally identifying and actively managing pediatric patients with chronic disease, Children and Adult Core Measures in this population should improve. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project.

**Project 138910807.1.4 Expand Access to Behavioral Health Services:** By providing behavioral health services within the medical home setting of MyChildren's, more children will receive coordinated behavioral and medical care. Children and Adult Core Measures should increase. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project.

**Project 138910807.2.1 Expand Medical Homes:** Providing pediatric primary care in a medical home setting will support better coordination of care, integrated primary and preventative care and a more comprehensive and cohesive care delivery system all of which should lead to improving Children and Adult Core Measures. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project.

**Projects 138910807.3.1, 138910807.3.2 and 138910807.3.5: OD 3.9.1: Reduce Inappropriate Emergency Department Visits.** By focusing on care delivery in the most appropriate outpatient setting, Children and Adult Core Measures should improve. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project

**138910807.3.2: OD 3.9.2 Reduce Pediatric and Young Adult Asthma Emergency Department Visits.** By focusing on disease management for patients with asthma, there should be a reduction in both emergency department visits as well as improvement in Children and Adult Core Measures with this population of patients. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project.

**Project 138910807.3.3: OD 3.1.18 Follow-up After a Hospitalization for Mental Illness.** By providing primary care and behavioral health care follow-up after a hospitalization for mental illness, better coordination of care should occur. Children and Adult Core Measures should improve as coordination of care improves. It is unknown at this time the specific impact this project will have in improving Children and Adult Core Measures; however, the information will be monitored over the lifetime of the project.

**Domain Valuation:** Each domain was given equal value based on size factor, project scope, populations served, community benefit, cost avoidance and addressing priority community need.

<b>Category 4: Population-Focused Measures</b> <i>Children's Medical Center 138910807</i>				
	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$295,270	\$171,128		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		\$171,128	\$183,068	\$198,986
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		\$171,128	\$183,068	\$198,986
<b>Domain 3: Potentially Preventable Complications (PPCs)</b> Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			\$183,068	\$198,986
<b>Domain 4: Patient Centered Healthcare</b>				
<b><i>Patient Satisfaction - HCAHPS</i></b>				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
<b><i>Medication Management</i></b>				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		\$171,128	\$183,068	\$198,986
<b>Domain 5: Emergency Department</b>				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		\$171,128	\$183,068	\$198,986
<b>OPTIONAL Domain 6: Children and Adult Core Measures</b>				

<b><i>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</i></b>				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
<b><i>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</i></b>				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 6 - Estimated Maximum Incentive Amount		\$171,128	\$183,068	\$198,986
<b>Grand Total Payments Across Category 4</b>	<b>\$295,270</b>	<b>\$1,026,770</b>	<b>\$1,098,405</b>	<b>\$1,193,919</b>

**DOMAINS: ALL**

All Category 4 Domains, including the optional Domain, are areas where the local hospitals should see improvements based upon the success of the urgent care center to meet and achieve its Category 1 and Category 3 metrics. An underlying purpose of creating the urgent care center is to make sure patients are seen in the most appropriate setting as efficiently as possible. Preventable admissions, complications, and readmissions congested area hospitals making it more challenging to see patients efficiently and in the appropriate care setting. The area of greatest impact is the Emergency Room. To date, the Texoma Medical Center (TMC) Emergency Room has seen a 13% increase in visits compared to last year (2011). Admissions as a percent of visits has decreased proportionally indicating that the greatest rise in visits have been from patients that may be able to seek services in a lower acute set setting. The increase in outpatient visits creates a situation where patients who need inpatient acute services may not be able to be treated as quickly as possible due to the share numbers needing medical attention. In regards to HCAHPS and Core Measures, hospitals are now subject to pay for performance from CMS. Reimbursement will be tied to these scores either positively or negatively. In order for hospitals to provide care accordingly, high quality and efficient care is a must. The success of the urgent care center is vitally important to give the hospitals the time and resources needed succeed with the new pay for performance metrics.

**Domain 1: Potentially Preventable Admissions (8 measures)**

*Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:*

Our Category 1 project (Expand Primary Care) to establish an urgent care center to serve the uninsured, underinsured, and indigent members of the community should impact potentially preventable admissions at the performing provider's hospital and other area hospitals. This project is being undertaken to provide the most appropriate access to healthcare services and multiple domains will be positively impacted by the project. The area Emergency Departments should see a decrease in non-emergency visits. In 2012 three area urgent care centers that closed their doors. The patients traditionally seen in these centers have strained the resources of the area Emergency Departments. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens.

*Valuation and Rationale:*

	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>Total DY3-5</b>
<b>Total Value</b>	\$100,000	\$150,000	\$150,000	\$400,000

Domains were valued at the maximum incentive amounts for each year. This is due to the incremental staff that will need to be hired, at both the urgent care center and the performing provider hospitals, in order to put systems in place to collect and monitor the necessary data.

*System Changes Necessary to Successfully Report Category 4:*

Most processes are in place to gather the raw data required for reporting in each domain. Personnel will be added to our health system to collect, extract, and monitor the required Category 4 data.

**Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)**

*Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:*

Our Category 1 project (Expand Primary Care) to establish an urgent care center to serve the uninsured, underinsured, and indigent members of the community should impact potentially preventable admissions at the performing provider's hospital and other area hospitals. This project is being undertaken to provide

the most appropriate access to healthcare services and multiple domains will be positively impacted by the project. The area Emergency Departments should see a decrease in non-emergency visits. In 2012 three area urgent care centers that closed their doors. The patients traditionally seen in these centers have strained the resources of the area Emergency Departments. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens.

Valuation and Rationale:

	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>Total DY3-5</b>
<b>Total Value</b>	\$50,000	\$55,000	\$55,000	\$160,000

The valuations were calculated the same for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:

Necessary system changes are the same for all domains. Most processes are in place to gather the raw data required for reporting in each domain. Personnel will be added to our health system to collect, extract, and monitor the required Category 4 data.

**Domain 3: Potentially Preventable Complications (64 measures)**

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Our Category 1 project (Expand Primary Care) to establish an urgent care center to serve the uninsured, underinsured, and indigent members of the community should impact potentially preventable complications at the performing provider's hospital and other area hospitals. This project is being undertaken to provide the most appropriate access to healthcare services and multiple domains will be positively impacted by the project. The area Emergency Departments should see a decrease in non-emergency visits. In 2012 three area urgent care centers that closed their doors. The patients traditionally seen in these centers have strained the resources of the area Emergency Departments. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens.

The data will be supplied by HHSC. As this is data that TMC currently collects, no change in practice is needed and all protocols will be met.

Valuation and Rationale:

	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>Total DY3-5</b>
<b>Total Value</b>	\$0	\$100,000	\$140,000	\$240,000

The valuations were calculated the same for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:

Necessary system changes are the same for all domains. Most processes are in place to gather the raw data required for reporting in each domain. Personnel will be added to our health system to collect, extract, and monitor the required Category 4 data.

**Domain 4: Patient Centered Healthcare**

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Our Category 1 project (Expand Primary Care) to establish an urgent care center to serve the uninsured, underinsured, and indigent members of the community should impact potentially patient centered health care metrics of patient satisfaction and medication management at the performing provider's hospital and other area hospitals. This project is being undertaken to provide the most appropriate access to healthcare

services and multiple domains will be positively impacted by the project. The area Emergency Departments should see a decrease in non-emergency visits. In 2012 three area urgent care centers that closed their doors. The patients traditionally seen in these centers have strained the resources of the area Emergency Departments. The increase in patient volume had the potential to cause dissatisfaction among patients. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens.

The data will be provided by the Performing Provider and TMC will rely on its 3<sup>rd</sup> party vendor, Press Ganey, to supply all HCAHPS responses to CMS.

Valuation and Rationale:

	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>Total DY3-5</b>
<b>Total Value</b>	\$200,000	\$200,000	\$230,000	\$630,000

The valuations were calculated the same for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:

Necessary system changes are the same for all domains. Most processes are in place to gather the raw data required for reporting in each domain. Personnel will be added to our health system to collect, extract, and monitor the required Category 4 data.

**Domain 5: Emergency Department**

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Our Category 1 project (Expand Primary Care) to establish an urgent care center to serve the uninsured, underinsured, and indigent members of the community should impact the emergency department at the performing provider's hospital and other area hospitals. This project is being undertaken to provide the most appropriate access to healthcare services and multiple domains will be positively impacted by the project. The area Emergency Departments should see a decrease in non-emergency visits. In 2012 three area urgent care centers that closed their doors. The patients traditionally seen in these centers have strained the resources of the area Emergency Departments. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens.

Valuation and Rationale:

	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>Total DY3-5</b>
<b>Total Value</b>	\$30,000	\$75,000	\$100,000	\$205,000

The valuations were calculated the same for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:

Necessary system changes are the same for all domains. Most processes are in place to gather the raw data required for reporting in each domain. Personnel will be added to our health system to collect, extract, and monitor the required Category 4 data.

**Domain 6: Adult/Child Core set of Health Care Quality Measures**

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Our Category 1 project (Expand Primary Care) to establish an urgent care center to serve the uninsured, underinsured, and indigent members of the community should impact the adult/child core set of health care quality measures at the performing provider's hospital and other area hospitals. This project is being

undertaken to provide the most appropriate access to healthcare services and multiple domains will be positively impacted by the project. The area Emergency Departments should see a decrease in non-emergency visits. In 2012 three area urgent care centers that closed their doors. The patients traditionally seen in these centers have strained the resources of the area Emergency Departments. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens.

Valuation and Rationale:

	<b>DY3</b>	<b>DY4</b>	<b>DY5</b>	<b>Total DY3-5</b>
<b>Total Value</b>	\$30,000	\$60,000	\$90,000	\$180,000

The valuations were calculated the same for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:

Necessary system changes are the same for all domains. Most processes are in place to gather the raw data required for reporting in each domain. Personnel will be added to our health system to collect, extract, and monitor the required Category 4 data.



<b>Category 4: Population-Focused Measures</b> <i>Texoma Medical Center/194997601</i>				
	<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$100,000	\$570,000		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		\$100,000	\$150,000	\$150,000
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		\$50,000	\$55,000	\$55,000
<b>Domain 3: Potentially Preventable Complications (PPCs)</b> Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			\$100,000	\$140,000
<b>Domain 4: Patient Centered Healthcare</b>				
<b><i>Patient Satisfaction - HCAHPS</i></b>				
Measurement period for report		1/1/2013-12/31/2013	1/1/2014-12/31/2014	1/1/2015-12/31/2015
Planned Reporting Period: 1 or 2				
<b><i>Medication Management</i></b>				
Measurement period for report		1/1/2013-12/31/2013		
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		\$200,000	\$200,000	\$230,000
<b>Domain 5: Emergency Department</b>				
Measurement period for report		1/1/2013-12/31/2013	1/1/2014-12/31/2014	1/1/2015-12/31/2015

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		\$30,000	\$75,000	\$100,000
<b>OPTIONAL Domain 6: Children and Adult Core Measures</b>				
<i>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</i>				
Measurement period for report		1/1/2013-12/31/2013	1/1/2014-12/31/2014	1/1/2015-12/31/2015
Planned Reporting Period: 1 or 2		2	2	2
<i>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</i>				
Measurement period for report		1/1/2013-12/31/2013	1/1/2014-12/31/2014	1/1/2015-12/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 6 - Estimated Maximum Incentive Amount		\$30,000	\$60,000	\$90,000
<b>Grand Total Payments Across Category 4</b>	<b>\$100,000</b>	<b>\$570,000</b>	<b>\$640,000</b>	<b>\$765,000</b>

**Performing Provider Name:** Centennial Medical Center/169553801

**Domain 1:** Potentially Preventable Admissions (8 measures)

**Description** – Centennial 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 (PPAs), which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Centennial expects that its provision of expanded primary care services under its Category 1 project will reduce the number of PPAs over the life of the Waiver. Patients with chronic diseases may also be aided in being better able to engage in self-management goals and activities of daily living through Centennial’s work with other primary care providers.

**Valuation**

**Rationale/Justification** – The value Centennial placed on this domain is based on 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 North Texas will have a beneficial impact on individual patient outcomes and reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Centennial intends to address with its Category 1 projects to expand access to primary care and specialty care. Centennial values this reporting domain at \$30,699 over Demonstration Years 3-5.

**Domain 2:** Potentially Preventable Readmissions – 30 days (7 measures)

**Description** – Centennial 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. Centennial expects that its provision of expanded primary care services through local clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Expanded access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

**Valuation**

**Rationale/Justification** - The value Centennial 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 RHP Region 18 will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Centennial values this reporting domain at \$28,567 over Demonstration Years 3-5.

**Domain 3:** Potentially Preventable Complications (64 measures)

**Description** – Centennial 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 Centennial is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Centennial expects that its Category 1 project to expand access to primary care will reduce the strain on hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Centennial can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Centennial's Category 1 and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

### **Valuation**

**Rationale/Justification** - The value Centennial 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. Centennial values this reporting domain at \$30,000 over Demonstration Years 3-5.

### **Domain 4: Patient-Centered Healthcare (2 measures)**

**Description** – Centennial 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. Centennial 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. Centennial expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Centennial's Category 1 project to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

### **Valuation**

**Rationale/Justification** - The value Centennial placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Centennial and how well Centennial performs its function of promoting medication management. Centennial 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 North Texas is costly to patients' health and to the delivery system, and Centennial 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. Centennial values this reporting domain at \$6,000 over Demonstration Years 3-5.

### **Domain 5: Emergency Department (1 measure)**

**Description** – Centennial 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. The patients may experience poor health outcomes as a result of delays in evaluation and lengthy waits that may lead to the patient leaving without being seen. Centennial is committed to reducing its ED admitting decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Centennial intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which Centennial expects will reduce the number of inappropriate ED visits.

### **Valuation**

**Rationale/Justification** - The value Centennial 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, failure to be seen, 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. Centennial values this reporting domain at \$5,380 over Demonstration Years 3-5.

### **Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures**

**Description** – Centennial will report on core sets of Health Quality Measures for Medicaid-Eligible Adults and for Children in Medicaid and CHIP. Centennial’s Category 1 project is expected to impact the adult/child core set of health care quality measures at the performing provider’s hospital and in the Region.

### **Valuation**

**Rationale/Justification** – The value Centennial placed on this domain is based on efforts to provide the most appropriate access to healthcare services, which should assist in reduced non-emergency visits in area Emergency Departments. This project will assist in creating the appropriate access points and ensure efficient and quality care for all county area citizens. Several NCQA measures in the Medicaid-Eligible results, including controlling high blood pressure, comprehensive diabetes care, annual HIV/AIDs Medical visits, and comprehensive diabetes care are all directly in the Category 1 and 3 projects affiliated with this Domain. Centennial values this reporting domain at \$4,500 over Demonstration Years 3-5.

<b>Category 4: Population-Focused Measures</b> <b>Centennial Medical Center – TPI: 169553801</b>				
	<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$8,100	\$8,752		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2		1	1	1
<b>Domain 1 - Estimated Maximum Incentive Amount</b>		\$8,000	\$10,000	\$12,699
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2		1	1	1
<b>Domain 2 - Estimated Maximum Incentive Amount</b>		\$8,000	\$10,000	\$10,567
<b>Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.</b>				
Planned Reporting Period: 1 or 2			1	1
<b>Domain 3 - Estimated Maximum Incentive Amount</b>			\$14,000	\$16,000
<b>Domain 4: Patient Centered Healthcare</b>				
<b><i>Patient Satisfaction – HCAHPS</i></b>				
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
<b><i>Medication Management</i></b>				
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
<b>Domain 4 - Estimated Maximum Incentive Amount</b>		\$4,000	\$1,000	\$1,000
<b>Domain 5: Emergency Department</b>				
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
<b>Domain 5 - Estimated Maximum Incentive Amount</b>		\$1,500	\$2,880	\$1,000
<b>OPTIONAL Domain 6: Children and Adult Core Measures</b>				
<i>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</i>				
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
<i>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</i>				
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
<b>Domain 6 - Estimated Maximum Incentive Amount</b>		\$1,500	\$2,000	\$1,000
<b>Grand Total Payments Across Category 4</b>	<b>\$8,100</b>	<b>\$31,752</b>	<b>\$39,880</b>	<b>\$42,266</b>

## **Section VI. RHP Participation Certifications**

Each RHP participant that will be providing State match or receiving pool payments has signed the required certification.

**These 11 participation certification documents are provided as a SEPARATE portable document format (pdf) file labeled RHP 18 Texas Healthcare Transformation and Quality Improvement Program: Section VI and Addenda.**



**Section VII. Addenda (pdf) files as part of RHP 18 Texas Healthcare Transformation and Quality Improvement Program: Section VI and Addenda (110 pages)**

1. Private Hospital Certifications, and Letters of Affiliation
2. Required letters of support/endorsement
3. Release of funds letters
4. Community Needs Assessment Maps  
and Plan Development Process Activities
5. References (additional to those reflected in each project)
6. Valuation information